NAMI Vermont
National Alliance on Mental Illness

NATIONAL ALLIANCE ON MENTAL ILLNESS OF VERMONT

THE NAMI VERMONT RESOURCE GUIDEBOOK

SEVENTH EDITION – 2015-16

Who We Are:

The National Alliance on Mental Illness of Vermont, Inc. (NAMI Vermont) is a statewide volunteer organization comprised of family members, friends, and individuals living with a mental illness. We have experienced the struggles and have joined together in membership to help ourselves and others by providing support, information, education and advocacy.

"This We Believe" – NAMI Vermont Statement of Principles and Values:

as adopted by Board of Directors, November 17, 2007

- *We believe* that bipolar disorder, schizophrenia, major depression and other serious mental health conditions are neurobiological-based illnesses that interfere with normal brain chemistry, and one's ability to think, feel, function and relate to others. Genetic factors may create a predisposition in some people, and life stresses (including trauma) may trigger the onset of symptoms.
- *We believe*, regardless of diagnosis, in the promise of recovery. With treatment and support, people can and do get better.
- *We believe* treatment and the recovery process are multi-dimensional. It may include access to some of the following: group and individual counseling, residential and hospital treatment, healthy exercise and nutritional choices, support from family members, friends and peers, access to supported work and housing, and the use of medications. Each individual with mental illness must find the unique mix that works best for them.
- *We believe* support and education about mental illness for family members, providers and peers is the key to reducing isolation, building connections and improving outcomes for individuals with serious mental illness and their family members.
- *We believe* stigma about mental illness will only be eradicated through consistent, effective outreach and improved public awareness that spotlights individual successes and positive outcomes. We understand shame and stigma about mental illness discourages individuals from getting help, and remains a key barrier to winning public support for improving our mental health system of care.

We believe advocacy for a better system of mental health care is more effective when peers, family members and providers work together. Divided, we will surely fail. Together, there is *no limit* to what we can accomplish.

NAMI Vermont Resource Guidebook

Table of Contents

FOREWORD 1
INTRODUCTION 2
Goal Of This Resource Guidebook 2
About NAMI 2
About NAMI Vermont 3
WHAT IS MENTAL ILLNESS? 3
Numbers of Americans Affected by Mental Illness 3
The Impact of Mental Illness in America 4
Symptoms of Mental Illness 5
Common Myths About Mental Illness 6
THE MAJOR MENTAL ILLNESSES 7
Schizophrenia 7
Bipolar Disorder 8
Depression 10
Schizoaffective Disorder 11
Anxiety Disorders 13
Panic Disorder 14
Post Traumatic Stress Disorder 16
Obsessive Compulsive Disorder 17
Borderline Personality Disorder 19
Dual Diagnosis: Mental Illness and Substance Abuse 21
Getting Help for Substance Abuse 23
Mental Illness and Developmental Disabilities 24
Serious Disorders of Children and Adolescents 24
HOW ARE MENTAL ILLNESSES TREATED? 25
Medications 26
Antipsychotic Medications 27
Atypical Antipsychotic Medications 28
Mood Stabilizer Medications 29
Antidepressant Medications 30
Anti-Anxiety Medications 31
Access To Health Care and Reduced-Cost Medications 31
Psychosocial Treatments 33
Peer Services and Supports 35
Team Approach in Treatment and Recovery 36
Recovery 37
COPING WITH MENTAL ILLNESS 40
The Family Perspective 40
Impact on the Family: A Parent's Thoughts 41
Adjustment, Coping and Family Support 42

Advice from Family Members: What Works 42
NAMI VERMONT PROGRAMS THAT CAN HELP 44
Family-to-Family Education Course 44
Mental Illness and Recovery Workshop 44
Provider Education Course 45
NAMI Family Support Group Program 45
NAMI Connection: Recovery Support Group Program 46
Annual Conference 46
Toll-Free Information and Referral Line 47
Lending Library 47
Advocacy 47
PREPARING FOR A CRISIS 48
Guidelines 48
Psychiatric Advance Directives 50
Suicide Prevention 51
HOSPITALIZATION 53
Voluntary Hospitalization 53
Involuntary Hospitalization and Commitment 54
Emergency Evaluation 55
Commitment Hearing 57
Involuntary Medication 57
During Hospitalization 58
After the Hospital 60
Alternatives to Hospitalization 60
COMMUNITY SERVICES IN VERMONT 60
Crisis Services 61
Assessment and Treatment 61
Treatment by a Psychiatrist 62
Outpatient Counseling / Therapy 62
Case Management 63
Residential Services 63
Peer Recovery Programs 64
Vocational Services 64
FINANCIAL CONSIDERATIONS 65
Federal Programs: SSDI, SSI, Medicaid and Medicare 65
SSDI (Social Security Disability Insurance) 65
SSI (Supplementary Security Income) 65
Medicaid and Medicare 67
Getting Help with Employment and Benefits 67
STATE PROGRAMS AND BENEFITS 69
Vermont Department of Mental Health 69
Guardianship and Protective Services 71
Wills and Estate Planning 73
Other Community Resources 73

Housing 73
Criminal Justice System 76
IF/WHEN THINGS GO WRONG 77
What To Do / Who To Call 77
Formal Grievances 78
Americans with Disabilities Act (ADA) 78
APPENDICES 80
APPENDIX A 80
Mental Health Crisis Hotlines – available 24/7 80
APPENDIX B 81
Vermont Community Mental Health Agencies 81
APPENDIX C 86
Other Mental Health Treatment Providers and Resources 86
Hospitals in Vermont with Psychiatric Inpatient Units 86
Other Psychiatric Inpatient Hospitals In and Nearby Vermont 86
Private Residential Treatment Programs in Vermont 86
Intensive Residential 86
Crisis Beds 87
APPENDIX D 88
Other Local/State Agencies, Departments and Organizations 88
Other Public and Private Agencies: 88
State and National Political Representatives 89
APPENDIX E 89
Vermont Coalition of Clinics for the Uninsured 89
Clinics Around the State 89
Other Clinics: 89
APPENDIX F 90
Vocational Rehabilitation Offices 90
APPENDIX G 91
Other Local and State Resources 91
Peer Support Resources: 91
Peer Support Lines and 91
Drop-In Peer Support Centers 91
Co-Occurring Resources: 92
Vermont Recovery Center Network: 92
Resources for Military Veterans and their Families: 93
APPENDIX H 94
Recommended Reading 94
Become a Member of NAMI Vermont 96

FOREWORD

Families coping with the mental illness of a loved one need information. Sometimes that need is unexpected and immediate. Questions never before considered become important. New questions arise from unforeseen circumstances. There are usually answers to these questions. Yet the search for these answers may require more energy and persistence than a family in crisis can muster.

This Resource Guidebook aims to provide practical answers to relevant and important questions for family members. It begins with basic information about the major mental illnesses and their treatment. Such information should enable you to have more productive discussions with service providers and your loved one. The Guidebook also provides information to help people negotiate the systems that treat, support, protect and encourage individuals who have a mental illness.

We apologize in advance for any errors and omissions such a publication will inevitably have. Please bring them to our attention so that we may correct them in future printings and editions. To comment or for more information, contact:

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As a volunteer organization, NAMI Vermont could use your help!
If you are interested in learning about
current volunteer opportunities, give us a call today.
(802) 876-7949 or (800) 639-6480 (toll-free)

INTRODUCTION

GOAL OF THIS RESOURCE GUIDEBOOK

Mental illnesses are devastating, not only on those who are ill, but also to the family members and friends who love and care about them. There is the initial shock, followed by a flood of questions. Why him or her? Why me? What went wrong? Why is this happening now? What did we do? What didn't we do? What can we do? People feel overwhelmed and confused, and experience strong feelings of anger, grief and guilt. The search for effective care can be expensive and bewildering.

Those of us in NAMI (the National Alliance on Mental Illness) can empathize with your experience because one of our loved ones, or we, ourselves, have lived experience with mental illness. We have struggled mightily, learned a great deal, and found some answers. We want to pass on this knowledge to you so that your path, difficult as it is, may be a bit smoother.

The language describing the experience of living with mental illness or mental health challenges is constantly evolving. In this Guidebook, we use the word 'peer' to refer to a person who has in the past or who is now experiencing symptoms of mental illness.

ABOUT NAMI

In 1979, a few family members of individuals with a mental illness began meeting in each other's homes to share their frustration and pain. They soon realized they were not alone, and vowed to work for more effective treatment and care. Since these first meetings in 1979, the National Alliance on Mental Illness (NAMI) has become the nation's most vocal grassroots, self-help and family advocacy organization dedicated to improving the lives of people with severe mental illnesses such as schizophrenia, bipolar disorder, post-traumatic stress disorder, major depression, borderline personality disorder, obsessive-compulsive disorder, and panic disorder.

NAMI is built on four cornerstones: support, education, advocacy and research. With over 200,000 members nationwide, and over 1,200 local and state affiliates, NAMI members work tirelessly to support and educate families and peers, end stigma and discrimination, and advocate for effective treatment and better services for those affected by mental illness. NAMI also supports increased funding for research leading to an understanding of the causes of mental illness and their eventual cures.

The national office of NAMI can be reached at:

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3803 North Fairfax Drive, Suite 100, Arlington, VA 22203
(703) 524-7600 • Helpline (800) 950-6264 • www.nami.org

ABOUT NAMI VERMONT

NAMI Vermont was founded in Burlington in 1983 by three visionary individuals: Rochford Thibodeau, Priscilla Welsh and Rita Hunt, their families, and the families of others. In 1984, it incorporated as a state affiliate of the National Alliance on Mental Illness (NAMI). NAMI Vermont has a Board of Directors and support groups for families and peers throughout the state. Professional staff works out of the central office in Williston. Through the work of its extensive network of volunteers and staff, NAMI Vermont provides family and peer support groups, educational classes for family members, peers, and providers, a statewide toll-free Helpline offering information and referral to mental health services, and advocates for improvements in the mental health system of care.

NAMI Vermont can be reached at:

600 Blair Park Road, Suite 301 – Williston, VT 05495
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Website: www.namivt.org ◆ Email: info@namivt.org

WHAT IS MENTAL ILLNESS?

NAMI has identified mental illness as a medical condition that disrupts a person's thinking, feeling, mood, ability to relate to others and daily functioning. Just as diabetes is a disorder of the pancreas, mental illnesses are medical conditions that often result in a diminished capacity for coping with the ordinary demands of life.

Serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, posttraumatic stress disorder (PTSD) and borderline personality disorder. The good news about mental illness is that recovery is possible.

Mental illnesses can affect persons of any age, race, religion or income. Mental illnesses are not the result of personal weakness, lack of character or poor upbringing. Mental illnesses are treatable. Most people diagnosed with a serious mental illness can experience relief from their symptoms by actively participating in an individual treatment plan.

NUMBERS OF AMERICANS AFFECTED BY MENTAL ILLNESS

- One in four adults – approximately 61.5million Americans – experience mental illness in a given year. One in 17—about 13.6 million – live with a serious mental illness such as schizophrenia, major depression or bipolar disorder.[1]
- Approximately 20 percent of youth ages 13 to 18 experience severe mental disorders in a given year. For ages 8 to 15, the estimate is 13 percent.[2]
- Approximately 1.1 percent of American adults — about 2.6 million people—live with schizophrenia.[3,4]
- Approximately 2.6 percent of American adults – 6.1 million people – live with bipolar disorder.[4,5]

- Approximately 6.7 percent of American adults – about 14.8 million people – live with major depression.[4,6]
- Approximately 18.1 percent of American adults – about 42 million people – live with anxiety disorders, such as panic disorder, obsessive-compulsive disorder (OCD), posttraumatic stress disorder (PTSD), generalized anxiety disorder and phobias.[4,7]
- About 9.2 million adults have co-occurring mental health and addiction disorders.[8]
- Approximately 26 percent of homeless adults staying in shelters live with serious mental illness and an estimated 46 percent live with severe mental illness and/or substance use disorders.[9]
- Approximately 20 percent of state prisoners and 21 percent of local jail prisoners have "a recent history" of a mental health condition.[10]
- Seventy percent of youth in juvenile justice systems have at least one mental health condition and at least 20 percent live with a severe mental illness.[11]
- Approximately 60 percent of adults[12], and almost one-half of youth ages 8 to 15 with a mental illness received no mental health services in the previous year.[13]
- African American and Hispanic Americans used mental health services at about one-half the rate of whites in the past year and Asian Americans at about one-third the rate.[14].
- One-half of all chronic mental illness begins by the age of 14; three-quarters by age 24.[15] Despite effective treatment, there are long delays – sometimes decades – between the first appearance of symptoms and when people get help.[16]
- Many people with serious mental illness have contributed extensively to our society. Vincent Van Gogh painted many of his famous paintings of irises while hospitalized for mental illness at St. Remy in France. Both President Abraham Lincoln and Prime Minister Winston Churchill suffered from mental illnesses, yet were extremely effective leaders of their countries at times of national crises. John Nash, the Nobel Prize winning mathematician whose life was recently documented in the movie *A Beautiful Mind*, also suffers with a mental illness.

THE IMPACT OF MENTAL ILLNESS IN AMERICA

- Serious mental illness costs America $193.2 billion in lost earnings per year.[17]
- Mood disorders such as depression are the third most common cause of hospitalization in the U.S. for both youth and adults ages 18 to 44.[18]
- Individuals living with serious mental illness face an increased risk of having chronic medical conditions.[19] Adults living with serious mental illness die on average 25 years earlier than other Americans, largely due to treatable medical conditions.[20]
- Over 50 percent of students with a mental health condition age 14 and older who are served by special education drop out – the highest dropout rate of any disability group.[21]
- Suicide is the tenth leading cause of death in the U.S. (more common than homicide) and the third leading cause of death for ages 15 to 24 years.[22] More than 90 percent of those who die by suicide had one or more mental disorders.[23]
- Although military members comprise less than 1 percent of the U.S. population[24], veterans represent 20 percent of suicides nationally. Each day, about 18 veterans die from suicide.[25]

***See reference: www.nami.org/factsheets/mentalillness_factsheet.pdf**

SYMPTOMS OF MENTAL ILLNESS

Mental illnesses cause severe disturbances in thinking, feeling and relating. Unfortunately, there are not yet blood tests or tissue samples that can diagnose a mental illness. Consequently, diagnoses must be *clinical*, i.e. based upon observations of behavior. Symptoms will vary from one person to another, and each individual responds somewhat differently. However, all individuals who have a mental illness experience at least some of the thought, feeling and behavior characteristics listed below.

This list of warning signs of mental illness has been developed by family members who have experience with individuals who have a mental illness, and is described in language common to families. While a single symptom or isolated event should not be automatically taken as proof of a mental illness, and some may be symptoms of other illnesses, you should seek professional help if several of these symptoms are present, and worsen over time:

1) **Social Withdrawal**
   - Sitting and doing nothing for long periods of time
   - Losing friends, unusual self-centeredness and self-absorption
   - Dropping out of previously enjoyed activities
   - Declining academic and/or athletic performance

2) **Depression**
   - Deep sadness coming out of nowhere and unrelated to recent events or circumstances
   - Depression lasting longer than 2 weeks
   - Loss of interest in once pleasurable activities
   - Expressions of hopelessness
   - Excessive fatigue and sleepiness, or an inability to fall asleep
   - Pessimism; perceiving the world as gray or lifeless
   - Thinking or talking about suicide

3) **Thought Disturbances**
   - Inability to concentrate
   - Inability to cope with minor problems
   - Irrational statements
   - Use of peculiar words or language structure
   - Excessive fears or suspiciousness, paranoia

4) **Irregular Expression of Feelings**
   - Hostility from one who was formerly pleasant and friendly
   - Indifference to situations, even highly important ones
   - Inability to express joy
   - Laughter at inappropriate times or for no apparent reason

5) **Change in Behavior**
   - Hyperactivity, inactivity, or alternating between the two
   - Deterioration in personal hygiene
   - Noticeable and rapid weight loss or gain

- Involvement in automobile accidents
- Drug and alcohol abuse
- Forgetfulness and loss of personal possessions
- Moving out of home to camping or living on the street
- Unplanned hitchhiking or bus trips out of town
- Staying up all night for several nights in a row
- Bizarre behavior, e.g. skipping, staring, strange posturing, grimacing
- Unusual sensitivity to noises, light, clothing

In some cases, other conditions such as hypothyroidism, multiple sclerosis, a traumatic brain injury or a brain tumor are found to be the cause of the changes noticed. A thorough physical examination should be the first step whenever mental illness is suspected. Other illnesses can cause changes in feeling, thought and behavior.

Often the symptoms of mental illness are cyclic, varying in sensitivity over time. The duration of an episode also varies. Some people are affected for a few weeks or months. For others, the symptoms may last for years, or a lifetime. There is no reliable way to predict what the course of an individual's illness may be. Symptoms may change over time. One person's symptoms may differ from those of another, even though the diagnoses are the same.

There is always reason for hope. New, more effective medications, support services, and therapeutic interventions are being developed. Recovery education and peer support can be very helpful in enabling people to cope with, and even lessen symptoms to the point that they are not a problem.

COMMON MYTHS ABOUT MENTAL ILLNESS

♦ **A person with schizophrenia has a "split personality" or is undecided between two options.**
False. "Split personality" is a very rare condition known as multiple personality disorder. It is a dissociative disorder and is usually the result of severe childhood trauma and abuse. The confusion arises in part because the word "schizophrenia" means "split brain."

♦ **"Poor parenting" causes mental illness.**
False. Although this is absolutely false, this misperception has caused great pain to countless parents, often preventing them from seeking effective treatments for their loved one.

♦ **Mental illness is a form of mental retardation.**
False. Intelligence among those who have a mental illness is as equally distributed as it is among those who do not. In fact, many of society's most gifted artists, musicians and actors live with major depression, bipolar disorder or other mental illnesses.

♦ **Stress causes mental illness.**
False. Although stress may exacerbate the symptoms, stress alone does not cause the illness. Mental illnesses are thought to result from a complex interaction of factors which include brain structure and chemistry, genetic vulnerability and a host of environmental factors, including (but not limited to) psychological stress and trauma.

♦ **Mental illness is contagious.**
False. You will not "catch" a mental illness by being around someone who has one.

♦ **People who have mental illness are dangerous.**
False. Outside a few cases sensationalized in the media, people who have mental illness and receive appropriate treatment are no more violent than anyone else. In fact, studies document that those with mental illness are 2.5 times more likely to become the victims of violence than to commit violence against others. An individual's past history of violence and/or substance abuse are more reliable predictors of future violence than a diagnosis of mental illness.

THE MAJOR MENTAL ILLNESSES

As referenced from NAMI Mental Illness Fact Sheets

SCHIZOPHRENIA

What is schizophrenia?

Schizophrenia is a serious mental illness that interferes with a person's ability to think clearly, manage emotions, make decisions and relate to others. Research has linked schizophrenia to changes in brain chemistry and structure. Like diabetes, schizophrenia is a complex, long-term medical illness that affects everybody differently. The course of the illness is unique for each person.

How is schizophrenia diagnosed?

There is no single laboratory or brain imaging test for schizophrenia. Treatment professionals must rule out multiple factors such as brain tumors, possible medical conditions and other psychiatric diagnoses, such as bipolar disorder.

Individuals with schizophrenia have two or more of the following symptoms occurring persistently. However, delusions or hallucinations alone can often be enough to lead to a diagnosis of schizophrenia.

Positive symptoms are also known as "psychotic" symptoms because the person has lost touch with reality in certain ways.

- Delusions or the belief in things not real or true
- Hallucinations are hearing or seeing things that are not real
- Disorganized speech expressed as an inability to generate a logical sequence of ideas

Negative symptoms refer to a reduction of a capacity, such as motivation.

- Emotional flatness or lack of expressiveness
- Inability to start and follow through with activities
- Lack of pleasure or interest in life

Cognitive symptoms pertain to thinking processes.

- Trouble with prioritizing tasks, memory and organizing thoughts
- Anosognosia or "lack of insight" being unaware of having an illness

What causes schizophrenia?

Research strongly suggests that schizophrenia involves problems with brain chemistry and structure and is thought to be caused by a combination of genetic and environmental factors, as are many other medical illnesses.

One percent of the world's population or one in every 100 people will develop the disorder in their lifetime. The most common onset is in the teens and 20s. It is uncommon for schizophrenia to be diagnosed before 12 years of age or after the age of 40.

What treatments are available?

The treatment of schizophrenia requires an all-encompassing approach that includes medication, therapy and psychosocial rehabilitation. Medication is an important aspect of symptom management. Antipsychotic medication often helps to relieve the hallucinations, delusions and, to a lesser extent, the thinking problems people can experience. Therapy has been shown to be an effective part of a treatment plan. Cognitive behavioral therapy (CBT), which engages the person living with schizophrenia in developing proactive coping strategies for persistent symptoms, is particularly effective. Cognitive enhancement therapy works with improving cognition.

Psychosocial rehabilitation helps with the achievement of life goals often involving relationships, work and living. Most often delivered through community mental health services, it employs strategies that help people successfully live in independent housing, pursue education, find jobs and improve social interaction.

Will people with schizophrenia get better?

Long-term research demonstrates that, over time, individuals living with schizophrenia often do better in terms of coping with their symptoms, maximizing their functioning while minimizing their relapses. Recovery is possible for most people, though it is important to remember that some people have more trouble managing their symptoms.

Families who are educated about schizophrenia can offer strong support to their loved one and help reduce the likelihood of relapse. Caring for a loved one with schizophrenia can be challenging and families benefit from education and supportive programs. NAMI Vermont's Family-to-Family education program is taught by families who have first-hand experience and provides education and support.

Bipolar Disorder

What is bipolar disorder?

Bipolar disorder is a persistent illness with recurring episodes of mania and depression that can last from one day to months. A manic state can be identified by feelings of extreme irritability and/or euphoria, and during an episode of mania several other symptoms can occur at the same time, such as agitation, surges of energy, reduced need for sleep, talkativeness, pleasure seeking and increased risk-taking behavior. The other state, depression, produces feelings of extreme sadness, hopelessness and lack of energy. Not everyone's symptoms are the same and the severity of mania and depression can vary.

More than 10 million Americans have bipolar disorder. Because of its irregular patterns, bipolar disorder is often hard to diagnose. Although the illness can occur at any point in life, more than one-half of all cases begin between ages 15 to 25. Bipolar disorder affects men and women equally.

How is bipolar disorder diagnosed?

As with all types of illness, a doctor must be seen to provide a proper diagnosis. Unfortunately, there is no simple blood test or brain scan that identifies bipolar disorder. The doctor will rule out other causes such as a hyperthyroidism. If other medical conditions are not diagnosed, a mental health professional such as a psychiatrist needs to be consulted.

A psychiatrist diagnoses bipolar disorder using the Diagnostic and Statistical Manual of Mental Disorders (DSM), and observing a spectrum of symptoms.

Symptoms of mania can include:

- Feeling overly happy for an extended period of time
- An abnormally increased level of irritability
- Overconfidence or an extremely inflated self-esteem
- Increased talkativeness
- Decreased amount of sleep
- Engaging in risky behavior, such as spending sprees and impulsive sex
- Racing thoughts, jumping quickly from one idea to another
- Easily distractible
- Feeling agitated or "jumpy"

Symptoms of depression can include:

- Diminished capacity for pleasure or loss of interest in activities once enjoyed
- A long period of feeling hopeless, helpless or low self-esteem
- Decreased amount of energy, feeling constantly tired
- Inability to concentrate and make simple decisions
- Changes in eating, sleeping or other daily habits
- Being agitated or slowed down in movement, speech or thought
- Thoughts of death or suicide attempts

The states of mania and depression can occur in distinct episodes or can switch rapidly, even multiple times in one week. A person who is experiencing a severe bipolar episode may also have psychotic symptoms such as hallucinations or delusions.

What are the treatments for bipolar disorder?

Recognition and diagnosis of the disorder in its earliest stages is important so effective treatment can begin. Effective treatment plans usually include medication, psychotherapy, education, self-management strategies and external supports such as family, friends and formal support groups.

Medication is often effective in the stabilization and treatment of bipolar disorder. However, not everyone responds to medications in the same way, and at times, multiple types of medication must be assessed. Medications used to treat bipolar disorder often include mood-stabilizing medications and some second-generation antipsychotics. For the most up-to-date information on use and side effects, contact the U.S. Food and Drug Administration (FDA) at www.fda.gov.

Psychotherapy and self-care interventions are essential components in the treatment of bipolar disorder. Most useful psychotherapies generally focus on understanding the illness, learning how to cope and changing ineffective patterns of thinking. Cognitive behavioral therapy (CBT) is one popular example. Family-focused therapy involves family members or friends in supportive roles. They participate by learning about the illness, and in developing and supporting a recovery.

What does recovery look like?

The recovery journey is unique for each individual. There are several definitions of recovery and all involve hope and strengths. The most important principle of recovery is this: recovery is a process, not an event. The uniqueness and individual nature of recovery must be honored.

DEPRESSION

What is major depression?

The normal human emotion we sometimes call "depression" is a common response to a loss, failure or disappointment. Major depression is different. It is a serious emotional and biological disease that affects one's thoughts, feelings, behavior, mood and physical health. Depression is a life-long condition in which periods of wellness alternate with recurrences of illness and may require long-term treatment to keep symptoms from returning, just like any other chronic medical illness.

All age groups and all racial, ethnic and socioeconomic groups can experience major depression. Some individuals may only have one episode of depression in a lifetime, but often people have recurrent episodes. If untreated, episodes commonly last anywhere from a few months to many years. An estimated 25 million American adults are affected by major depression in a given year, but only one-half ever receive treatment.

What are the symptoms of major depression and how is it diagnosed?

Depression can be difficult to detect from the outside, but for those who experience major depression, it is disruptive in a multitude of ways. It usually causes significant changes in how a person functions in many of the following areas:

- Changes in sleep. Some people experience difficulty in falling asleep, waking up during the night or awakening earlier than desired. Other people sleep excessively or much longer than they used to.
- Changes in appetite. Weight gain or weight loss demonstrates changes in eating habits and appetite during episodes of depression.
- Poor concentration. The inability to concentrate and/or make decisions is a serious aspect of depression. During severe depression, some people find following the thread of a simple newspaper article to be extremely difficult, or making major decisions often impossible.
- Loss of energy. The loss of energy and fatigue often affects people living with depression. Mental speed and activity are usually reduced, as is the ability to perform normal daily routines.
- Lack of interest. During depression, people feel sad and lose interest in usual activities.
- Low self-esteem. During periods of depression, people dwell on memories of losses or failures and feel excessive guilt and helplessness.
- Hopelessness or guilt. The symptoms of depression often produce a strong feeling of hopelessness, or a belief that nothing will ever improve. These feelings can lead to thoughts of suicide.
- Movement changes. People may literally look "slowed down" or overly activated and agitated.

Mental healthcare professionals use the criteria for depression in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) to develop a diagnosis.

There is a strong possibility that a depressive episode can be a part of bipolar disorder. Having a physician make the right distinction between unipolar major depression and bipolar depression is critical because treatments for these two depressive disorders differ.

What treatments are available?

There are three well-established types of treatment for major depression:

- Medications. Medications often effectively control the serious symptoms of depression. It often takes two to four weeks for antidepressant medications to have their full effect.
- Psychotherapy. Several types of psychotherapy have been shown to be effective for depression, including cognitive behavioral therapy (CBT) and interpersonal therapy (IPT). Support groups offer opportunities to share frustrations and successes, referrals to specialists and community resources, and information about what works best when trying to recover. Research has shown that mild to moderate depression can often be treated successfully with either medication or psychotherapy alone but that both together are often more helpful. Severe depression appears more likely to respond to a combination of medication and psychotherapy.
- Electroconvulsive therapy (ECT). ECT is a highly effective treatment for select severe depression episodes and for severe depression with psychosis. When medication and psychotherapy are not effective in treating severe symptoms (e.g., acute psychosis or thoughts of suicide) or if a person cannot take antidepressants, ECT may be considered. Memory problems can follow ECT treatments, so a careful risk-benefit assessment needs to be made for this intervention.

Other forms of treatment that may be helpful, either combined with the more traditional treatments or alone, include transcranial magnetic stimulation (TMS), aerobic exercise, and complementary and alternative medicine.

As devastating as this disease may be, it is very treatable in most people. Today the availability of treatment and understanding of depression has lessened the barriers that can prevent early detection, diagnosis and decision to seek treatment.

SCHIZOAFFECTIVE DISORDER

What is schizoaffective disorder?

Schizoaffective disorder is a serious mental illness that affects about one in 100 people. Schizoaffective disorder as a diagnostic entity has features that resemble both schizophrenia and also serious mood (affective) symptoms. Many of the strategies used to treat both schizophrenia and affective conditions can be employed for this condition. These include antipsychotic and mood stabilizing medications, family involvement, psychosocial strategies, self-care peer support, psychotherapy and integrated care for co-occurring substance abuse (when appropriate).

A person who has schizoaffective disorder will experience delusions, hallucinations, other symptoms that are characteristic of schizophrenia and significant disturbances in their mood (e.g., affective symptoms). According to the DSM-IV-TR, people who experience more than two weeks of psychotic

symptoms in the absence of severe mood disturbances—and then have symptoms of either depression or bipolar disorder—may have schizoaffective disorder. Schizoaffective disorder is thought to be between the bipolar and schizophrenia diagnoses as it has features of both.

Depressive symptoms associated with schizoaffective disorder can include—but are not limited to—hopelessness, helplessness, guilt, worthlessness, disrupted appetite, disturbed sleep, inability to concentrate, and depressed mood (with or without suicidal thoughts). Manic symptoms associated with schizoaffective disorder can include increased energy, decreased sleep (or decreased need for sleep), distractibility, fast ("pressured") speech, and increased impulsive behaviors (e.g., sexual activities, drug and alcohol abuse or gambling).

While it is a hot-topic of debate within the mental health field, most experts believe that schizoaffective disorder is a type of chronic mental illness that has psychotic symptoms at the core and with depressive and manic symptoms as a secondary—but equally debilitating—component. Because it consists of a wide range of symptoms, some people may be inappropriately diagnosed with schizoaffective disorder. This is problematic because it can lead to unnecessary treatments, specifically medication-treatment with antipsychotics when they are not otherwise indicated.

People who have depression or mania as their primary mental illness may experience symptoms of psychosis (including disorganized speech, disorganized behavior, delusions, or hallucinations) during severe episodes of their mood disorder but will not have these symptoms if their mood disorder is well treated. Sometimes people with other mental illnesses including borderline personality disorder may also be incorrectly diagnosed with schizoaffective disorder. This further underscores how important it is to have regular and complete mental health assessments from one's doctors, preferably over time so that patterns of what is happening and what works can be fully understood together.

What treatments are available?

For most people with schizoaffective disorder, treatment will be very similar to treatment of schizophrenia and will include antipsychotic medications to help addresses symptoms of psychosis. Finding the right type and dose of antipsychotic medication is important and requires collaboration with a doctor. In some cases, people with schizoaffective disorder will be offered treatment with long-acting-injectable (also called LAI, decanoate) formulations of antipsychotic medications. These FDA approved medications—including haloperidol (Haldol Decanoate), risperidone (Risperdal Consta), palperidone (Invega Sustenna)—are given in the form of an intramuscular injection ("shot") approximately once or twice each month and have been shown to decrease the rates of relapse and hospitalization.

Treatments such as cognitive behavioral therapy to target psychotic symptoms, supports groups including NAMI's Family-to-Family to increase family and community support, peer support and connection, and work-and-school rehabilitation, such as social skills training, are very helpful for people with schizoaffective disorder. Maintaining a healthy lifestyle is also of critical importance: the role of good sleep hygiene, regular exercise, and a balanced diet cannot be underestimated. Omega-3 fatty acids (commonly marketed as "Fish Oil") are an over-the-counter supplement that some may find useful.

Symptoms of depression—in people with schizoaffective disorder—may be treated with antidepressant medications or lithium in addition to antipsychotic medications. People with bipolar symptoms may be treated with mood-stabilizers such as lithium or anti-convulsants, including valproic acid (Depakote), lamotrigine (Lamictal), and carbamazepine (Tegretol), in addition to their antipsychotic medications.

There are some studies that suggest that older ("first-generation," "typical") antipsychotic medications are not as effective in controlling the mood symptoms associated with schizoaffective disorder as newer ("second-generation," "atypical") antipsychotic medications. Newer antipsychotic medications may be less likely to cause side effects such as tardive dyskinesia but they are more likely to cause weight gain, high cholesterol, and increased blood sugars, which can lead to diabetes. Given how complicated these choices may be, it is necessary for any individual with schizoaffective disorder and their loved ones to discuss medication management strategies with their doctors.

Families, friends, and others can be most helpful in providing empathic and non-judgmental support of their loved one. With this support, the proper medications, and effective psychosocial treatments, many people with schizoaffective disorder will do well and will be able to actively participate in a recovery journey.

ANXIETY DISORDERS

What are anxiety disorders?

Anxiety disorders are a group of mental illnesses that cause people to feel excessively frightened, distressed, or uneasy during situations in which most other people would not experience these same feelings. When they are not treated, anxiety disorders can be severely impairing and can negatively affect a person's personal relationships or ability to work or study and can make even regular and daily activities such as shopping, cooking or going outside incredibly difficult.

Anxiety disorders are the most common mental illnesses in America: they affect around 20 percent of the population at any given time. Fortunately there are many good treatments for anxiety disorders. Unfortunately, some people do not seek treatment for their illness because they do not realize how severe their symptoms are or are too ashamed to seek help.

What are the most common anxiety disorders?

- Panic Disorder – Characterized by "panic attacks," panic disorder results in sudden feelings of terror that can strike repeatedly and sometimes without warning. Physical symptoms of a panic attack include chest pain, heart palpitations, upset stomach, feelings of being disconnected, and fear of dying.
- Obsessive-Compulsive Disorder (OCD) – OCD is characterized by repetitive, intrusive, irrational and unwanted thoughts (obsessions) and/or rituals that seem impossible to control (compulsions). Some people with OCD have specific compulsions (e.g., counting, arranging, cleaning) that they "must perform" multiple times each day in order to momentarily release their anxiety that something bad might happen to themselves or to someone they love.
- Posttraumatic Stress Disorder (PTSD) – When people experience or witness a traumatic event such as abuse, a natural disaster, or extreme violence, it is normal to be distressed and to feel "on edge" for some time after this experience. Some people who experience traumatic events have severe symptoms such as nightmares, flashbacks, being very easily startled or scared, or feeling numb/angry/irritable, that last for weeks or even months after the event and are so severe that they make it difficult for a person to work, have loving relationships, or "return to normal."
- Phobias – A phobia is a disabling and irrational fear of something that really poses little or no actual danger for most people. This fear can be very disabling when it leads to avoidance of objects or situations that may cause extreme feelings of terror, dread and panic.

- Generalized Anxiety Disorder (GAD) – A severe, chronic, exaggerated worrying about everyday events is the most common symptom in people with GAD. This is a worrying that lasts for at least six months, makes it difficult to concentrate and to carry out routine activities, and happens for many hours each day in some people.
- Social Anxiety Disorder – An intense fear of social situations that leads to difficulties with personal relationships and at the workplace or in school is most common in people with social anxiety disorder. Individuals with social anxiety disorder often have an irrational fear of being humiliated in public for "saying something stupid," or "not knowing what to say."

People with anxiety disorders are more likely to use or abuse alcohol and other drugs including benzodiazepines, opiates (e.g., pain-killers, heroin) or cigarettes. This is known as self-medication. Some people use drugs and alcohol to try and reduce their anxiety. This is very dangerous because even though some drugs make people feel less anxious when they are high, anxiety becomes even worse when the drugs wear off.

Are there any known causes of anxiety disorders?

Although studies suggest that people are more likely to have an anxiety disorder if their parents have anxiety disorders, it has not been shown whether biology or environment plays the greater role in the development of these disorders. Some anxiety disorders have a very clear genetic link (e.g., OCD) that is being studied by scientists to help discover new treatments to target specific parts of the brain. Some anxiety disorders can also be caused by medical illnesses. Other anxiety disorders can be caused by brain injury.

What treatments are available for anxiety disorders?

Effective treatments for anxiety disorders include medications and psychotherapy. Psychotherapy techniques such as cognitive behavioral therapies are most useful in the treatment of anxiety disorders and are referred to as "first-line treatments." In most cases, a combination of psychotherapy and medications is most beneficial for people with severe anxiety disorders. Some commonly used medications for anxiety disorders are antidepressant medications called selective serotonin reuptake inhibitors (SSRIs).

The importance of having a good diet and getting enough sleep are known to decrease symptoms in people with anxiety disorders. Regular exercise has also been scientifically proven to be effective.

PANIC DISORDER

What is panic disorder?

Panic disorder is characterized by recurrent panic attacks—an uncontrollable and terrifying response to ordinary, nonthreatening situations. There is also persistent anxiety or fear about the panic attacks and changes in behavior in an attempt to avoid further attacks.

The symptoms of a panic attack include some combination of the following: sweating, hot or cold flashes, choking or smothering sensations, racing heart, labored breathing, trembling, chest pains, faintness, numbness, nausea or disorientation. Some experiencing an attack may feel like they are dying, losing control or losing their mind. Panic attacks typically last about five to 10 minutes but can be shorter or as long as an hour. During the attack, the physical and emotional symptoms increase quickly in a wave-like fashion and then slowly subside. A person may feel anxious and jittery for many hours after experiencing an attack.

Sometimes, panic attacks are mistaken for heart attacks or respiratory problems, as symptoms can be similar. Therefore, prior to the diagnosis of panic disorder, a thorough physical evaluation should be performed to ensure that no underlying medical condition is the cause.

What are some problems that people with panic disorder experience?

Many with panic disorder "fear the fear," or worry about when the next attack is coming. In some people, this fear can lead to agoraphobia, an intense fear of feeling trapped in a public place. People with panic disorder may avoid the places or things that they think trigger their panic attacks, which can cause significant occupational and social problems.

Like people with other anxiety disorders, those with panic disorder are at increased risk of developing other mental illnesses. Half of the people with panic disorder may eventually be diagnosed with major depressive disorder. Alcohol and drug abuse can also be a serious problem, both as a trigger for panic attacks and as a type of self-medication that can quickly get out of control. Panic disorder, particularly left untreated, can raise the risk of suicidal thoughts or acts. Even people without depression or substance abuse may feel very scared and ashamed. The associated secretiveness and low self-esteem can cause some people to isolate themselves from their friends and family or avoid leaving the house.

What causes panic disorder?

Panic attacks occur frequently, and approximately one in 20 Americans will be diagnosed and treated for panic disorder each year. Females are twice as likely to be affected than males. Chemical or hormonal imbalances, drugs or alcohol, poor sleep and other situations can cause panic attacks. People who experience high levels of stress in their lives and those with severe medical illnesses are also at increased risk of developing panic disorder.

Although scientists have not isolated a single gene in studying panic attacks, it is generally thought that there is a genetic component to panic disorder. Scientific studies have suggested that there is inappropriate activation of a region of the brain called the amygdala.

Is panic disorder treatable?

Panic disorder is generally very responsive to treatment. People who are able to remain in treatment can expect to have less severe and less frequent panic attacks as well as anxiety in between these events. Complete recovery is a reasonable goal for many people, although a significant percentage of individuals will experience further episodes later in life. This suggests that ongoing treatment may be indicated in certain situations.

Recovery from panic disorder can be achieved either by medication or by a form of cognitive behavioral therapy (CBT) that is specific for panic disorder. Studies suggest that medication and CBT are about equally effective, and there is also evidence that the combination may offer some benefits over either one alone. Some medications work a bit faster but are likely to have more adverse side effects. Also, when treatment is finished, people who have had CBT tend to remain without symptoms for longer than those who have taken medications.

CBT involves exploring the connection between thoughts, feelings and behaviors. People learn to understand the links between their bodily sensations and their emotions and how fear can increase the symptoms of panic attacks. For some people, exposure therapy is useful in learning how to experience the symptoms of a panic attack without "losing control."

Medications are most effective when they are used as part of an overall treatment plan that includes supportive therapy. Antidepressants and anti-anxiety medications are the most frequently used medications for this disorder. Medications called selective serotonin reuptake inhibitors (SSRIs) are commonly used. A serotonin norepinephrine reuptake inhibitor (SNRI) also has FDA approval for panic disorder. Another commonly used class of medications is benzodiazapines. Medications can be highly effective in the short-term but not indicated for long-term treatment. All decisions should be discussed with one's doctor.

Healthy living practices (e.g., aerobic exercise, a proper and balanced diet, decreased use of caffeine and alcohol) can help decrease symptoms. For many, learning how to reduce stress through meditation and mindfulness are also very useful. Family and friends can play a critical role in the treatment process, as support is a vital part of overcoming panic disorder.

POST TRAUMATIC STRESS DISORDER

What is posttraumatic stress disorder (PTSD) and who is at risk?

Combat, sexual assault, and surviving a natural disaster or an attack are examples of traumatic psychological events that can cause PTSD. These severely traumatic events often have a direct physical impact on a person's safety. Veterans who have been injured in combat are at high risk for PTSD because they have sustained a direct injury in a violent setting. Survivors of rape have experienced physical and emotional trauma which is associated with very high rates of posttraumatic responses.

These events can be a single occurrence in a person's lifetime or occur repeatedly, such as ongoing physical abuse or an extended or repeated tour of duty in a war zone. The severity of traumatic events and duration of exposure are critical risk factors for the risk of developing PTSD.

What happens when we are involved in a traumatic event?

Humans have a set of adaptive, life-saving responses in times of stress. During the "fight of flight" response when faced with terror, less critical body functions (e.g., the parts of the brain where memory, emotion and thinking are processed) get "turned off" while the body prioritizes immediate physical safety. As a result, the traumatic experiences are not integrated. Unprocessed feelings associated with the terror and memories of the trauma can appear unexpectedly and unpredictably, causing complex problems. People living with PTSD may experience abnormal responses to the normal flow of emotion such as the following:

- Hypoarousal is a numbness and avoidance of events or feelings that represent self-protective efforts by the brain to keep overwhelming feelings under control.
- Hyperarousal is a heightened "startle response" to triggers seen as threatening. This state is an attempt to prevent a repeat traumatic experience.

These states demonstrate the difficulty people living with PTSD have in regulating their emotional and physical responses. Brain imaging studies show that these psychological problems are biologically controlled. The area of the brain involved in emotional processing (hippocampus) is reduced in size, the brain's "alarm system" (amygdala) is over-reactive, and its integration system (prefrontal cortex) is under-reactive.

How is PTSD diagnosed?

The DSM-5 criteria for identifying PTSD requires that symptoms must be active for more than one month after the trauma and associated with a decline in social, occupational or other important area of functioning. The three broad symptom clusters can be summarized as follows:

1. **Persistent Re-experiencing**. A person experiences one or more of the following: recurrent nightmares or flashbacks, recurrent images or memories of the event, intense distress at reminders of trauma, or physical reactions to triggers that symbolize or resemble the event.
2. **Avoidant/Numbness Responses.** A person experiences three or more of the following: efforts to avoid feelings or triggers associated with the trauma; avoidance of activities, places or people that remind the person of the trauma; inability to recall an important aspect of the trauma; feelings of detachment or estrangement from others; restricted range of feelings; or difficulty thinking about the long-term future.
3. **Increased Arousal.** A person experiences two or more of the following: difficulty falling asleep or staying asleep, outbursts of anger/irritability, difficulty concentrating, increased vigilance that may be maladaptive, or exaggerated startle responses.

What are the treatment options for coping with PTSD and achieving recovery?

Treatment strategies should be customized to the individual's needs and preferences. The stage of recovery is important because interventions that are useful immediately after a trauma may not be appropriate years later.

- Psychological first aid includes support and compassion and is critical immediately after the traumatic event.
- Medications can play a role in reducing symptom intensity but are usually not enough alone.
- Avoidance of use of substances to attempt to moderate the experience is important.
- Psychotherapy that includes structured interventions and is very supportive seems to work best for people with PTSD:
- Cognitive behavior therapy (CBT) employs tailored exposure to the traumatic event by increasing tolerance and gradually reducing anxiety and symptoms.
- Exposure therapy and eye movement desensitization and reprocessing (EMDR) may also be useful for some people.
- Group therapy with other survivors of trauma is supportive and uplifting.
- Service dogs are becoming increasingly common, especially for veterans.

OBSESSIVE COMPULSIVE DISORDER

What is obsessive-compulsive disorder (OCD)?

Obsessions are intrusive, irrational thoughts—unwanted ideas or impulses that repeatedly appear in a person's mind. Again and again, the person experiences disturbing thoughts, such as "My hands must

be contaminated;" "I need to wash them;" "I may have left the gas stove on;" "I need to go check it fast." On one level, the person experiencing these thoughts knows their obsessions are irrational. But on another level, he or she fears these thoughts might be true. Trying to avoid such thoughts creates great anxiety, distress and dysfunction.

Compulsions are repetitive rituals such as hand washing, counting, checking, hoarding or arranging. An individual repeats these actions many times throughout the day and performing these actions releases anxiety, but only momentarily. People with OCD feel they must perform these compulsive rituals or something bad will happen to them or their loved ones.

Obsessive-compulsive disorder occurs when an individual experiences obsessions and compulsions for more than an hour each day, in a way that interferes with his or her life. The National Institute of Mental Health estimates that more than 2 percent of the U.S. population, or nearly one out of every 40 people, will be diagnosed with OCD at some point in their lives. The disorder is two to three times more common than schizophrenia and bipolar disorder.

Who can get OCD?

People from all walks of life can get OCD. It strikes people of all social and ethnic groups and both males and females. Symptoms typically begin during childhood, the teenage years or young adulthood. The sudden appearance of OCD symptoms later in life merits a thorough medical evaluation to ensure that another illness is not the cause of these symptoms.

What causes OCD?

People with OCD can often say "why" they have obsessive thoughts or "why" they behave compulsively, but the thoughts and the behavior continue. A large body of scientific evidence suggests that OCD results from a chemical imbalance in the brain. For years, mental health professionals incorrectly assumed OCD resulted from bad parenting or personality defects. This theory has been disproven over the last few decades. People whose brains are injured sometimes develop OCD, which suggests it is a medical condition.

Genetics are thought to be very important in OCD. If you, or your parent or sibling, have OCD, there's close to a 25 percent chance that another of your immediate family members will have it.

What are behaviors typical of people who live with OCD?

People who do the following may have OCD:

- Repeatedly check things, perhaps dozens of times, before feeling secure enough to leave the house. Is the stove off? Is the door locked?
- Fear they will harm others. Example: A man's car hits a pothole on a city street and he fears it was actually a pedestrian and drives back to check for injured persons.
- Feel dirty and contaminated. Example: A woman is fearful of touching her baby because she might contaminate the child and cause a serious infection.
- Constantly arrange and order things. Example: A child can't go to sleep unless he lines up all his shoes correctly.

- Are ruled by numbers, believing that certain numbers represent good and others represent evil. Example: a college student is unable to send an email unless the "correct sequence of numbers" is recalled prior to using his computer.
- Are excessively concerned with sin or blasphemy in a way that is not the cultural or religious norm for other members of their community. Example: a woman must recite "Hail Mary" thirty-three times every morning before getting out of bed and is frequently late for work because of this.

Can OCD be effectively treated?

OCD will not go away by itself, so it is important to seek treatment. Although symptoms may become less severe from time to time, OCD is a chronic disease. Fortunately, effective treatments are available that make life with OCD much easier to manage. OCD symptoms are not cured by talking about them and "trying to make it go away." With medication and behavior therapy, OCD can be treated effectively. Both medications and behavioral therapy affect brain chemistry, which in turn affects behavior. Doctors are also increasingly aware of the role that regular exercise, getting enough sleep, and a healthy diet have in the treatment of OCD. If a person with OCD can live a healthy lifestyle and receive effective treatment of any other medical conditions they might have, it is likely that their OCD symptoms will improve.

BORDERLINE PERSONALITY DISORDER

What is borderline personality disorder (BPD) and how is it diagnosed?

Borderline personality disorder is diagnosed by mental health professionals following a comprehensive psychiatric interview that may include talking with a person's previous clinicians, review of prior records, a medical evaluation, and when appropriate, interviews with friends and family. There is no specific single medical test (e.g., blood test) to diagnose BPD and a diagnosis is not based on a single sign or symptom.

Individuals with BPD have several of the following symptoms, detailed in the DSM-IV-TR:

- Marked mood swings with periods of intense depressed mood, irritability and/or anxiety lasting a few hours to a few days
- Impulsive behaviors that result in adverse outcomes and psychological distress, such as excessive spending, sexual encounters, substance use or shoplifting
- Recurring suicidal threats or non-suicidal self-injurious behavior, such as cutting
- Unstable, intense personal relationships, sometimes alternating between "all good," idealization and "all bad," devaluation
- Persistent uncertainty about self-image, long-term goals, friendships and values
- Chronic boredom or feelings of emptiness

BPD is relatively common—about 1 in 20 or 25 individuals will live with this condition. Historically, BPD has been thought to be significantly more common in females, however recent research suggests that males may be almost as frequently affected by BPD.

What is the cause of borderline personality disorder?

The exact causes of BPD remain unknown, although the roles of both environmental and biological factors are thought to play a role. While no specific gene has been shown to directly cause BPD, a number of different genes have been identified as playing a role in its development. The brain's functioning, as seen in MRI testing, is often different in people with BPD, suggesting that there is a neurological basis. A number of hormones (including oxytocin) and signaling molecules within the brain (e.g., neurotransmitters including serotonin) have been shown to potentially play a role in BPD.

The connection between BPD and other mental illnesses is well established. People with BPD are at increased risk for anxiety disorders, depressive disorders, eating disorders, and substance abuse. BPD is often misdiagnosed and many people find they wait years to get a proper diagnosis, which leads to a better care plan.

What are the treatments for borderline personality disorder?

Psychotherapy is the cornerstone of treatment for individuals who live with BPD. Dialectical behavioral therapy (DBT) is the most well researched and effective treatment for BPD. DBT focuses on teaching coping skills to combat destructive urges, encourages practicing mindfulness (e.g., meditation, regulated breathing and relaxation), involves individual and group work, and is quite successful in helping people with BPD to control their symptoms.

While cognitive behavioral therapy (CBT), psychodynamic psychotherapy and certain other psychosocial treatments are useful for some people with BPD, the majority of people with this illness will find dialectical behavioral therapy (DBT) to be the most useful form of psychotherapy.

Medications can be an important component to the care plan, yet it is important to know that there is no single medication treatment that can "cure" borderline personality disorder. Furthermore, no medication is specifically approved by the FDA for the treatment of BPD. Medications are however useful in treating specific symptoms in BPD. Off label use of a number of medications may help manage key symptoms, such as valproate (Depakote), that may be useful in decreasing impulsivity, omega-3 fatty acids (fish oil) that may be helpful in decreasing mood fluctuations, and naltrexone (Revia), which has helped some people decrease their urges for self-injury.

While not usually indicated for the chronic symptoms of BPD, short-term inpatient hospitalization may be necessary during times of extreme stress, impulsive behavior, or substance abuse. In other cases however, inpatient psychiatric hospitalization may be paradoxically detrimental for some people with BPD.

The support of family and friends is of critical importance in the treatment of BPD as many people with this illness may isolate themselves from these relationships in times of greatest need. With the support of family and friends, involvement in ongoing treatment, and efforts to live a healthy lifestyle—regular exercise, a balanced diet and good sleeping habits—most people with BPD can expect to experience significant relief from their symptoms.

Will people with borderline personality disorder get better?

Recent research based on long-term studies of people with BPD suggests that the overwhelming majority of people will experience significant and long-lasting periods of symptom remission in their lifetime. Many people will not experience a complete recovery, but nonetheless will be able to live meaningful and productive lives. Many people will require some form of treatment—whether medications or psychotherapy—to help control their symptoms even decades after their initial diagnosis with borderline personality disorder.

DUAL DIAGNOSIS: MENTAL ILLNESS AND SUBSTANCE ABUSE

What is dual diagnosis?

Dual diagnosis is a term used to describe people with mental illness who also have problems with drugs and/or alcohol. The relationship between the two is complex, and the treatment of people with co-occurring substance abuse (or dependence) and mental illness is more complicated than the treatment of either condition alone. This is unfortunately a common situation—many people with mental illness have ongoing substance abuse problems, and many people who abuse drugs and alcohol also experience mental illness.

Certain groups of people with mental illness (e.g., males, individuals of lower socioeconomic status, military veterans and people with more general medical illnesses) are at increased risk of abusing drugs and alcohol. Recent scientific studies have suggested that nearly one-third of people with all mental illnesses and approximately one-half of people with severe mental illnesses (including bipolar disorder and schizophrenia) also experience substance abuse. Conversely, more than one-third of all alcohol abusers and more than one-half of all drug abusers are also battling mental illness.

What is the relationship between substance use and mental illness?

The relationship between mental illness and substance abuse/dependency is complex. Drugs and alcohol can be a form of self-medication for people with mental illness experiencing conditions such as anxiety or depression. Unfortunately, while drugs and alcohol may feel good in the moment, abuse of these substances does not treat the underlying condition and, almost without exception, makes it worse. Drugs and alcohol can worsen underlying mental illnesses during both acute intoxication and during withdrawal from a substance. Additionally, drugs and alcohol can cause a person without mental illness to experience the onset of symptoms for the first time.

Abuse of drugs and alcohol always results in a worse prognosis for a person with mental illness. Active users are less likely to follow through with their treatment plans. They are more likely to experience severe medical complications and early death. People with dual diagnosis are also at increased risk of impulsive and violent acts. Those who abuse drugs and alcohol are more likely to both attempt suicide and to die from their suicide attempts.

Individuals with dual diagnosis are less likely to achieve lasting sobriety. They may be more likely to experience severe complications of their substance abuse, to end up in legal trouble from their substance use and to become physically dependent on their substance of choice.

What treatments are available for individuals with dual diagnosis?

Treatment of individuals with dual diagnosis is also complicated. Of primary importance is addressing any life-threatening complications of intoxication. The following situations would require immediate care in a hospital: severe cases of alcohol intoxication; heart problems or stroke caused by use of amphetamines, crack, cocaine and other drugs; overdose on benzodiazapines (e.g., diazepam [valium], clonazepam [klonopin]), opiates (e.g., oxycodone, oxycontin) and other "downers." Untreated, any of these conditions can lead to death.

Drug and alcohol withdrawal can also lead to medical emergencies requiring immediate treatment. Alcohol withdrawal can result in heart problems (e.g., arrhythmias), seizures or delirium tremens (an acute delirious state), all which can be potentially fatal. Benzodiazapine withdrawal can result in tremors ("shakes"), seizures and potentially death. Opiate withdrawal is not thought to be life-threatening in most cases but can be a very traumatic and painful experience.

Many people seek assistance in going through the process of stopping their drug and alcohol abuse. This may include inpatient detoxification involving admission to a hospital—either a general hospital or a detoxification facility—and treatment with the appropriate medications to avoid serious complications of acute drug and alcohol withdrawal.

Multiple scientific studies have shown that psychiatric treatments are more effective in people who are not actively abusing drugs and alcohol. Many options exist for people who are newly sober or who are trying to avoid relapse on drugs and alcohol. These can include inpatient rehabilitation centers or supportive housing. Some people find therapy to be a helpful part of maintaining their sobriety. This can include individual therapy (e.g., cognitive behavioral therapy) as well as self-help groups such as Alcoholics Anonymous, Narcotics Anonymous or Smart Recovery.

Certain medications to help maintain sobriety have been safely tested in multiple studies. For alcoholism, available medications include disulfiram (Antabuse), acamprosate (Campral) and naltrexone (Revia). For opiate abuse, available medications include naltrexone (Revia, Vivitrol), methadone and buprenorphine (Subutex, Suboxone). Given how complicated these choices may be, it is necessary for any individual with dual diagnosis and their loved ones to discuss medication management strategies with their doctors.

Families, friends and others can be most helpful in providing empathic and non-judgmental support of their loved one. This can be critically important as a significant majority of people will relapse into drug and alcohol abuse at some point in their lives, even if they are eventually able to achieve long-lasting sobriety. With this support, the proper medical treatment and effective psychosocial treatments, many people with dual diagnosis will be able to actively participate in their journey to recovery.

Vermont has taken significant and important steps over the last several years to increase the system's capacity to provide accessible, effective, comprehensive, integrated and evidence-based services for adults and adolescents with co-occurring conditions.

GETTING HELP FOR SUBSTANCE ABUSE

If your loved one has both a mental illness and a substance abuse disorder, ask their treating clinicians if they are familiar with integrated, stage-wise treatment for dual diagnosis. Make sure your relative's treatment team understands that both illnesses are primary and should be treated as such, preferably by the same team.

There are some "best practices" for treatment of dually diagnosed individuals. Briefly, these are:

- Assertive outreach: Clinicians meet people where they live and hang out. They do not expect people to come to them at first.
- Stage-wise treatment: There is engagement, persuasion, active treatment, and finally relapse prevention.

In the early stages of treatment, people do not think they have a problem. Or even if they do think they have a problem, they are nowhere near ready to do anything about it. So you give people what they need. Clinicians must engage with them and ask "What do you need from me right now to make your life easier? How can I help you?"

In the **persuasion** stage, clinicians work with people to have them recognize what they want out of life, what they want to accomplish, where they want to be in a few years' time. Such work helps individuals begin to see how alcohol and/or drugs help and how they get in the way.

If people reach the **active treatment** stage, sometimes known as harm reduction, they work on reducing their use before eliminating it entirely. "Progress in the direction" is more important than abstinence, at this stage.

Eventually the person may be ready for **relapse prevention**. Here they learn to recognize and avoid triggers to using. This is the "people, places and things" of Alcoholics Anonymous. Obviously, successful treatment of dual disorders requires the long-term commitment of the treatment team, and infinite patience with the inevitable relapses.

For a comprehensive listing of Vermont's inpatient and outpatient substance abuse and treatment programs, see: www.vtaddictionservices.org. Services offered through accredited treatment programs are often covered by public and private health insurance.

In addition, there are **Turning Point Centers** throughout Vermont. These storefront centers provide a safe, welcoming, substance-free environment for those in recovery, those who have family or friends in recovery, and those who have an interest in the needs of individuals recovering from substance abuse. They provide peer-to-peer support and a reliable source of information, security, recreation and fellowship for those within the recovering community. Although the centers are not officially affiliated with the various "twelve-step fellowships", they support these programs, and provide meeting rooms for their use. The centers do not provide nor endorse specific therapeutic regimens. Rather, they encourage participation in and provide information concerning all programs and approaches that can assist in healing from all forms of addiction. For a listing of Turning Point Centers throughout Vermont see APPENDIX G. For more information about recovery groups for peers,

youth and family members, contact Friends of Recovery Vermont, at **(800) 769-2798,** or visit them on the web at**:** www.friendsofrecoveryvt.org.

MENTAL ILLNESS AND DEVELOPMENTAL DISABILITIES

A small percentage of those who have a mental illness also have a developmental disability, and vice versa. Here the treatment picture is brighter than for those who have only a mental illness. Vermont has a system to treat people with developmental disabilities that is accessible from every area of the state. If the case manager and family decide a person has a developmental disability, an integrated service plan is developed.

For a complete guide to developmental disability services in Vermont, see this website: http://ddas.vermont.gov/ddas-programs/programs-dds/programs-dds-default-page.

SERIOUS DISORDERS OF CHILDREN AND ADOLESCENTS

Unfortunately, children are not immune to serious emotional, behavioral or mental disorders. Causes are varied and include a combination of biological, psychological and social factors. Between 5 and 10 percent of children and teens live with a "serious emotional disturbance," which is the term used by many schools, providers and agencies in the mental health system of care.

However, only about 1 in 5 of those affected have ever been evaluated by a qualified mental health professional, or received any form of mental health treatment. Untreated, these conditions interfere with learning and normal development, and put those affected at greater risk of school failure, delinquency, and even suicide, which is the 3rd leading cause of death for people under 24.

Affected children and youth come from a wide variety of families. Just because a child is having problems does not mean he or she comes from a troubled family, or is the product of poor parenting. Yet parents of children and teens are often and unfairly blamed.

Typical diagnoses of childhood and teenage mental health disorders include:

1) **Adjustment Disorders** – A child has great difficulty adapting to stressful events which other children take in stride.
2) **Affective Disorders** – Like adults, children can have bipolar disorder and depression. Note that in children depression can often take the form of irritability, and aggressive and hostile behavior. Other children may isolate themselves and spend unusual amounts of time alone in their rooms.
3) **Anxiety Disorders** – Children may be afraid to go to school, may suffer from post-traumatic stress disorder (PTSD), and may avoid situations in which children normally find themselves. The predominant feature of these disorders is exaggerated anxiety out of proportion to the situation.
4) **Autism Spectrum Disorders** – Children who have autism spectrum disorders fail to develop social relatedness to parents, other family members, and friends and acquaintances. They do not develop normal patterns of language. The play of an autistic child is often rigid and repetitive, and is over- or under-responsive to external stimuli. Asperger's Syndrome is a less severe form of

autism. (Note: autism spectrum disorders are considered developmental disabilities, not mental illnesses.)

5) **Conduct Disorders** – The behavior of a child or teen violates accepted social norms. The child is very difficult to discipline and may be hostile to others.
6) **Oppositional Defiant Disorder** – The child defies accepted rules of conduct, despite negative consequences.
7) **Disruptive Behavior Disorders** – The child or teen is excessively inattentive, impulsive, and/or hyperactive. These disorders include Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD).
8) **Obsessive Compulsive Disorder** – The child engages in repetitive behaviors which have little outward purpose or benefit, but serve to relieve anxiety. OCD can develop in young children.
9) **Pervasive Development Disorder** – The child or adolescent's brain has difficulty processing information. There are distortions, deviations, and delays in the development of social and motor skills, language, perception, and reality testing.
10) **Thought Disorders or Psychosis** – Schizophrenia can affect children and adolescents and, as with adults, is characterized by impairments in judgment.
11) **Tourette Syndrome** – is a neurological disorder characterized by involuntary muscle movements, uncontrollable vocal sounds, and inappropriate words, e.g. constantly repeating the words of other people or, in rare cases, swearing.

To learn about local and statewide services and resources for children's mental health in Vermont, call the Child, Adolescent & Family Mental Health Services at (802) 878-7997. Also see: http://mentalhealth.vermont.gov/cafu. The Department has published a booklet called *Pathways: A Resource Guide Connecting Families with Services and Supports for Children and Adolescents Who Experience Serious Emotional Disturbance.* You may also download it from their website at: http://mentalhealth.vermont.gov/sites/dmh/files/publications/DMH-CAFU_Pathways.pdf

The Vermont Federation of Families for Children's Mental Health, and the **Vermont Family Network** (born of a merger between Parent to Parent of Vermont and the VT Parent Information Center) are nonprofit organizations specifically set up to help younger families navigate the system of care in schools and among providers. They offer training, advice and other resources to assist parents in getting the services and supports their children need to be supported at school and home. Contact the Vermont Federation for Children and Families at (800) 639-6071 (www.vffcmh.org), and the Vermont Family Network (800) 800-4005 (www.vermontfamilynetwork.org) for more information and assistance.

HOW ARE MENTAL ILLNESSES TREATED?

Most people diagnosed with mental illness can experience relief from their symptoms by actively participating in an individual treatment plan. Numerous treatments and services for mental illnesses are available. The choice and combination of treatment and services selected depends in most cases on the type of mental illness, the severity of symptoms, the availability of options and decisions determined by the individual, often in consultation with their health care provider and others. Most

people with mental illness report that a combination of treatments, services and supports works best to support their recovery.

MEDICATIONS

Medications often help an individual with mental illness to think more clearly, gain control of his or her thoughts and actions, and bring his or her emotional state back into equilibrium. Although any licensed physician can prescribe medication, psychiatrists and psychiatric Nurse Practitioners are the most knowledgeable about psychotropic medicines (those used to treat mental illnesses). Ask the prescribing Doctor or Nurse Practitioner:

- What to expect from the medication;
- What is the therapeutic range of dosage?
- What side effects are common (and not so common)?
- How long does it take for the medication to start working?
- How do we know the medicine is working?
- What should we look for? and
- What are some strategies to use if the person does not want to take the medicine, or takes it sporadically?

It is important to know that medications have both a trade and a generic name. Trade names are generally capitalized, while generic names are in lower case.

Keep a written record of all medications prescribed, the recommended dose, and how well (or poorly) they work and are tolerated. Individual responses to the same medicines vary widely. What works well for one person may be ineffective or intolerable for another. If the medicine does not work well it is important to tell the doctor, even if your loved one does not. Pharmacists are an excellent (and often overlooked) source of information. Talk with them and read the package inserts that come with the medicine. More detailed information can also be obtained from a current edition of the Physician's Desk Reference, available in most public libraries. It is important to discuss this information with the doctor who knows the patient and is prescribing the medication(s). Information taken out of context can be misleading. There are also several other drug reference books that are more accessible to the lay person. Ask a librarian, bookseller, or search online for information on such books.

In addition to their intended therapeutic effects, psychotropic medications often have side effects which vary, both among individuals and in intensity and severity. It is important to monitor both intended and unexpected side effects of medicine(s) and report these to the doctor.

The beneficial effects of medication may not become noticeable until after the drug has been taken for several weeks. The **maximum** beneficial effect may take months of continuous use to become apparent. Likewise, the beneficial effects of a medicine may take days or weeks to wear off after a person stops taking the medicine. Therefore, an ill person who stops taking medication, either with or against medical advice, may not have an immediate noticeable effect or relapse.

ANTIPSYCHOTIC MEDICATIONS

Antipsychotic medications are used to counteract the "positive" symptoms of psychotic disorders such as schizophrenia. Such "positive" symptoms (those "added to" the individual that were not there before) include delusions, hallucinations, agitation, bizarre mannerisms, and disturbed thought processes and speech patterns. Antipsychotic medications are sometimes used to calm the excessively hyperactive behavior seen in the manic phase of bipolar disorder. They are increasingly prescribed for those who have bipolar disorder and no psychotic symptoms.

Antipsychotic medicines are not always effective in treating the "negative" symptoms, those traits seemingly taken away from the person, such as the ability to experience joy and empathy. First-generation antipsychotics, sometimes called 'typical' because of their once-widespread use, include chlorpromazine (Thorazine), thioridazine (Mellaril), mesoridazine (Serentil), trifluoperazine (Stelazine), perphenazine (Trilafon), fluphenazine (Prolixin), thiothixine (Navane), chloroprothixine (Taractan), loxapine (Loxitane), haloperidol (Haldol), and molindone (Moban). Note the generic name appears first in lower case, and the trade name is capitalized and in parentheses.

Both haloperidol and fluphenazine can be administered by injection in intervals of one, two, or more weeks, thus doing away with the need to take daily medication ("long-acting"). Injections can be useful and helpful for those individuals who are resistant to taking medication, tend to forget it, or simply prefer the convenience of a shot. Keep in mind, however, that these are among the oldest of the antipsychotic medications, and carry the increased risk of neurological side effects some of which are irreversible.

In addition to a lack of insight that they are ill in the first place, the main reason individuals stop taking medication is that they experience unpleasant or even intolerable side effects. Ask your family member how the medicine(s) make him or her feel. Listen to their response. Take any complaints seriously, and bring them to the attention of your family member's doctor. Some of the more important and unpleasant side effects are:

Allergic reactions: These will usually occur during the first two months of taking the medication. Symptoms include yellowish skin, skin rash, flu-like symptoms such as fever, sore throat, diarrhea, vomiting, and stomach or intestinal pain or tenderness. Call the doctor immediately if any of these occur.

Autonomic nervous system reactions: Such reactions have to do with the autonomic nervous system, which controls the secretion of the salivary glands, control of the heart and the circulatory system, function of the digestive system, and numerous other functions. The most common symptoms are dizziness or even fainting when sitting up after lying down or standing up after sitting down, dry mouth, blurred vision, difficulty in urinating, and constipation. Usually appearing within the first two weeks of treatment, they may decrease or disappear after a few weeks.

Drowsiness: The person may be very drowsy and may sleep a lot. This tends to decrease or disappear after a few weeks.

Extrapyramidal reactions (problems with movement): There are several types of extrapyramidal reactions. Most can be treated by reducing the dose of antipsychotic medications and/or taking medicines that counteract these reactions. Dystonias are mild to severe muscle spasms. They usually appear within the first few days of taking medication. Akathisia is a sense of internal tension and agitation, signaled by an inability to stay still. People will pace, rock, jiggle their leg, tap their foot, etc. This one side effect accounts for more instances of non-adherence than does any other because it feels so awful. Pseudo parkinsonism produces tremors, shuffling gait, muscle stiffness, slowed movement, and drooling. Both akathisia and pseudo parkinsonism usually first appear within the first three months of treatment. Tardive dyskinesia does not often appear until at least a year of taking an antipsychotic medicine. Symptoms include involuntary movements of the mouth or face such as tongue protrusion, chewing movements, lip smacking, grimacing, or frowning. Early signs of tardive dyskinesia should be reported to the doctor immediately. Unless the dose is reduced or the medicine is changed, these symptoms may worsen and/or become irreversible. The outcome can be improved if the dose of medication is lowered or a different medication is tried (see below).

ATYPICAL ANTIPSYCHOTIC MEDICATIONS

The newest medications used to treat psychosis are clozapine (Clozaril), risperidone (Risperdal), olanzapine (Zyprexa), quetiapine (Seroquel), ziprasidone (Geodon), and aripiprazole (Abilify) – approved in 2003. More are being developed and tested in clinical trials.

Clozapine (Clozaril) is widely heralded because it is effective for one-third to one-half of those individuals who have not responded to other antipsychotic medicines. Furthermore, it not only controls the "positive" symptoms of schizophrenia, such as hallucinations and delusions, but it also may have greater efficacy for the "negative" symptoms of apathy and social withdrawal. Unfortunately, about 1% of those who take clozapine develop agranulocytosis (a precipitous and dangerous loss of white blood cells), a condition that can be fatal if not recognized and treated early. Therefore, those taking clozapine must have blood drawn weekly for the first six months, and thereafter, every two weeks, to check their white blood cell count. Seizures have been reported in some individuals who take clozapine.

The other atypical antipsychotics cause fewer neurological side effects, and are much less likely to cause tardive dyskinesia. They are equally as effective as the older antipsychotics in treating the positive symptoms (and risperidone and olanzapine may have greater efficacy). Some investigators assert that they are more effective than the older drugs in treating negative symptoms. None of these newer medications cause agranulocytosis. They do, however, have some significant side effects that will be discussed below.

Risperidone (Risperdal) can cause weight gain, sexual dysfunction and, at higher doses, the stiffness and tremor that is observed in individuals taking the older antipsychotic drugs.

Olanzapine (Zyprexa) was released in 1996. It is both effective and reasonably well- tolerated, however, many individuals who take this medication report significant weight gain of at least 15 pounds, and often much more. Furthermore, there is growing evidence that those who take olanzapine, either because of the weight gain or through some other mechanism, are at higher risk to develop diabetes.

Ziprasidone (Geodon) and quetiapine (Seroquel) are newer antipsychotics. They have the benefits of the above mentioned medicines. Quetiapine can cause headaches and may cause less weight gain than previously mentioned drugs. Ziprasidone can cause insomnia.

Aripiprazole (Abilify) appears to be weight-neutral, in that it does not cause weight gain, and has the benefits of the above. It can be activating, which people tend to describe as feeling "antsy".

The newer antipsychotics are preferred because they are generally better tolerated than the older drugs. If you have a relative who is on an older antipsychotic, it would be worth discussing the pros and cons of switching to another medicine, particularly if that person is experiencing neurological side effects. There are occasions, however, when patients experience relapse during a switch to another medication. If someone is doing well on an older medication and is not experiencing side effects, it's appropriate to ask lots of questions when a provider recommends switching to a different medication. Careful monitoring of symptoms and side effects during any change in medications or dosage is essential.

MOOD STABILIZER MEDICATIONS

At present, there are three types of medicines used to control the wide swings of mood which are characteristic of bipolar disorder (manic depression). These are lithium, anti-convulsant medications, and calcium channel blockers.

Lithium carbonate, as it is more accurately called, includes the brand names Eskalith, Lithane, Lithonate, and Lithobid. About half of those who have bipolar disorder respond very well to lithium. However, among its common side effects are nausea, diarrhea, abdominal cramps, dry mouth, lethargy, hand tremors, weight gain, and acne. Anyone taking lithium must have their blood serum level checked periodically to monitor the level of the medicine in their blood. Lithium has what is called a "narrow therapeutic window" which means that there is not a big difference between the therapeutic and the toxic dose for this drug. If any of the above-mentioned side effects worsen suddenly, or an unusual one develops, the person should contact his or her doctor immediately. Lithium can also affect the kidney and thyroid gland. Blood tests need to be done fairly frequently initially to help discern the best dose, and every 4-6 months when someone is stable in order to check both the level and the affect of the drug on other organs (i.e. the kidney and thyroid).

For people who do not respond to lithium or cannot tolerate its effects, the anti-convulsant medicines divulproex sodium (Depakote), valproic acid (Depakene), or carbemazepine (Tegretol) may work well. The side effects of these medicines may make people feel "off their game," not sharp or coordinated. Bloating, indigestion, nausea, and blurred or double vision may also occur. Lamotrigine (Lamictal) has recently been approved for the treatment of depression in patients who have bipolar disorder. It is generally well-tolerated but it has a high incidence of causing allergic rashes which in some individuals can be extremely serious.

For those individuals who continue to be unresponsive to the above mood stabilizers there are alternative medications that have been reported to possibly have some efficacy for individuals with bipolar disorder. These include topiramate (Topamax), another anti-convulsant, and the calcium

channel blockers verapimil (Calan) or nimodipine (Nimotop). Edema and constipation are the side effects most commonly associated with verapimil and nimodipine.

It is not unusual for people who have treatment-refractory bipolar disorder, for example when the patient's symptoms do not improve with a single drug, to be taking several medications. An example of such a medicine regimen is: a mood stabilizer, an atypical antipsychotic (clozapine, olanzapine, or risperidone), and an anti-anxiety medicine (see below). Some may also take an antidepressant, although it is important to note that those who have bipolar disorder who take an antidepressant (see below) are at higher risk of experiencing a manic episode, especially if not taking a mood stabilizer concurrently. In fact, if a person who has bipolar disorder begins with an episode of depression and is prescribed an antidepressant they will typically experience a manic episode fairly soon thereafter, in which case the diagnosis changes from depression to manic depression.

ANTIDEPRESSANT MEDICATIONS

Antidepressants are used primarily to treat depression. However, some are also used to help people cope with panic disorder and obsessive compulsive disorder. They are divided into four groups: 1) tricyclics and tetracyclics; 2) monoamine oxidase inhibitors; 3) selective serotonin reuptake inhibitors; and 4) miscellaneous agents.

1) **Tricyclics** include: imipramine (Tofranil), doxepine (Sinequan, Adapin), amoxapine (Ascendin), desipramine (Norpramin), trimiprimine (Surmontil), nortriptyline (Pemelor, Aventyl), amitriptiline (Elavil), protriptiline (Vivactil), clomiprimine (Anafranil), amoxapine (Ascendin), trimiprimine (Surmontil). **Tetracyclics** include: maprotiline (Ludiomil) and mirtazepine (Remeron)
   Side effects of these medications can include dry mouth, tremors, sweating, urinary retention and constipation, bloating, and weight gain, and lightheadedness when standing up suddenly. A more serious side effect is irregularities in heartbeat. People with certain heart conditions cannot take them. The tetracyclics have more mild side effects, although maprotiline can cause seizures. However, both the tri- and tetracyclics can be fatal in an overdose, intentional or accidental. They can be potentially lethal when given to a suicidal individual.

2) The second group of antidepressants are the **monoamine oxidase (MAO) inhibitors**. These are phenelzine (Nardil), tranylcypromine (Parnate), and isocarboxazid (Marplan). They can cause weight gain and light headedness when standing up, they can also be lethal if taken in overdose or in a suicide attempt. In addition, they have a side effect all their own. If individuals taking MAO inhibitors eat certain foods containing amines (beer, red wine, alcohol free beer, aged cheddar cheese, chocolate, yogurt, pickled fish, sour cream, soy sauce, meat tenderizers, sauerkraut, tofu, aged meats, protein dietary supplements), their blood pressure can soar to dangerous levels and they need to get to a hospital, fast!

3) **Selective serotonin reuptake inhibitors** include fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil), fluvoximine (Luvox), citalopram (Celexa), and duloxetine (Cymbalta), which is also a norepinephrine reuptake inhibitor (SNRI). Side effects of these drugs are mild but can include diminished sexual interest, erectile dysfunction, inability to achieve orgasm, headaches, nausea and weight loss.

4) The **miscellaneous agents** referred to above are buproprion (Wellbutrin), nefazodone (Serzone), trazodone (Desyrel), venlafaxine (Effexor), and reboxitane (Vestra). Side effects of each vary.

While there are a great number of antidepressant medications to choose among, it is vital to get an accurate diagnosis because there are many different syndromes that can include depression as a symptom, and the treatment of these distinct syndromes differs. Furthermore, many antidepressants can take 4 to 6 weeks to take effect. This can seem a very long time for someone who is deeply depressed. Sometimes, a person may need to take an additional medication to augment the effects of the antidepressant.

ANTI-ANXIETY MEDICATIONS

These medicines work to reduce anxiety. Although they may be prescribed to reduce the anxiety of individuals who have obsessive compulsive disorder, they seldom have an effect on the obsessions or rituals characteristic of this disorder. They can also be prescribed to help people sleep. This class of drug can lose their efficacy over time, can be habit-forming, and have the disturbing side effects of drowsiness, confusion, decreased muscle coordination, and a "hang over" grogginess upon awakening. Benzodiazepines can cause varying degrees of physical dependence; a person on them for at least three months should not stop taking them abruptly. To get off this medication, doctors will prescribe a decreasing dose to prevent the unpleasant symptoms of withdrawal.

There are many benzodiazepines. Among them are: alprazolam (Xanax), chlordiazepoxide (Liritabs, Librium), clonazepam (Klonopin), clorazepate (Tranxene), diazepam (Valium), estazolam (ProSom), flurazepam (Dalmane), halazepam (Paxipam), lorazepam (Ativan), oxazepam (Serax), quazepam (Doral), temazepam (Restoril), triazolam (Halcion)

Buspirone (BuSpar) is another anti-anxiety drug, but it is both non-addictive and non-sedating. However, it may cause dizziness, nausea, headache, and nervousness. Hydroxyzine (Atarax, Vistaril) is an anti-histamine that is sometimes used to treat anxiety. It may cause drowsiness or confusion.

To learn more about what medications are being developed or are in clinical trials, visit:
National Institute of Mental Health (NIMH): www.nimh.nih.gov/health/trials/index.shtml

ACCESS TO HEALTH CARE AND REDUCED-COST MEDICATIONS

Vermont Health Connect is the health insurance marketplace where individuals, families and small businesses in Vermont can compare public and private health plans and select one that fits their needs and budget. All of the plans offered through Vermont Health Connect offer benefits like doctor visits, hospital stays, preventive care, and prescription coverage. Depending on how much you earn, you might qualify for a low-cost or free health plan - or you may get financial help to lower your monthly premium costs or what you pay when you go to the doctor. Young adults up to age 26 can stay on their parents' health plan. This even covers young adults who are married and don't live at home.

Information about Vermont Health Connect information is available online at http://info.healthconnect.vermont.gov/. For those who do not use the internet or want personal assistance selecting a health plan they can call the Customer Support Center at (855) 899-9600 or contact a Navigator.

The following healthcare programs in Vermont are run by the Department of Vermont Health Access. For more information or to apply for these programs, call 800-250-8427 or visit either www.greenmountaincare.org or http://info.healthconnect.vermont.gov/.

- **Medicaid** is low-cost or free health coverage for adults.
- **Dr. Dynasaur** provides low-cost or free health coverage for children, teenagers under age 19 and pregnant women.
- **Long Term Care:** Vermont's Long-Term Care Medicaid program helps eligible Vermonters pay for long-term care services in the setting of their choice.
- **Prescription Assistance:** Vermont offers prescription assistance to uninsured Vermonters and those enrolled in Medicare. Eligibility is based on income, disability status and age.

For additional information about state programs see section on "State Programs and Benefits".

The Vermont Coalition of Clinics for the Uninsured is an association of ten free medical clinics and two free dental clinics serving the needs of 40,000 Vermonters who do not have medical and dental insurance and are without the means to pay for medical care. These clinics are governed by community-based boards of directors and located throughout the state. They are supported by volunteers, community hospitals, local fund-raising, and an annual grant from the State of Vermont. Each of the clinics offers free primary health care and referral services to low income uninsured or underinsured Vermonters. See Appendix E for a list of clinics throughout the state.

Psychiatric medicines can be expensive, particularly the newer ones. If your relative is not insured by Medicare or Medicaid, it is important to shop around. Pricing can vary considerably from one pharmacy to another. Fortunately, there are many programs that can help reduce the cost of these medications to you, and provide access to health care to those without private insurance.

With the new health care system coming on board, the following information may become outdated. However, we are including it because it may remain helpful.

Low-income patients who are dual eligible (for both Medicare and Medicaid) should sign up for the Medicare Part D prescription drug plan, which offers access to a broad range of medications. For more info, see: www.medicare.gov/part-d/

Another approach is to look into special pricing for generic medications at some of the large retailers, such as Costco, Wal-Mart and Hannaford. Also, a program called the 'Partnership for Prescription Assistance,' sponsored by the pharmaceutical industry, provides access to medications at steep discounts to eligible patients. For more info, see: www.pparx.org.

Once you have been evaluated, diagnosed and been given a prescription by your provider, many doctors will provide samples of a medication at no additional cost to get you started. If cost is an issue for you, consider asking your doctor for a two-week (or longer) supply at the time of your appointment. This will give you time to explore some of the programs outlined here. You can also ask your doctor if there are generic equivalents to any brand-name medications prescribed, and if so, to write the prescription to allow a generic substitution.

There are two Vermont programs that offer assistance in covering the cost of prescription medications for eligible Vermonters.

- **Healthy Vermonters** provides a discount on prescription medicines, with no monthly premiums for i**ndividuals who meet income guidelines and have no prescription coverage or have reached their maximum benefit amount on their current prescription coverage.**
- **VPharm** helps pay for prescription medicines, with affordable monthly premiums for i**ndividuals who meet income guidelines and are currently enrolled in Medicare Part D coverage.**

To apply: Complete the 201P Pharmacy Programs Application that can be downloaded from: http://dcf.vermont.gov/esd/prescriptions or call 1-800-250-8427 and ask that a 201P be mailed to you.

PSYCHOSOCIAL TREATMENTS

What are psychosocial treatments?

Psychosocial treatments—including certain forms of psychotherapy (often called "talk-therapy") and social and vocational training—are helpful in providing support, education, and guidance to people with mental illnesses and their families. Studies tell us that psychosocial treatments for mental illnesses can help individuals decrease the negative effects of their illnesses and increase their functioning (leading to fewer hospitalizations and less difficulties at home, at school, and at work).

Individual psychotherapy involves regularly scheduled sessions between the patient and a mental health professional. The goal of this treatment is to help individuals understand why they are acting and thinking in ways that are troubling or dangerous to themselves (or others). This allows a person to have more control over their behaviors and to change these behaviors when possible. Talk-therapy sessions may focus on a person's current or past problems, experiences, thoughts, feelings or relationships.

Psychoeducation involves teaching people about their illnesses and how they are treated. This allows people and their families to recognize signs of relapse in order to get necessary treatment before mental illness worsens or occurs again. Family psychoeducation includes teaching coping strategies and problem-solving skills to families (and friends) of people with mental illnesses to help them deal more effectively with their friends and relatives.

Self-help and support groups for people and families dealing with mental illnesses are becoming increasingly common. Although not led by a professional therapist, these groups may be therapeutic because members give each other ongoing support. These groups are comforting because ill people learn that others have problems similar to theirs: they are not alone in this world with their mental illness.

What are examples of specific psychotherapies?

Therapists offer many different types of psychotherapy. In general no one type of therapy is necessarily "better" than another type, although certain mental illnesses have been shown to respond better to specific psychotherapies. When deciding which therapy, or therapies, will likely be the most successful treatment option for an individual, a psychotherapist considers the nature of the problem to be treated and the individual's personality, cultural and family background, and personal experiences.

Interpersonal therapy focuses on the relationships a person has with others. The goal of interpersonal therapy is, of course, to improve interpersonal skills. The therapist actively teaches individuals to evaluate their interactions with others and to become aware of self-isolation and difficulties getting along with, relating to, or understanding others. He or she also offers advice and helps individuals make decisions about the best way to deal with other people.

Interpersonal therapy is a psychosocial treatment used most frequently to help people with bipolar disorder, ADHD, depression, eating disorders and generalized anxiety disorder. It is often expected to last for approximately 3-4 months and to target specific symptoms over this time period.

Cognitive behavioral therapy (CBT) is a treatment that focuses on the relationship between an individual's thoughts, feelings, and behaviors. A CBT therapist will try to explore the links between the thoughts and emotions that occur prior to disruptive behaviors in people with mental illness. By establishing these connections, individuals learn to identify and change inappropriate or negative thought patterns and as a consequence, can address the behaviors associated with their illness. CBT is often thought of as a "first-line treatment" in many anxiety disorders (including OCD, Panic Disorder, and PTSD).

A type of behavioral therapy known as **exposure therapy** (or exposure and response prevention) is specifically useful for treating obsessive-compulsive disorder (OCD) and posttraumatic stress disorder (PTSD). During exposure therapy, an individual is deliberately exposed to whatever triggers the obsessive thoughts or reaction to a previous traumatic experience under controlled conditions. The individual is then taught techniques to avoid performing the compulsive rituals or to work through the trauma.

Dialectical behavior therapy (DBT) was initially developed to treat chronically suicidal individuals with Borderline Personality Disorder (BPD). Over time, DBT has evolved into a treatment for individuals with multiple different disorders, although many people who are treated with DBT have borderline personality disorder (BPD) as a primary diagnosis. DBT combines the basic strategies of behavior therapy with a philosophy that focuses on the idea that 'opposites may really not be opposite when looked at differently.'

Psychodynamic Psychotherapy has its fundamental roots in the teachings of Sigmund Freud, Carl Jung, and other psychiatrists who practiced in the early twentieth century. Yet most therapists who offer this treatment are no longer driven by the rigid rules of traditional "psychoanalysis." Psychodynamic psychotherapy is practiced differently by different therapists and will likely vary depending on the needs of their client. There is not as much scientific data supporting the

effectiveness of psychodynamic psychotherapy in some illnesses (such as schizophrenia) as opposed to other treatments (including CBT).

PEER SERVICES AND SUPPORTS

Peer support is getting help from someone who has been there. People with similar experiences may be able to listen, give hope and guidance toward recovery in a way that is different, and may be just as valuable as professional services. Peer services include mutual support groups, peer-run programs and services in traditional mental health agencies provided by peer support specialists. While peer support groups may be composed entirely of people who have simply learned through their own experience, some types of peer providers undergo training and certification to qualify. In addition to direct services, many peer-run organizations advocate to improve opportunities for people recovering from mental illnesses.

A peer support group is a voluntary gathering of people with similar challenges, usually weekly or monthly for an hour or two, to share experiences and coping strategies and offer understanding. NAMI Connection is one type of peer support group in which trained facilitators, who themselves have lived experience with mental illness, guide group members to listen and provide supportive, meaningful feedback to each other.

Peer recovery education is structured instruction taught by people who have lived experience of mental illness and can take place in a single session or series of lessons. Peer education can include information such as the process of recovery, wellness and self-care, symptoms and diagnoses of mental illness, what to expect from professional mental health services, coping skills and self-advocacy. The Wellness Recovery Action Plan (WRAP), a widely recognized self-assessment and planning program, is a peer education process that can take place in one or more sessions.

Peer-run services are mental health programs where the staff uses information, skills and resources they have gained in their recovery to help others. Peer services are based on principles of empowerment, choice, mutual help and recovery. The goal of peer-run programs is to create a supportive place in which people can find understanding peers, can learn recovery skills and can help others. Common types of peer-run programs include, but are not limited to:

- Drop-in or peer support center: for friendship, peer counseling, recovery learning and skill-building, wellness supports, community-based activities and connection to services. Often open in evenings and weekends as well as during the business day, peer support centers serve as a "home away from home."
- Peer mentoring, peer case management: On a one-to-one basis, certified peer support specialists listen, help plan recovery and help identify supporters. Peer mentoring can occur at a center or in the community. Peer mentors not only teach coping skills, but also emphasize physical wellness through careful attention to sleep, good nutrition, stress management and social support.

Peer-providers in traditional mental health programs

Peer support is gaining acceptance as a valuable part of service delivery in professional inpatient and community-based services. Medicaid and public mental health systems increasingly pay for services provided by certified peer support specialists as part of the service delivery team. The peer support specialist may be able to connect on the same level as the person, offer information and guidance from within the person's frame of reference and help the person navigate the service system to obtain income, housing, treatment and social support. Peer support may be particularly valuable for people who mistrust professionally delivered services. Service models such as Assertive Community Treatment (ACT) require inclusion of a peer support specialist as part of the team.

How can I find peer support services? Peer support services are increasingly common and are often provided at little to no cost. See Appendix G for a listing.

TEAM APPROACH IN TREATMENT AND RECOVERY

Because of the extreme difficulties and complexities of serious and persistent mental illness, research has found a team approach to be the most effective form of treatment and community support. The Vermont Department of Mental Health, NAMI Vermont family members, and community mental health centers are working to establish a model of family/peer/professional collaboration, or a team approach. Each member of the team (family member, client, mental health professional) can bring his or her own areas of expertise to the table. The family can often tell the service providers about the person's medical and family history, especially if the providers are meeting the client for the first time, and the client is very symptomatic. Clients can tell family members and professionals how they feel, what they need, when symptoms are active and what they are like, what is most and least helpful to them, and what effects various medications have on them. Professionals have knowledge about treatment and recovery, and know what income, housing and support services are available.

If the perspectives of all members of the treatment team are respected, there is a better chance for forward progress and good outcomes. Families need to understand the nature of the illness, just as they would need to understand any other illness (heart disease or diabetes, for example), in order to provide a healthier environment for the ill person. After all, at this stage in our history mental illnesses are bigger than all of us, and we need all the help and information we can get.

We all need to find the time and energy to continue to educate one another – professionals, families, and peers. We need to recognize that any and all members of the team can burn out. We need to be supportive of one another, learn to negotiate, compromise and forgive. We need to appreciate one another's strengths and skills. It is important to recognize cultural, environmental and individual differences. Needs may be fairly constant, but how they are expressed will vary.

All members of the team need to be part of periodic evaluations of progress. What is effective now? How have things changed? Where is the client in his or her progress? What risks can be taken? Who is ready and who is not?

Even when families and professionals think clients are not ready for particular situations (moving to a more independent living situation or starting a job, for example), we all need to listen to their desires and dreams. The team may then be better able to creatively assist the individual client to begin, perhaps slowly at first, to work on his or her recovery.

Just because someone has a serious illness does not mean they should be cut off from who they are, and who they want to become. People with mental illnesses have dreams just like everyone else. Do we hold to a "punishment" mode, or a "creative progress" mode? The latter may provide larger challenges for family members and professionals. Peers may become bored with not moving ahead more quickly and put themselves at risk of a devastating failure, or conversely, be afraid to risk anything new. We know people are more satisfied when engaged in productive endeavors that fit their dreams and desires.

When and where possible, your faith community (church, synagogue, mosque etc.) and friends and relatives play a part in the healing process. Their team involvement can be integral or minimal. Whoever can contribute to positive development and progress for and with the client helps expand the team and, in turn, strengthens the support network.

RECOVERY

It was once thought that individuals who had a mental illness were destined to live life forever in the shadow of a chronic and debilitating illness that never got better. Yet people who were institutionalized in the first half of the twentieth century in this country, and discharged in the latter half of the century, could and did find jobs, have families, and/or participate in community life. Many did so with the help of medications and mental health services. Some did so on their own, or with the help of peers.

Recovery, in the context of mental illness, is a very charged word. Before going on to say what recovery is and how to bring it about, let's first say what it is not.

- Recovery is NOT a cure;
- Recovery is NOT freedom from symptoms, pain, loss or problems;
- It is NOT always moving forward, never feeling pain or having a relapse; and
- Recovery is certainly NOT the life you had originally planned.

What <u>do</u> we know about recovery?

- Many people get much better from the disturbing behaviors, moods and thoughts characteristic of mental illnesses.
- With effort and commitment, most people get somewhat better.
- Everyone can improve from where they are now.
- The potential for recovery does not seem to be affected by how severe an individual's illness is. In other words, the level of severity does not predict how a person will do over time.
- We do not know how to predict who will get better, and how much better they will get.
- Even very ill people have some control over their own happiness and recovery.

So, if most people get better, many get significantly better, and everyone can improve from where they are now, AND there's no way to predict, based on the severity of the illness, who will do well, AND if people have some control over their progress, THEN we need to do our best for everyone and give everyone access to the best recovery strategies out there. There is hope for **everyone**.

Definitions of Recovery

The Substance Abuse and Mental Health Services Administration (SAMHSA) has announced a new working definition of "recovery" from mental disorders and substance use disorders as follows: ***"A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."***

William Anthony, PhD, previous Executive Director of the Center for Psychiatric Rehabilitation and Professor Emeritus at Boston University (1993), identifies recovery as ***"a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness."***

Anthony often says that everyone is recovering from something. No life is untouched by sadness, even tragedy. In our own lives we can all think of horrible, shocking, sad events – the death of loved ones, fighting or being caught up in a war, bankruptcy, being in an accident or having a severe, life-threatening or debilitating illness. When these things first happen, we think nothing will ever be the same. We will never again have joy, happiness or even contentment.

Yet eventually the sting fades. We gradually resume our patterns or embrace new ones. We learn what things, people, habits and activities are helpful to us through this time, and which are not. Therefore, recovery is the natural process we go through following any traumatic event. Over time, most of us do recover from even the most tragic events of our lives. That is not to say that we emerge unchanged. We likely are not who we were before the tragedy struck, and our lives may become very different, even more difficult. But we are often better, stronger, more resilient, more compassionate.

Recovery is what happens as we come back. We reclaim our place in our world. We achieve some measure of peace of mind. We find comfort in friends and family, or we find new people. We discover new ways to improve and be who we want to be, things we did not know about before. We learn to find pleasure again. We re-achieve a good life, although perhaps a very different life. All of us have a natural tendency to recover. We recover as we do things that help us to feel better. We may not be able to precisely define recovery, but we know it when we see it.

The *National Consensus Statement on Mental Health Recovery* suggests:

> Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.

Their definition of recovery includes several key elements: Having hope for one's future, in the face of the awareness of one's illness is vital. Hope is prerequisite for the other aspects of recovery. Empowerment, or the ability and means to have a say in important aspects of one's life is another

dimension of recovery. Quality of life is another. Inclusion in community life, independence, and the right to make choices for one's life are also important. Having relationships with people outside the mental health system is particularly important. Vital to recovery is the individual's knowledge that he/she is (or will be) making a significant contribution to others. Thus, having paid or volunteer work is often important.

Today, the recovery movement is gaining strength. The chief message of the recovery movement is that it is realistic to expect the restoration of a meaningful and satisfying life, despite having been diagnosed with a mental illness. The focus of the recovery movement goes beyond that of "symptom relief." An individual in recovery discovers personal strengths and abilities, develops an identity beyond that of a person with mental illness, attains meaningful roles in the community, and, thus, gains self-respect. Some people consider themselves recovered while still experiencing symptoms. They learn and use coping skills to lessen the impact of these symptoms. Many continue to take medications – some do not, relying totally on new life skills and habits. Perhaps the most telling is the "mantra" of Recovery Educators: there is no end to recovery!

The Recovery Education Project is based upon the work of Mary Ellen Copeland, a consumer from Vermont. The table of contents for her Wellness Recovery Action Plan (WRAP) booklet includes the following teaching topics: hope, personal responsibility, education, advocacy, support, health care, medication issues, making a Recovery Action Plan, suicide prevention, self esteem, changing negative thoughts to positive ones, trauma recovery, and lifestyle issues. This booklet and the recovery classes help individuals to use self-help skills to monitor their symptoms, decrease their severity and frequency, and improve the quality of their life.

Mary Ellen Copeland's website (see http://www.mentalhealthrecovery.com/about/overview.php) states that:

"WRAP is a self-designed plan for staying well, and for helping you to feel better when you are not feeling well, to increase personal responsibility and control over your own life, and to help make your life the way you want it to be."

Participants in WRAP workshops develop a Daily Maintenance Plan, which includes three parts:

1) Description of yourself when well;
2) Wellness Tools that you can use every day to feel well, e.g. eating well, getting a good night's sleep, contacting friends and other supportive people, and getting exercise; and
3) List of things to do every day.

Participants also list Triggers, or life events that will make the person feel worse, such as an argument, receiving a large bill, or experiencing distressing symptoms. They identify Early Warning Signs of beginning to feel worse, such as irritability, nervousness, and fatigue. If allowed to go on too long, such early warning signs can develop to the point that action must be taken When Things Are Breaking Down. Part of the Wellness Recovery Action Plan is to develop and act upon a plan to head off a relapse or hospitalization.

If things get really bad, WRAP includes a section on a Crisis Plan or Advanced Directive. In this Crisis Plan people identify the signs that let others know they need to take over your care, who you want to do this, and what is and isn't helpful to you when in crisis.

Many people with mental illnesses have participated in WRAP workshops throughout the state. For more information about this course and its availability around the state, call Vermont Psychiatric Survivors (VPS) at (802) 775-6834.

In 2003, Mary Ellen Copeland, along with other people in recovery and supportive allies, founded the Copeland Center for Wellness and Recovery to promote mental health recovery through education, training, and research based on WRAP®. Visit http://copelandcenter.com/

There are some great resources on the web about recovery, such as www.vtrecoverynetwork.org. There you will find more information about peer recovery programs and resources in Vermont, links to useful web-based consumer resources, and much more.

COPING WITH MENTAL ILLNESS

THE FAMILY PERSPECTIVE

The sometimes gradual, sometimes sudden descent of a loved one into mental illness is a traumatic event in the life of a family. Rarely are the members of a family knowledgeable about or prepared to cope with mental illness. As with any traumatic event, there is a natural tendency to deny that it is happening, while at the same time hoping against hope that it will simply "go away."

The feelings and reactions vary from family to family, and among the individuals in the same family. Nevertheless, there are predictable emotional reactions family members have. Dr. Joyce Burland, author of the NAMI Family to Family Education Course referred to below, has identified the following emotional stages through which family members pass as we come to terms with mental illness in our families.

The initial onset of illness can be overwhelming for a family. Something catastrophic has just happened, and we do not know how to deal with it. We use denial as a natural and protective response to that which has turned our lives upside down. We think there must be a perfectly logical explanation for what is going on and that it will quickly pass. When we come to realize that this problem will be of longer duration than we had hoped, we think that if we make a superhuman effort to change everything, our lives will be normal again.

When this does not work, we become angry and resentful, and start to blame our loved one for not "snapping out of it." At the same time, we feel guilty, as if something we did or did not do is to blame, and then we become overly involved all over again. This ambivalence is truly draining. Deep down, there is the dawning recognition that the mental illness is truly a serious fact of our loved one's life, and we grieve the loss of the person we once knew.

Finally comes an understanding of the illness, of what our loved ones are experiencing, and we gain respect for their (and our) courage and strength. Bad things do happen to good people. We surely wish this trouble had not come into our lives, but it did. It is not our fault; it is not their fault. We will find a way to manage and even thrive. We begin to focus our anger and grief into advocating with and on behalf of our family member.

None of these states is bad or wrong. For some of us it has taken years to get to a place of understanding and acceptance. We do not necessarily progress through these stages in a linear fashion. Rather, we cycle back and forth, depending upon the severity of our loved one's illness at any given time.

IMPACT ON THE FAMILY: A PARENT'S THOUGHTS

How could this be happening? "A living nightmare," "a knowledge that one's world will never again be the same" are among the more common phrases routinely used by relatives to describe the complex diseases classified as chronic, severe, long-term mental illnesses. What does a family do when it "wakes up" in the middle of acute or chronic schizophrenia, bipolar illness, or any one of a myriad of similar diseases for which we currently have inappropriate labels, a proliferation of theories, and few diagnostic techniques and procedures?

The feelings, reactions, and responses vary from family to family and individual to individual, and may encompass among others: guilt, anger, fear, fatigue, or denial. Families may feel:

- Confusion and disorientation;
- Distancing or denial, that whatever it is that's happening, it can't be happening to me and my relative;
- Extreme fatigue, possibly accompanied by feelings that death would be better than this;
- Guilt based on a very much alive stereotype that the "parents are to blame."
- Fear for the safety of one's relative, the family, and society;
- Outrage over the injustice of such a horrendous occurrence in one's own relative and one's family;
- Anger over the lack of adequate services and facilities for proper treatment;
- Anger at some mental health professionals in particular, over the fact that parents, close relatives, and/or the patient are rarely listened to;
- Concern for the reactions of friends, relatives, and colleagues outside the immediate family circle;
- Exhaustion from being on call 24 hours a day, 7 days a week, 52 weeks a year;
- Exhaustion from working harder and urging the sick relative to work harder because, according to some individuals, if you and he/she will only work harder, "there is no reason why the person can't get better, or function better"
- Desire to escape the "nightmare," including thoughts of relocation to another part of the country or world.

The previously described feelings, reactions, and responses are by no means inclusive. Nor does each individual necessarily share them. However, they do suggest the range of concerns and discrimination the family is dealing with, in addition to coping with a family member who has manifested one of the most difficult and severe diseases known.

ADJUSTMENT, COPING AND FAMILY SUPPORT

For many people with severe, long-term mental illness, community treatment in the government-supported mental health system is clearly the way to go. It does, however, involve great efforts on the part of the individual, the family and providers – at least in the initial periods of treatment. It is, and must be, a shared challenge. Positive effects may not be instant.

Adjustment to mental illness can be a roller coaster ride. Family members need to learn what community treatment can and cannot do at any given time. They need to know the professionals working with their relative, and they need to know that the ill family member is also adjusting. Some hours, days, weeks or months, or even years will be better than others. The unevenness of progress can be difficult.

Grieving for the person who "used to be," or "was" is real and essential. But then there is a time to move forward, though usually hesitantly and painfully, at first – and, as time goes on, with more determination and strength to meet the challenges. As with any other illness we can succumb to the tragedy or become stronger.

Ill family members may make progress or may relapse or decompensate; medications may lose their effectiveness; toxicity may occur; regimens of medications may need to be altered; staff changes occur; persons with mental illness mature and their ideas, needs and wants continue to change. Family members experience their own health problems, job changes, retirements, etc. The adjustments always continue.

The importance of caring, supportive family members cannot be overestimated. By the same token, the need for family members to maintain their own sense of self, their individual identities, and their independent lives is crucial to health, well-being, and the ability to remain an integral part of the support system for the ill person. It is essential to remember that through all the challenges mental illness brings, families have a role and place in the treatment process. The Vermont Department of Mental Health has a Statewide Program Standing Committee (SPSC) where family members, peers, and providers are all represented to help advise DMH on key issues and developments and increase family and peer involvement in public mental health in Vermont.

ADVICE FROM FAMILY MEMBERS: WHAT WORKS

In NAMI family support groups and Family to Family Education Courses around the country, families have shared hard-won wisdom and advice. Here is some of that advice:

- Learn all you can about the illness your family member has.

- Remember that other family members (siblings, grandparents, aunts and uncles…) are also affected, and may be experiencing denial, guilt, reactive depression, anger, etc., just as you may be. Keep lines of communication open by talking with each other.
- Avoid guilt and assigning blame to others. It is not helpful or useful to do so. The illness is no one's fault.
- Find out about benefits and support systems when things are going well. Do not wait until there is a crisis. Support systems should encompass both physical and mental health.
- Learn to recognize early warning signs of relapse, such as changes in sleeping patterns, increasing social withdrawal, inattention to hygiene, and signs of irritability.
- Talk to your family member, especially when they are doing well. They can usually identify such signs (and other more individual ones). Let him or her tell you what helps to reduce symptoms and relieve stress. A visit to a psychiatrist, case manager, therapist, support group, or friend may help prevent a full-blown relapse. The person may also need an adjustment in medication.
- Anticipate troublesome situations. If someone in your family does not handle your loved one's illness well, do not have that person over until things calm down. If holiday gatherings or family reunions are a problem, make contingency plans.
- Do not agree with your relative that it is a good idea to stop taking medication because "I feel better" or "I am cured" or "the medicine makes me feel worse," or "the medicine isn't helping." However, take problems with side effects of medicine seriously. Listen and then contact a doctor to change the medication regimen to address the side effects or lack of effectiveness.
- Set reasonable rules and limits, and stick to them. If you find this difficult, ask a doctor, case manager, or other professional for their help and suggestions. Choose the issues that are most important, and do not make a fuss over less important ones. "Choosing one's battles" makes good sense.
- Do not suggest the person "pull herself together." If they could they would. Not being able to do so is part of the illness.
- Recovery is a process that cannot be rushed if it is to be successful. Remember that your relative's suffering and distress are at least as great as your own. When they are ready, they will move.
- Do not expect all peculiar habits or behaviors to change at once. Focus on what has been accomplished, rather than on what remains to be done.
- At times individuals with mental illnesses may experience memory loss, or inability to concentrate. This can be frustrating and frightening. Instead of insisting that the person try harder to concentrate, simply repeat the information in a straightforward, nonjudgmental way.
- Do not agree or go along with delusional thinking, but rather acknowledge whatever feelings the person has in response to them, e.g. fear, anger, amusement, etc. It is useless to attempt to argue a person out of his or her delusions, or to correct faulty logic.
- If your family member experiences hallucinations (things seen, heard, felt, etc. that are not there) be honest. Say that although you believe these sensations are real to him or her, you are not aware of them.

NAMI VERMONT PROGRAMS THAT CAN HELP

FAMILY-TO-FAMILY EDUCATION COURSE

The NAMI Family-to-Family Education Program is a free, evidence-based 12-week course structured to help families and friends of individuals living with a mental health condition understand and support their loved ones while maintaining their own well-being.

- The course is taught by trained NAMI family members
- All instruction and course materials are free to class participants
- Over 300,000 family members have graduated from the national Family-to-Family Program
- The Family-to-Family course is made possible in part by a grant from the Vermont Department of Mental Health

The course offers invaluable information about schizophrenia, major depression, bipolar disorder, borderline personality disorder, panic disorder, and obsessive compulsive disorder. Topics covered include: the emotional trauma of mental illness; illness symptoms as a "double-edged sword" of qualities both added to and taken away from the person we know and love; symptoms and diagnosis of various illnesses and their subtypes; basic brain biology; medications and their side effects; self-care for family members; developing a crisis plan; the potential for recovery; and how to advocate for ourselves, our loved ones, and others. The course offers valuable "hands on" classes on how to solve problems common in families dealing with mental illness, and how to communicate with someone who has a thought or mood disorder.

Joyce Burland, a Ph.D. psychologist and family member, wrote the Family-to-Family Education Course in Vermont. This invaluable course is offered at various locations around Vermont in the spring and fall, as well as in forty-eight states, Canada and Mexico.

Call NAMI Vermont at (800) 639-6480 or visit our website at www.namivt.org to find out about the location of upcoming courses being taught in your region.

MENTAL ILLNESS AND RECOVERY WORKSHOP

If you'd like to know more about mental illness, but have limited time right now, a good place to start is NAMI Vermont's one-day workshop, Mental Illness and Recovery. Offered throughout the state, these sessions introduce family members, peers, and community members to NAMI Vermont's education programs. Workshop leaders:

- Present a brief description of the disturbances in thoughts, moods and behaviors caused by mental illnesses such as depression, obsessive compulsive disorder, borderline personality disorder, post traumatic stress disorder, schizophrenia, bipolar disorder and panic disorder.
- Review how these disorders are best treated, and make available detailed information on services available throughout the state.
- Discuss what recovery means in the context of living with mental illness, and detail some coping strategies.
- Close the day with some suggested next steps.

Call NAMI Vermont at (800) 639-6480 or visit our website at www.namivt.org to find out the schedule for upcoming workshops.

PROVIDER EDUCATION COURSE

The NAMI Provider Education Course offers 15 hours of training to professionals and providers who work directly with people experiencing mental illness. The course is taught by a trained five-member team of family members, individuals living with mental illness, and a mental health provider. This course helps providers realize the hardships that families and individuals experience and appreciate the courage and persistence it takes to live with and recover from mental illness. The Provider Education Course emphasizes the involvement of individuals living with mental illness and family members as faculty in provider-staff training.

The course reflects a new knowledge base – the "lived experience" of people coping with a mental illness or caring for someone who lives with a mental illness. Including this deeply personal perspective creates an appreciable difference in the program's content. It adds a means of teaching the emotional aspects and practical consequences of these illnesses to the academic medical information in the course. CEUs are available for social workers, psychologists, and LCMHCs. Call the NAMI Vermont office at (800) 639-6480 to host the Provider Education course at your organization.

NAMI FAMILY SUPPORT GROUP PROGRAM

The NAMI Family Support Group is a free, monthly, 90-minute support group for families, partners and friends of individuals living with mental illness. Family support group participants can talk frankly about their challenges and help one another through their learned wisdom.

Family Support Groups empower and educate family members and close friends of individuals with persistent mental health challenges. All groups are led by trained individuals who have a family member living with a mental illness and understand the same challenges that attendees experience.

In these support groups, people learn from each other, share information and resources, and give each other support. Doctors and case managers do not or cannot always take the time to explain these illnesses and their treatments to family members, so we must educate ourselves. Other members of your own family may not be able to provide the support you need. It is difficult for our friends and acquaintances who do not live with mental illness to understand the daily challenges and concerns of those of us who do. Somehow, it is comforting to meet with others dealing with very similar issues, and who can understand and empathize. Sometimes they even have suggestions and answers, and sometimes they can only say "yes, I know." And they do.

Below are the Principles of Support which NAMI support groups use:

- We will see the individual first, not the illness.
- We recognize that mental illnesses are medical illnesses that may have environmental triggers.
- We understand that mental illnesses are traumatic events.
- We aim for better coping skills.

- We find strength in sharing experiences.
- We reject stigma and do not tolerate discrimination.
- We won't judge anyone's pain as less than our own.
- We forgive ourselves and reject guilt.
- We embrace humor as healthy.
- We accept we cannot solve all problems.
- We expect a better future in a realistic way.
- We will never give up hope.

For more information about the NAMI Family Support Group schedule visit **www.namivt.org**.

NAMI Connection: Recovery Support Group Program

NAMI Connection is a weekly recovery support group for people living with mental illness in which people learn from each others' experiences, share coping strategies, and offer each other respect, encouragement, understanding, and hope for recovery.

NAMI Connection groups offer a casual and relaxed approach to sharing the challenges and successes of coping with mental illness. Each group:

- Meets weekly for 90 minutes
- Is offered free of charge
- Follows a flexible structure without an educational format
- Does not recommend or endorse any medications or other medical therapies

All groups are **confidential** - participants can share as much or as little personal information as they wish. Support groups are open to all adults with mental illness, regardless of diagnosis. Participants should feel welcome to drop by and share feelings, difficulties, or successes. Everyone is a valued participant. Group leaders are individuals who are in recovery themselves. They understand your daily challenges and can offer you encouragement and support.

Groups meet regularly around the state and we are developing plans to form new groups while sustaining current ones through facilitator trainings. If you are interested in being trained as a facilitator, or would just like to know more about the program, contact the NAMI Vermont office at (800) 639-6480.

For more information about the NAMI Connection program and schedules visit www.namivt.org.

Annual Conference

Each year NAMI Vermont brings nationally known keynote speakers and knowledgeable presenters for an annual conference to inform, inspire and educate providers, peers, and family members about current approaches to understanding and treating mental illness. The conference features workshops on current topics and plenary sessions, along with exhibits and networking opportunities.

Registration fees are kept low to enhance access. CEUs are available for social workers, psychologists, and LCMHCs. Visit our website at www.namivt.org to learn more or call the NAMI Vermont office at (800) 639-6480 to sign up for our mailing list.

Toll-Free Information and Referral Line

With support from the Vermont Department of Mental Health, NAMI Vermont staffs a toll-free 'Warm Line' for family members, peers and the general public. Call (800) 639-6480 during business hours to access Vermont's premiere information and referral resource on services for individuals living with a serious mental illness and their family members. In addition to referrals, callers may request free copies of NAMI Vermont Guidebooks, newsletters, and informational brochures about various mental illnesses.

Lending Library

The NAMI Vermont office offers many books, DVDs, videos and audio resources on living with mental illness, treatment, and care giving issues. Resources may be viewed during business hours, and materials may be borrowed by NAMI Vermont members.

Advocacy

NAMI Vermont has a proud tradition of making a positive difference in the mental health system of care in Vermont. Our current efforts are led by our Executive Director and a vibrant volunteer Advocacy Committee, which works hard to make sure the voices of family members and peers are heard in the Vermont legislature and in the public policy arena. Our Advocacy Priorities presents our policy goals and is updated annually and endorsed by NAMI Vermont's Board of Directors. We coordinate with other Vermont advocacy organizations to hold an annual Advocacy Day at the statehouse, where NAMI members, family, peers, and providers have the opportunity to talk directly to our legislators about issues important to us.

Our effectiveness as a grassroots organization depends on mobilizing many people to get informed and get involved in the process of working for change. We offer leadership training, useful resources for policy-makers, and work to build common ground with other mental health advocacy groups in Vermont. Here are some of the things we have learned along the way:

Personal advocacy starts with working for or with your relative to get services, understand his or her rights, file grievances, if necessary, etc. Personal advocacy includes helping families work through their problems with the system of care, and is closely tied to support. We empower individuals and families to advocate for themselves through our educational opportunities and resources that we provide.

Public advocacy includes speaking to a service or church group, club, school class, or other group about your experience in living with mental illness. Every time you write a letter to the editor, speak to someone outside your work and social circle, write a column for a newspaper, you are doing public advocacy. These actions help erode stigma against people with mental illness by normalizing the public's understanding of how mental illness affects people.

Legislative advocacy is what most of us think of when we hear the word 'advocacy.' It is actually easier than it sounds. Every time you call, write, meet with, or testify in front of elected representative(s) you are doing legislative advocacy. Here are some DOs and DON'Ts of legislative advocacy:

DO be informed, and start early. Read newspapers and legislative/advocacy bill alerts carefully. Know both sides of the issue. Know when the bill is in committee, when the hearings will be, who the co-sponsors are, etc. Pay attention to issues and proposals early in the process, and you will have a better chance of influencing the outcome.

DO be concise and specific. The more simply and clearly you explain your position, the better your chance of getting people to listen and respond to you. Know exactly what you want your legislator to do. Do you want him or her to draft legislation? Propose an amendment? Vote for or against a bill? Appropriate more money for a particular program or department?

DO be honest. Don't exaggerate or make things up to make a point or answer a question if you're not sure of the facts. Every issue has at least two sides. Be honest about admitting the pros and cons of your issue.

DO give personal examples. This puts the issue in memorable, human terms. Saying that you or a family member went without dinner for a week because there wasn't enough money to buy food and medicine is much more powerful than giving statistics which show how expensive medications are and that SSI/SSDI recipients live well below the poverty level.

DO practice. Try explaining your position to friends and family before you meet with a legislator or testify before a committee.

DO be courteous, but firm and confident. DON'T make threats. Telling your legislators that they have to do what you want or you will not vote for them again will only turn them off.

DON'T argue with your legislator. If it is clear the person won't support your position, just give them the facts, ask them to at least consider your position and reconsider theirs, and then move on. You want to keep the lines of communication open for discussing future issues.

DON'T GIVE UP!

To learn more about our advocacy efforts or get involved, call us at (800) 639-6480.

PREPARING FOR A CRISIS

GUIDELINES

Unfortunately, the nature of thought disorders, such as schizophrenia, and mood disorders, such as bipolar disorder, means that a crisis is more likely to occur than not. The NAMI Family-to-Family Education Course offers valuable information about how to handle crisis situations. There are actions

family members can take to reduce or even avoid difficult situations and crises. Work to reverse any escalation of symptoms and to provide immediate protection and support for the individual who is experiencing them.

It is rare that a person suddenly loses control of thoughts, feelings and behavior. You will likely be aware of a variety of general behaviors, as well as those specific to your loved one that signal impending trouble. Sleeplessness, ritualistic preoccupation with certain activities, increased suspiciousness, unpredictable outbursts, increased hostility, angry staring and grimacing, verbal threats – any or all may signal an impending crisis.

In these early stages, the crisis may be prevented. Perhaps the individual has stopped taking prescribed medication. If you think this is the case, encourage your family member to visit the doctor or nurse practitioner. The more symptomatic your family member becomes, the more difficult this will be.

Above all, trust your intuitive feelings. If you feel worried, frightened, or panic-stricken, chances are it is time to take immediate action. Your primary job is to help your relative regain control. Do nothing further to agitate him or her. It is helpful to know that your family member is likely terrified by this experience of loss of control over thoughts and feelings. Furthermore, auditory hallucinations, or "voices," may be giving life-threatening suggestions or commands. The person may be thinking messages are coming through electrical appliances, smelling "poisonous" fumes in the air or tasting "tainted" food, or "seeing" things on the walls. Do not underestimate the reality and vividness of hallucinations to your relative. Accept that your loved one has an altered state of reality. In extreme situations, the person may act on these sensory distortions. It is vital that you appear calm, no matter what internal turmoil you may be experiencing.

If you are alone, call a trusted friend, neighbor or family member to come be with you until professional help arrives. In the meantime, the following guidelines may be helpful.

- Do not threaten. This may be interpreted as a play for power and increase fear or prompt an assault.
- Do not shout or raise your voice. If your relative does not appear to hear or be listening to you, it is not because he or she is hard of hearing. Other voices or sensory input is likely interfering or predominating.
- Do not criticize or make fun of the individual. It cannot make matters better and may make them worse.
- Do not argue with other family members, particularly in your relative's presence. This is not the time to argue over best strategies, or to allocate blame. This is not the time to prove a point. You can discuss the situation when everyone has calmed down.
- Do not bait the individual. He or she may just act on any threats made if you do. The consequences could be tragic.
- Do not stand over the person. If the person is sitting down, you sit down (or stand well away from him or her). If the person is standing, keep your distance.
- Avoid direct, continuous eye contact or touching the person. Such contact may seem threatening.

- Do what your relative wants, as long as it is reasonable and safe. Complying with reasonable requests helps your loved one regain some sense of control.
- Do not block the doorway or any other exit. You do not want to give your relative the feeling of being trapped. However, do keep yourself between your family member and an exit.

Sometimes your relative may actually become violent, particularly if he or she has been drinking alcohol or has taken a street drug. (Substance use increases the risk of violence for anyone, not just those who have a mental illness). Get to know the cues. These include clenched fists, a prominent blood vessel in the neck or forehead, working of the jaw, a hard and set expression to the face, and angry staring or talking. Your own uneasiness is a good clue. It is alright to tell your relative that their behavior is scaring you, if it is. Sometimes such feedback can diffuse the situation. But do not act scared. If this does not work, then it is time to get help.

If you and the rest of your family have made a limit setting plan, now is the time to carry out the consequences. If you have not already warned your relative of the consequences of certain behaviors while he or she was calm, use your judgment and past experience to decide to warn him or her, or simply go ahead with the plan. (It may be advisable to leave the room or leave the building to make phone calls or other arrangements.)

Give your relative plenty of physical and emotional space. Never corner a person who is agitated, unless you have the ability (and the need) to physically restrain him or her for mutual safety. This is not the time to make verbal threats or sarcastic remarks. Do not try to lecture or reason with your relative when he or she is agitated or losing control. Give yourself an exit, and leave immediately if he or she is scaring you or becoming violent. When your relative is calm again, the knowledge that he or she has assaulted a family member can be devastating. Also, you do not want to become incapacitated.

Get help! Having other people there, even the police, can defuse the situation. Furthermore, if you or someone else witnesses your relative commit a violent or dangerous act, involuntary commitment becomes possible. Although something to be avoided if at all possible, such commitment may get your relative needed care and treatment when other efforts to do so have failed. Under no circumstances should you drive your loved one to the hospital by yourself.

It is ideal to develop a crisis plan in advance, preferably with the participation of your ill loved one. Better that you never need to implement it, than that you do not have one if there is a crisis. For more information, call the Crisis line of your local mental health agency (see Appendix C).

PSYCHIATRIC ADVANCE DIRECTIVES

Psychiatric advance directives are legal instruments that may be used to document a competent person's specific instructions or preferences regarding future mental health treatment. Psychiatric advance directives can be used to plan for the possibility that someone may lose capacity to give or withhold informed consent to treatment during acute episodes of psychiatric illness. The **National Resource Center on Psychiatric Advance Directives (NRC-PAD),** located at www.nrc-pad.org, is continuing to provide new information for peers, family members, clinicians, and policy makers interested in PADs.

Vermont does not have a specific statute for a *psychiatric* advance directive, so the information about general advance directives for health care in Vermont applies equally to psychiatry. You can get more information at Caring Connections or visit www.caringinfo.org. Once you have an advance directive completed and signed, it can be made available online to all your health care providers through Vermont's Advance Directive Registry. For more info, see: www.healthvermont.gov/vadr/.

SUICIDE PREVENTION

The risk of suicide is a major concern for family members. Most individuals with a mental illness will not die by suicide. However, in the United States, over 90% of completed suicides ARE associated with psychiatric illness, especially depression and alcoholism. Tragically, only about one-third of those with a mental illness receive treatment. Encouraging someone to get help is a huge first step towards safety.

People who attempt suicide feel overwhelming emotional pain, frustration, loneliness, hopelessness, powerlessness, worthlessness, shame, guilt, rage and/or self-hatred. The social isolation so common in the lives of those who have a mental illness only reinforces the belief that no one else cares if one lives or dies.

Any talk of suicide by a family member or friend should always be taken seriously: 75% of all people who commit suicide give some warning of their intentions to a friend or family member. If someone has attempted suicide before, the risk is even greater. Often we miss the cues which might tell us a loved one is thinking of suicide, such as:

- giving away personal possessions;
- talking as if they are saying goodbye or going away forever;
- taking steps to tie up loose ends, like organizing personal papers, or paying off debts;
- making or changing a will;
- stockpiling pills or obtaining a weapon;
- preoccupation with death;
- sudden cheerfulness or calm after a period of despondency;
- dramatic changes in personality, mood, and/or behavior;
- increased drug or alcohol use;
- saying statements such as "it's no use," or "nothing matters anymore," or "you'll be better off without me," or "I'm worth more dead than alive," or "life isn't worth living."
- withdrawal from friends, family and normal activities;
- a failed love relationship;
- a sense of utter hopelessness and helplessness.

The last of these warning signs, hopelessness and helplessness, may be the most common contributing factor in suicide. People who want to kill themselves see no other way out of their pain. When hope dies, every experience is viewed in negative terms, the cup is always half empty rather than half full. Suicidal individuals expect the worst and cannot see any way to solve their problems.

WHAT TO DO

- Call the local Crisis Services hotline (available 24/7 – See Appendix A). If there are weapons involved, and/or you fear for your own safety, it's probably best to call 911 first, then the local Crisis Hotline.
- Call the National Suicide Prevention Lifeline: (800) 273-8255
- If you are sure that your loved one has not already harmed themselves (e.g. deliberate overdose) and there are no weapons involved, here are some first steps that you can take before calling for help.

A SUICIDE THREAT OR ATTEMPT IS A MEDICAL EMERGENCY REQUIRING PROFESSIONAL HELP. Do not minimize the risk! Remember: **Q – P – R:**

QUESTION - PERSUADE - REFER

QUESTION: If you think someone you love or care about is contemplating suicide, **take it seriously.** Ask if he or she is thinking of suicide. You will not be "putting the idea in their head." It can sometimes be a great relief for the person to talk about it, particularly if you can discuss it openly with him or her without showing shock, judgment or disapproval. Question your loved one in detail: ask if the person has a specific plan, and how far he or she has gone in carrying it out. **Be willing to listen**: Even if professional help is needed, your friend or loved one will be more willing to seek help if you have listened to him or her.

PERSUADE: **Voice your concern**: and attempt to overcome any reluctance your loved one may have to talking about his/her troubles, and suicidal ideas. **Let the person know you care and understand**: Reassure your friend or loved one that he/she is not alone. Explain that, although powerful, suicidal feelings are temporary. Tell the person that hopelessness is a sure sign of depression, depression can be treated, and problems can be solved. Persuade your loved one to let you help. **If for any reason, you are unsure, uncomfortable or unable to persuade them to take action,** find someone else (a responsible adult) with whom to share your concerns, or contact your local police. It is better to have an angry friend or loved one, than a dead one.

REFER: **Get professional help immediately**: Bring your friend or loved one to a local hospital emergency room or crisis center. If he or she is already in treatment, contact the professional(s) involved. The person will be more likely to seek/accept help if you accompany him or her. Consider calling your local mental health screeners. If all else fails, notify police, who are trained to handle situations like this. **Follow up on treatment**: Take an active role in following up with the treatment process and medications. Help your friend to notify the physician about any unexpected side effects or changes in behavior.

- Don't assume the situation will take care of itself.
- Don't leave the person alone.
- Don't be sworn to secrecy.
- Don't act shocked or surprised by what the person says.
- Don't challenge or dare.

- Don't argue or debate moral issues.

Whatever you choose to do, the important thing is to make the effort. DO something: your loved one's life may be saved by your willingness to intervene. Like CPR (cardio-pulmonary resuscitation), QPR can save lives.

The Vermont Department of Mental Health (DMH) is working in partnership with the Center for Health and Learning (CHL) to continue the development of the Vermont Suicide Prevention Center (VT-SPC), a state-wide resource fostering a sustainable approach to suicide prevention in Vermont. Visit http://vtspc.org/.

Note: this document is a compilation from multiple sources including: www.qprinstitute.com; a *National Depression Screening Day* questionnaire, and *Reducing Suicide: A National Imperative*, S.K. Goldsmith, et al. (2002).

HOSPITALIZATION

You may need to use a hospital for emergencies, voluntary hospitalization and even involuntary hospitalization and/or commitment. If you choose to work through a hospital rather than through a publicly funded community mental health center, there are several things to consider.

Private insurance may cover a short hospitalization only. Read your insurance policy carefully to see how many hospital days are covered, both per year and per lifetime. Although Vermont now has "parity insurance coverage" (meaning psychiatric conditions are now supposed to be covered in the same way "physical" health conditions are), there are many exceptions to such coverage. For example, employees of companies that self-insure are not covered by this legislation. Be sure to check with your insurance company about the age at which coverage of your children stops. It may be possible to continue coverage beyond that age on your policy.

VOLUNTARY HOSPITALIZATION

If a person needs to be hospitalized or thinks they would benefit greatly from a hospital stay, voluntary admission is always preferable. The immediate outlook is brighter for the individual who understands the need and benefit of hospitalization, and is willing to participate in a treatment plan. Individuals who are willing to go to a hospital voluntarily can go to one of the Vermont hospitals with psychiatric inpatient units listed in Appendix C.

When payment is made through the family's or individual's insurance company, or privately, and the individual consents to treatment, the admission process is straightforward. Decisions concerning the need to be hospitalized are made by the individual, his or her doctor, and the hospital admitting staff, often in consultation with the area community mental health services crisis worker. Crisis Services may be called in to assist with assessment and intake by hospital staff. For many reasons, a person may not get admitted even if he and his family request this. Hospitals are required to insure that this level

of care is required and hospitalizations are typically used when a person is not able to get care in any other setting.

In Vermont, if you do not have private insurance, public funding will cover the expenses of psychiatric hospitalization at one of the hospital programs in Vermont. Hospitals routinely help patients covered by Medicaid and/or Medicare. Admissions staff at each hospital can advise voluntary patients or their family members about patient eligibility and about any unique procedures or restrictions that apply. Staff at your local community mental health center or the Vermont Department for Children and Families at (800) 479-6151 may also be able to help you apply for Medicaid coverage.

INVOLUNTARY HOSPITALIZATION AND COMMITMENT

If your relative is seriously disturbed or symptomatic, violent or suicidal, but refuses to go to a hospital, you may have to consider how to have him or her involuntarily hospitalized. If the police and/or mental health professionals become involved, you may have no choice, particularly if there is misconduct or a violation of a law. This is a traumatic experience for both the individual and the family and should only be pursued as a last resort, after all attempts to engage the individual in voluntary care have been tried and have failed. The Vermont Legislature has established a policy of moving toward a mental health system free of coercion, and involuntary treatment is to be used only when voluntary treatment is not possible.

Assessments for involuntary hospitalizations are most often made by staff at the designated agencies (see below under Emergency Evaluation). These assessments are done at the centers, in hospital emergency rooms as well as at people's homes. On occasion, DA staff will be called into court to do an assessment on someone who has been arrested. There are several hospitals in Vermont which admit people on an involuntary basis. These are The University of Vermont Medical Center in Burlington, Central Vermont Medical Center in Berlin, the Rutland Regional Medical Center in Rutland, Brattleboro Retreat, and the Vermont Psychiatric Care Center.

Obtaining a court order for the involuntary hospitalization of an adult with mental illness is complex. It is designed to balance the need to provide treatment in the least restrictive environment, with protection of the civil liberties of the individual who is ill. When families are witness to the serious and rapid deterioration of a loved one, our instincts to protect this person from harm are strong. We are terrified that this person may get hurt, injure someone else, never get better, or even die. For those of us who must watch helplessly the downward slide of someone we love it sometimes seems that Vermont laws do not guarantee the rights of our ill relatives to receive the medical care they need until they become desperately ill.

Balancing the need for treatment of a very ill person with his or her basic civil rights is one of the dilemmas of our laws. One of the greatest challenges a family may face is seeking involuntary hospitalization of a family member with dignity and love, without having it seriously damage or destroy family relationships, and the self-esteem of the individual.

The two pre-requisites to involuntary hospitalization are:

1) the presence of mental illness, which results in
2) dangerousness to self or others and/or an inability to care for oneself

The State of Vermont has defined 'mental illness' to include disorders that grossly impair the individual's judgment and ability to meet the ordinary demands of life. Dangerousness is currently defined in our statutes (at 18 VSA § 7101) as follows:

(A) A danger of harm to others may be shown by establishing that:

(i) he or she has inflicted or attempted to inflict bodily harm on another; or

(ii) by his or her threats or actions he or she has placed others in reasonable fear of physical harm to themselves; or

(iii) by his or her actions or inactions he or she has presented a danger to persons in his or her care.

(B) A danger of harm to himself or herself may be shown by establishing that:

(i) he or she has threatened or attempted suicide or serious bodily harm; or

(ii) he or she has behaved in such a manner as to indicate that he or she is unable, without supervision and the assistance of others, to satisfy his or her need for nourishment, personal or medical care, shelter, or self-protection and safety, so that it is probable that death, substantial physical bodily injury, serious mental deterioration or serious physical debilitation or disease will ensue unless adequate treatment is afforded.

EMERGENCY EVALUATION

The most common means of getting a person suffering from a crisis arising out of mental illness admitted to a hospital is to get an assessment and referral from a doctor. However, if the ill person refuses to go to the Emergency Department of a hospital, the next option is to call the Crisis Service of your local community mental health center. (See Appendix A for Crisis Services hotline numbers available 24/7 in every region of Vermont.) If the crisis team member decides that an on-site evaluation is justified, arrangements will be made to meet the person immediately. Sometimes the crisis worker will be able to persuade the person to enter voluntary treatment, thus sparing everyone the ordeal of an involuntary admission process. If this is not successful, the other option is to complete what is called an emergency evaluation ("EE").

There are two parts of this evaluation that need to be completed before a person can be transported against his will to a hospital. The first portion is typically completed by a crisis clinician from a DA, sometimes called a "screener". Only mental health clinicians trained and designated by the state as Qualified Mental Health Professionals (QMHP) can complete this part of the evaluation. However, the law allows for others to do this as well. This includes a guardian, spouse, parent, adult child, close adult relative, a responsible adult friend, a person who has the individual in his or her charge or care (e.g., a superintendent of a correctional facility), a law enforcement officer, a licensed physician (who cannot be the same as the physician who completes the other part of the assessment.

The crisis clinician will assess the person to see if he or she meets the criteria for involuntary admission, i.e. has a mental illness, is in need of immediate care, and is a danger to self or others. If the ill person meets these criteria, a psychiatrist also needs to evaluate the individual to determine if she agrees that the person meets the statutory standard for involuntary hospitalization. At that point, arrangements can be made for transport to a hospital if the person is not already in an emergency room. If it is not safe for family or mental health clinicians to transport, local law enforcement or the local sheriff's department to will drive the person to an emergency room. At the hospital, the clinicians will attempt to find an available bed at one of the hospitals who admit people on an involuntary basis.

If a psychiatrist is not available to evaluate and certify that the person meets the criteria for involuntary admission, and observation of the person's conduct "constitutes reasonable grounds to believe the person is…in need of treatment, and he presents an immediate risk of serious injury to himself or others if not restrained", a law enforcement officer or mental health professional may make an application, not accompanied by a physician's certificate, to any district or superior judge for a warrant for an immediate examination." The law enforcement officer or the mental health professional *may* take the person into temporary custody while applying for the warrant. If the warrant is granted, the person is transported to a designated hospital for an evaluation by a psychiatrist. If the warrant is denied, the person must be returned home or where she or he chooses to go. Except in the case of a warrant for immediate examination, Vermont law does not authorize the involuntary detention or transportation of a person to be "screened" or undergo an emergency examination.

After the emergency examination is conducted, a second psychiatrist needs to certify that the individual meets the criteria for involuntary hospitalization ("second Certification" or "second cert"). When the individual is admitted to a hospital, the Department of Mental Health files an application for involuntary treatment; the person may be held until the commitment hearing. Treatment can begin as soon as the person is admitted to the extent that he is willing to accept it.

Families take note:

1. Most of the time, it can sometimes take days before a hospital is admitted to a hospital. During this time, the person is held in the emergency dept. (or jail if he has been arrested).
2. When a law enforcement officer, either a police officer or a sheriff, drives your family member in a car to a hospital, some law enforcement policies dictate that the person be handcuffed and possibly shackled. Nothing can prepare you for the horror of seeing your loved one bound as if he or she were a criminal. Remember that you are acting to keep your loved one safe. There is a new program that provides transportation to the hospital in a non-police vehicle by mental health agency staff, but that service is not yet available in all parts of Vermont.

If at any time during this process the ill person is deemed to not meet the specific criteria for involuntary commitment, he or she may be discharged to the community, returned to the place from which he or she was taken, and referred for outpatient treatment.

If a person who is alleged to be mentally ill is in crisis and refusing treatment, but appears not to be in immediate danger of hurting anyone, it is possible for a relative, friend, family doctor, guardian, or mental health worker to petition Family Court for a "non-emergency involuntary hospitalization." Such a petition should state that the individual thinks the ill person requires hospitalization and give

the reasons for such an opinion. However, the same criteria for involuntary commitment apply, i.e., the person has to have a serious mental illness and also be in danger of causing harm to himself or others. This approach can be useful when some is not eating. While this does not pose an immediate danger, it will pose a danger over time. A psychiatrist still needs to evaluate the individual and submit her evaluation. The psychiatrist needs to complete the evaluation within five days of submitting the application. If your ill family member is already in treatment, the therapist or case worker may be asked to testify at the hearing. The purpose of the hearing is to determine whether or not the ill person meets the criteria stated above. In other words, the person must have a mental illness by clinical standards and meet the criteria of dangerousness to self or others.

Commitment Hearing

A commitment hearing is usually held within several weeks of the emergency detention at the designated hospital. The individual who has been hospitalized is represented by a lawyer, often assigned by the Mental Health Law Project of Vermont Legal Aid. Those who know the individual, e.g. family members, may be asked to testify. Hospital staff, the police (if they were involved), and community mental health staff may also be asked to testify. A psychiatrist will provide his or her opinions about the mental illness, its symptoms, and treatment options. The proposed patient has the right to obtain an independent psychiatric examination, cross-examine witnesses called by the state, and call witnesses in his or her defense.

After hearing all testimony, a judge makes the decision to either commit the individual to the "care and custody" of the Commissioner of Mental Health for involuntary treatment, or release the individual with no obligation to undergo treatment. However, the judge may rule that treatment outside the hospital is adequate and order the person to receive treatment outside the hospital for a period of 90 days. This is called an "order of non-hospitalization" or an ONH. The law provides that the court may order hospitalization only if outpatient treatment is not appropriate to meet the needs of the patient.

Involuntary Medication

Once someone is committed to the care and custody of the state, i.e. hospitalized in a psychiatric hospital, he or she may stop taking medication or refuse to start taking it. A psychiatrist may then make an application to Family Court to involuntarily medicate the person. The psychiatrist must state his or her reasons why such medication would be beneficial. After the psychiatrist files the application a hearing is scheduled before a judge. The patient may be represented by the Mental Health Law Project. The judge makes a determination after listening to all sides who wish to speak, usually within days after the court hearing. In an involuntary medication proceeding, the State is required to prove that the patient is not competent to make a decision on whether to accept medication, and that, taking into account all of the risks and benefits of treatment, involuntary medication is warranted. If the judge decides involuntary medication is in the best interests of the individual it is so ordered for a period of 90 days. Note that in some cases the time period is less than 90 days. If the individual decides to stop taking medication once the involuntary medication order has expired, the psychiatrist may file another application for involuntary medication and the process begins again.

There are several steps that can be taken to avoid the trauma of involuntary hospitalization and involuntary medication. While enjoying a period or wellness and stability, any Vermonter can draw up a Durable Power of Attorney (also known as an Advanced Directive) that specifies where, how, by whom and with what he or she would like to be treated, if their condition deteriorates. In Vermont, you can now file an Advance Directive online, so it's available to all health care providers. For more info, see: www.healthvermont.gov/vadr.

Individuals can also take the Recovery Education Class and draw up an individualized Wellness Recovery Action Plan, or WRAP. This allows the individual to determine and then write out with great detail what he or she needs to do to stay feeling well, what conditions or circumstances trigger their illness to flare up into distressing symptoms, and what to do and in what order should they become more symptomatic. See the Recovery section of this Guidebook for more information on WRAP planning.

DURING HOSPITALIZATION

Upon your loved one's admission to the hospital, or as soon as possible thereafter, it is very helpful to hospital staff for you to provide the following information:

- Dates of any previous hospitalizations, and the addresses, phone numbers and fax
- numbers of these hospitals;
- Names of any treating doctors;
- Names and dosages of any medications prescribed for your relative;
- Which medications worked and which did not, and what side effects they had;
- A complete medical history of your relative; and
- What street drugs they may have taken recently, and whether or not (and how much) they drink alcohol.

Please Note: ***Your family member must first give their written consent before staff may provide you with any information about their care.*** Without the patient's written consent, it is illegal under state and federal law for providers to release any information about your loved one's care. The staff may not even acknowledge that your loved one is in treatment in that facility or program. ***However, you can give the providers information about your family member, even if your family member has not consented to have the hospital share information about him or herself with you.***

For best results, ask your relative to sign an authorization for release of this medical information to you during the admission process or during their emergency evaluation. If your relative refuses at first, ask staff to keep asking them to do so. Your relative may want you to know only certain information, and may specify so on the consent form. He or she may be relieved to know that the specific information to be withheld can be indicated on the form.

If your loved one has signed a release, family members should make an appointment with the treatment team, usually a psychiatrist (who may be either the attending or a resident), a social worker, and a nurse. If you have the opportunity to meet with the team, ask for information on the following:

- Diagnosis and what the diagnosis means;
- Course of the illness and its prognosis;
- Treatment plan;
- Specific symptoms about which you and they are most concerned, what they indicate, and how they are being monitored;
- Medications prescribed, why these particular medicines have been selected, their dosage, the hoped for response to them and any side effects they may have;
- Whether or not the diagnosis, medications, and treatment plan have been discussed with your loved one and if not, why not;
- Pamphlets and books that tell more about the illness(es) being treated;
- Number and location of the NAMI Vermont office, its nearest support group, and the Family to Family Education class;
- How often you can meet with them to discuss progress;
- Whom you can call for information between meetings; and
- What is the aftercare plan once your family member has been discharged from the hospital, and what contingencies are in place should your relative leave against medical advice.

At the treatment team meeting, you can describe what factors you think contributed to your relative's decline, tell staff about particular stressors your loved one has, and let them know anything else you think might be helpful for effective treatment, e.g. how to best persuade them to take medicine. It is also helpful for you to suggest the most appropriate living situation for your relative after their discharge from the hospital. Be honest and do not apologize if living with you is not an option.

Assembling such information can be very time consuming, not to mention emotionally difficult in time of crisis. For this reason it is important to keep an ongoing record of such information to which you can refer when necessary. Don't worry, however, if you do not have such information readily available. Anything you can tell the hospital staff will be useful.

As you follow the progress of your family member's treatment in the hospital give staff feedback on what you notice. You are the expert on "who" your relative is, and how he or she looks and acts when doing well. You can give staff valuable clues on what indicates worsening or improvement in their state of mind.

Before your relative leaves the hospital, you should receive information and/or a plan for:

- Referrals for a doctor and other forms of follow-up care;
- Prescription slips for medication refills;
- Arrangements for supervised housing, if she/he is unable to return to where they lived previously;
- Information about how to apply for income (SSI and SSDI) and medical (Medicaid, Medicare, or the Vermont Health Access Plan) benefits. See the 'Financial Considerations' section of this Guidebook, as well.
- How you can get help, e.g. information about NAMI, its support groups around the state, and the Family-to-Family education course.

AFTER THE HOSPITAL

Serious mental illnesses of the type discussed in this Guidebook are most often long-term conditions. Recovery is always possible, but it is a process, and it may be slow. Plan ahead for what you can do to avoid future crises and/or hospitalizations. Remember that expensive care is not necessarily the best care. Private care is not necessarily better than public care.

What most individuals with mental illness need is continued medical treatment (often involving medication), a safe and stable place to live, a chance to learn or relearn social and vocational skills, and people who care about them and believe in their ability to live the life they want. Community mental health centers are often the best places to look for long-term, comprehensive services.

ALTERNATIVES TO HOSPITALIZATION

Vermont offers a number of residential alternatives to hospitalization, especially for people experiencing a "first break". The community mental health centers offer "crisis beds" at a group home or other facility, where overnight beds with close observation by staff may be available, as an alternative to hospitalization. Examples include the ASSIST program at the HowardCenter in Burlington, the Home Intervention Program at Washington County Mental Health Services, and similar programs at UCS in Bennington, Northwest Counseling in St. Albans, Rutland Mental Health Services, and Northeast Kingdom Human Services in St. Johnsbury. These programs are staffed around the clock, seven days a week.

Peer-staffed residential programs, and other longer-term residential placements, also exist. There are programs such as Hilltop Recovery Residence, Meadowview, Allysum, and Soteria. There are also residential programs such as Second Spring for people with severe mental illness who are not ready to live independently but do not need hospital level care.

Either you or your family member can call the Crisis Services program in your area (see Appendix A) to ask about these facilities. If Crisis thinks your family member would benefit from spending several nights away from home, but not in a hospital, this may be a good alternative.

COMMUNITY SERVICES IN VERMONT

This section provides a brief overview of services and treatments available at most of Vermont's ten community mental health centers and elsewhere in the community, such as in the private health care sector. Appendix B includes a directory of specific public mental health services offered in each area of Vermont. ***Please Note***: not all these services are available in all communities and some services have waiting lists, or are otherwise not immediately available even if you qualify.

Crisis Services

Despite the best of intentions and the best-laid plans, a crisis may and probably will happen, particularly early on in the illness. Crisis services are available throughout Vermont.

If you or your loved one's crisis puts you and/or them at risk of serious and immediate harm, you can dial 911. Let them know the individual has a mental health condition and is in crisis. You can expect Police Officers, Emergency Medical Technicians (or EMT's), or Fire Department workers to respond, depending on the nature of your emergency. NAMI advocates for getting first responders trained to respond appropriately to the particular circumstances of psychiatric crises. While response is improving, many first responders have not yet had this training, and may not know how to best contain and de-escalate your loved one into accepting care. Sometimes individuals are detained in local police holding cells or correctional facilities, simply because officers can't wait for hours at the hospital for someone in a psychiatric crisis to be seen by emergency room staff.

If you feel safe in doing so, a better option is to call your local crisis response team (Appendix A) and ask them to respond. Vermont's designated agencies provide 24-hour, 7-day-a-week Crisis Services for anyone in a mental health crisis. Family members can call Crisis Services to get help for their ill family member. The goal of Crisis Services is to offer help to resolve the crisis, or at least to stabilize the situation, so that no one is at risk of harm. Referrals to other services can be made, and it is the Crisis clinician's job to figure out which services at which agencies can help. If you find yourself calling Crisis Services, give the crisis worker as much background as you can as quickly as possible, so that they can work most effectively to resolve the situation.

Assessment and Treatment

Ideally, there is not a crisis, but you sense something is brewing, or you recognize behaviors, thoughts or moods in your loved one that may signal a problem. You can call the agency in your county and ask for an appointment for an assessment. A mental health professional will meet with your relative and ask a series of questions, assess the responses, observe your relative's behavior, and, ideally, talk with and take information from you.

If they do not talk with you because your relative doesn't want them to, or the worker is not particularly family-friendly, a situation you may unfortunately encounter, you may write to, call or email them with your valuable input.

All of this will be put together to form a preliminary sense of what may be going on. However, there may not be an actual diagnosis at this point. A treatment plan is often designed to treat specific problems, rather than a specific diagnosis, which will come later.

Depending on what the assessment shows you may receive a referral to a private practitioner in the community, to outpatient counseling at the agency, or to the agency's psychiatrist and case management team.

Treatment by a Psychiatrist

Each of the ten designated mental health agencies has at least one psychiatrist who is skilled at working with people with mental illnesses. Another option could be to find a psychiatrist in private practice. Psychiatrists are medical doctors who can prescribe medicines. Regular visits may be scheduled with the psychiatrist.

Referrals to psychiatrists can be obtained from Psychiatry Departments of hospital-affiliated medical schools, such as The University of Vermont Medical Center in Burlington and Dartmouth-Hitchcock Medical Center in Lebanon, New Hampshire. Perhaps the best way to find a psychiatrist is to network with NAMI members in classes and support groups or with others who are dealing with a similar situation. Other resources include your insurance provider, the internet, and your local phone book. The NAMI Vermont office staff cannot recommend a particular psychiatrist. Please be aware that there is a severe shortage of psychiatrists in Vermont and you may have to travel some distance.

As an alternative, Psychiatric Nurse Practitioners and Physician Assistants may also prescribe medications and help you with integrating medication management and physical health care. Ask around for such a person in your area. Ask if the designated agency in your county has one.

Outpatient Counseling / Therapy

Adult Outpatient services are provided by the ten designated agencies. If your relative does not meet the eligibility criteria for case management (see next page), then it may be possible for him or her to be seen by an Adult Outpatient clinician. Admission to Adult Outpatient services is determined by the distress/disability/danger level of the individual's needs within the limitations of available funds. It helps to be persistent when trying to access these services, as there may be waiting times of several months. Individual and group counseling are the services most Adult Outpatient clients receive. Sometimes case management and medication are provided, with the back-up of psychiatric and emergency services for a team approach. These back-up services are not usually available outside a community mental health center, (i.e., in the private sector).

Therapy is also available from private practice counselors and group clinics throughout Vermont. Many offer services on a sliding fee basis. Many offer individual, family, couples and group therapy. Please be aware that some therapists in private practice may not work with those who have a mental illness. Therefore, it is important to ask about this over the phone before making an appointment.

It is best to keep therapeutic interventions focused on the present and on how the person may best cope with their illness and its symptoms, so that they can go on to live satisfying lives. Such therapy can be called cognitive-behavioral, rational-emotive, exposure therapy, or dialectical behavioral therapy (DBT).

CASE MANAGEMENT

There is a saying among people who receive "case management" services: **"I am not a case and I don't need to be managed!"** It may help to instead think of a case manager as a "personal assistant" or a "life coach."

Whatever you call them, case managers can be very helpful, because they know how to help you apply for Social Security and Medicaid. They are aware of housing options in their area and know how to get housing vouchers or rental assistance. They know about community programs and groups, and about job training and possible work.

Case management is sometimes referred to as 'CRT Services.' This stands for Community Rehabilitation and Treatment. In other centers, similar services are grouped under the heading CSP. This stands for 'Community Support Programs.'

In order to receive case management or CRT services an individual must:

- Have a major mental illness;
- Have long-term disability as shown by a poor work history, receiving financial support such as SSI, social isolation, or poor social functioning;
- Have a recent history of intensive and on-going mental health treatment, for example multiple hospitalizations or six consecutive months of outpatient treatment.

If these conditions are not met, an individual may still receive case management services through a waiver.

A good case manager can help a person apply for and get disability benefits, housing vouchers, a place to live, and medical attention, if needed. Case managers can be coaches in life skills such as budgeting, menu planning, grocery shopping, maintaining a place to live, even cooking. They are often very knowledgeable about various community programs, from food shelves, to volunteer opportunities, to peer programs. Ultimately, the goal of case management is to support the individual to have a more independent and enjoyable life.

It can set up an unhealthy and adversarial dynamic between parents and adult children to have parents acting in this role. This is not to say that your relatives don't need you to look out for them. They do! In fact, you are probably the only one who has done so for years – and you know them best. However, some of the responsibilities and burdens of care can be lifted from family members and you can get some much-deserved respite so that you can start getting your own lives back.

RESIDENTIAL SERVICES

Often our relatives live either at home with us, or because of their difficulty or inability to work, they may live in squalid, unsafe conditions. Even worse, they may be homeless. There are few more painful things for us than seeing our loved ones in dirty, unsafe housing, or on the street, where they may be preyed upon by others. Sometimes, we may not even know where they are.

All of Vermont's community mental health agencies have what are called group homes. Some have a wider variety of housing options than others. Some are for short-term crisis management; some are transitional, until such time as an individual can get their own home; some are long-term. A few agencies actually provide permanent housing where an individual may live their entire life if they so choose.

While not ideal solutions, such homes do provide staffed, safe places, and companionship. Many provide at least one daily meal, or food to prepare meals. If your loved one would prefer to live independently, see section on 'Housing Services,' below.

Peer Recovery Programs

As one agency states, "recovery is not only possible but, under the right circumstances and with the courage to change, inevitable." Sometimes the best support comes from others who have a mental illness, and are working to enrich and reclaim their lives. Although each is a little different, peer programs operated by community mental health agencies have at their core some form of recovery education that emphasizes hope, personal responsibility, self-advocacy, education about the illness and its management, and support.

Some agencies have clubhouses or drop-in centers, managed by clients of the agency. These offer a wide range of recreational, social and therapeutic opportunities. Some double as the center of the vocational program. Some have what is called a "Warm Line." This is peer-run support over the phone. Trained peer workers talk to those who call in who may be bored, lonely, scared, or dealing with struggles related to their illness or to simply living. Those who answer the phones of Warm Lines are trained to foster wellness and recovery in those who call.

Vocational Services

Nearly everyone who has a mental illness says that they want to work. The Department has made competitive employment of CRT clients a high priority. Most agencies have staff whose sole job is to help people find employment. They work with the person to find out what they would like to and can do. They help them write a resume, search out necessary training or education for such a job, and coach people in interviewing and job search skills (including use of the internet). The worker can go to the interview with the client and even work side by side with them, if necessary, so that the person can not only get the job, but also keep it and be successful in it. This model is called 'supported employment,' and many of Vermont's public mental health agencies and the Division of Vocational Rehabilitation offer these services.

These employment specialists also work in the community to find employers willing to hire and work with those who have a psychiatric disability. With the right support, often very ill people are able to hold a part-time, even a full-time job, if given the chance.

FINANCIAL CONSIDERATIONS

FEDERAL PROGRAMS: SSDI, SSI, MEDICAID AND MEDICARE

Serious mental illness is a neurobiological condition that can be disabling. Given the nature of the disability, there are financial burdens that can accompany it. Sometimes there are hospital bills, costly medications, outpatient therapy, and uncertainties surrounding employment. Applying for SSI (Supplemental Security Income), SSDI (Social Security Disability Insurance), Medicaid, Medicare, and other benefits can be essential to the preservation of family assets while recovery proceeds. Taking responsibility for income and health insurance is important. You should help your relative use the disability benefits to which he/she is entitled. Navigating the complicated maze of benefits can be daunting.

Social Security Disability Income (SSDI) and Supplemental Security Income (SSI) are two federal financial support programs for people with disabilities. SSDI requires a work history and is an insurance program. People who receive SSDI checks are known as "beneficiaries" to the Social Security Administration (SSA). Benefits are paid from a trust fund.

SSI, on the other hand, is an income replacement program that requires no work history. Those who get SSI are known as "recipients" to the Social Security Administration (SSA). SSI benefits are paid from general tax dollars. The State of Vermont, unlike some other states, supplements the federal SSI payment with additional funds.

SSDI (SOCIAL SECURITY DISABILITY INSURANCE)

To be eligible for SSDI a person must:

- Have worked and earned sufficient Social Security credits through the payment of F.I.C.A. Requirements vary with the applicant's age and onset of disability at the time of application.
- Be considered medically disabled; and
- Not be working, or working but with limited income*
- An individual may also receive SSDI survivor benefits by drawing off the SSDI of a deceased parent, provided that individual had a disability prior to their turning 22.

SSI (SUPPLEMENTARY SECURITY INCOME)

To be eligible for SSI based on a medical condition a person must:

- Have little or no income or resources;
- Be considered medically disabled; and
- Not be working, or working but with limited income*

* *Please Note:* income limits and benefit levels are adjusted annually; special rules may apply.

Here is the process one should use when applying for Social Security benefits:

- Call the SSA toll free number (800) 772-1213 at or shortly after 7:00 AM. Schedule an appointment with a representative from the Social Security office in your district. There are three district offices in Vermont: Burlington, Montpelier and Rutland.
- Prepare for your appointment (often a phone interview) by gathering up information necessary to apply. Start with your family member's personal data: social security number, birth date, mailing address, and phone number. Have ready documents concerning your ill relative's current medical history – include names, addresses, and phone numbers of doctors, clinics, hospitals, and therapists, along with specific dates of hospital admissions and discharges. Obtain names, mailing addresses, and phone numbers of employers and dates of employment for your relative.
- Ask your relative's doctor if he/she has experience in documenting disability on Social Security applications. If this professional does not, ask for a referral to a doctor who has this experience. Note: the major cause of early denial is the way the treating physician describes the impairment on the Social Security application. The SSA does not use DSM-5 to qualify impairments as disabilities, so if your relative's doctor is using this reference in writing his/her section of the application it could lead to an unnecessary denial of a claim, lots of lost time, and mounting bills. To greatly increase the chances of early acceptance, make sure that your relative's doctor has the SSA Listing of Impairments, and that the doctor write the description of your relative's impairment using SSA criteria and language. Furthermore, the SSA does not automatically give benefits based solely upon the nature of the disability, but on what the individual applying can and cannot do.
- When the representative calls, do not try to learn about the Social Security system or determine if your relative is eligible for benefits. *Just Apply*. The representative is required to explore for which program your relative is eligible. SSA will send you the medical report to be filled out as a result of your call. Fill out as much of the medical report as possible for your relative, using the information which you have available and are ready to give. During the interview the representative will complete the application, marking those areas still in need of more detailed information, and will then mail you the completed application, along with 3 medical releases. Have your relative sign the releases and return them with the completed medical form and application. After the interview has taken place, your relative needs to sign the completed application and return it to SSA. The signature of the person applying for benefits is the only one needed on all of these documents.
- Notify your relative's doctor(s) that your relative has applied for Social Security benefits and that their name and addresses have been referred. Disability is a medical determination. As stated above, the medical section must be written in language familiar to the SSA, and it must carefully describe your relative impairment.

Note that a person who receives SSI may not have assets in excess of $2,000, excluding a car.

If benefits are denied, the ruling may be appealed in sequential order:

a) Ask for a reconsideration of the determination;
b) If upon reconsideration the application is again denied, ask for a hearing before an administrative law judge. Take either a lawyer experienced in Social Security cases or your relative's doctor to the hearing. The investment of several hundred dollars at this stage of

the process is normally a wise one. Many attorneys will agree to represent you on a contingency basis, with no up-front fees.

c) If the administrative law judge denies the request, appeal the decision. The case will be sent to the Appeals Council in Washington, DC.
d) If the Appeals Council denies the application, bring civil action in federal court.

Most cases, if valid according to the basic disability criteria, are approved before going to the Appeals Council. However, the wait for the decision can be six months to two years. If finally approved, benefits will be awarded retroactively to the date of the initial application.

MEDICAID AND MEDICARE

Medicaid is a state-administered, federal program and is available to those individuals who qualify for SSI. However, your relative does not necessarily have to wait until the SSI application is approved in order to receive Medicaid benefits. You can apply for Medicaid at the local office of the Vermont Economic Services Division, Department for Children and Families. You can apply for Medicare at the Social Security office. Medicare is federal health insurance available to individuals who qualify for Social Security Disability Insurance (SSDI), but it does not become effective until two years after the SSDI is granted. It is possible, depending on the amount of income, for an applicant to receive both SSI and SSDI, and have both Medicaid and Medicare.

The amount of SSI benefits varies from year to year. It may be less if the person with the mental illness lives at home, rather than independently. People who receive SSI in Vermont usually qualify for "3SquaresVT" (formerly known as food stamps). These come in the form of a card, much like an ATM card, with a pre-approved amount credited to the card. You (your relative) must sign up for food stamps at the Economic Services Division, Department for Children and Families.

Income from work does not necessarily mean that the person will lose his or her Medicaid. Social Security Administration rule 1619 (b) allows for a continuation of Medicaid, even if earnings exceed the limit, if the person can demonstrate that he or she is working, that coverage is vital to keeping his or her job, that no adequate private coverage is available, and that the disability continues.

GETTING HELP WITH EMPLOYMENT AND BENEFITS

Division of Vocational Rehabilitation
VocRehab Vermont is a Division of the Vermont Department of Disabilities, Aging and Independent Living of the Agency of Human Services. The mission of VocRehab is to help Vermonters with disabilities prepare for, obtain, and maintain meaningful employment. VocRehab helps local businesses recruit, train and retain employees with disabilities.

Vermont is a national leader in promoting employment among Social Security Beneficiaries who have the most significant disabilities and face the greatest disincentives to working. VocRehab has dedicated benefits counselors who advise SSA recipients on available work incentives programs and help them manage their benefits as they transition into employment, increase their income and gradually reduce their dependence on public benefits.

Social Security Work Incentives:
The Federal government's Social Security Administration (SSA) offers two programs that pay disability benefits: the Social Security Disability Insurance program (SSDI) and the Supplemental Security Income program (SSI). Here's how they compare:

- SSDI provides benefits to people who are blind or disabled, have worked, and have paid money into the Social Security trust fund. Their dependents can also get benefits. SSDI recipients get Medicare health insurance after a two-year waiting period.
- SSI is for people who are elderly, blind, or disabled, and who have limited assets and low incomes. SSI recipients automatically receive Medicaid health coverage.

Both SSDI and SSI offer special incentives to help you go to work. The incentives can make it safe for you to try working and gradually increase your income. Some incentives may help you even if you can only work a little.

Over time, your income may grow enough to allow you to get off benefits entirely — but this will be your own choice to make. Remember, you have your own unique needs and goals. That's why it's important to work with a benefits counselor who can help you plan and track any changes in your earnings and benefits.

Benefits Counseling
Social Security rules for disability programs are complicated. Trying to figure out how changes in your work situation (a new job, a raise, going back to school) are going to affect your benefits can be an overwhelming prospect for anyone. Benefits Counseling is an innovative service established in 1999 by the VWII project of Vermont's Division of Vocational Rehabilitation. Vermont now has a statewide network of professional benefits counselors serving over 500 individuals each year.

Benefits Counselors work with:

- Adults on Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) benefits; and
- Youth with disabilities transitioning from high school to adult life.

Services a Benefits Counselor can provide include:

- Comprehensive and accurate information on the impact of employment on benefits
- Advice and assistance on taking advantage of available work incentives
- Help in developing a financial / benefits management plan for transitioning to employment
- Ongoing support as recipients increase their earned income and reduce their dependence on public benefits

For more information, call 866-VRWORKS (866-879-6757) or contact the local VocRehab office in your area (see Appendix F).

STATE PROGRAMS AND BENEFITS

VERMONT DEPARTMENT OF MENTAL HEALTH

It is the mission of the Vermont Department of Mental Health to promote and improve the mental health of Vermonters. The Department of Mental Health (DMH) resides under the Agency of Human Services and has the same critical mission in mind: to improve the conditions and well-being of Vermonters and protect those who cannot protect themselves.

Vermont's Department of Mental Health contracts with and oversees a network of ten private nonprofit community mental health centers, or designated agencies (DAs), which provide mental health services described in the statewide system of care plan. Adult programs offered by these designated agencies include Community Rehabilitation and Treatment (CRT), Adult Outpatient Services, and Emergency Services. The public mental health system is a primary provider of the community support programs that are so important for rehabilitation and recovery from severe mental illness. These programs are detailed in the previous section 'Community Services in Vermont'.

The Department contracts with each of Vermont's ten community mental health agencies to provide a range of comprehensive services for adults living with mental health conditions. For more information about the Department of Mental Health and community programs available in Vermont, telephone (802) 828-3824 - toll free at (888) 212-4677 or visit DMH's website: http://mentalhealth.vermont.gov/.

Economic Services Division (ESD) of the VERMONT DEPARTMENT FOR CHILDREN AND FAMILIES

The Economic Services Division (ESD) helps Vermonters meet their basic needs through programs such as 3SquaresVT, Essential Person, Fuel Assistance, and Reach Up. These programs provide a safety net for individuals and families who may be experiencing unemployment, single parenthood, aging, disability, or other life-changing events. ESD serves over 110,000 families at any given time. This means more than one in five Vermonters will benefit from ESD programs this year.

To access the Benefits Service Center

Call: (800) 479-6151 – Visit: www.mybenefits.vt.gov

Health Care for Vermonters

You can learn about and apply for the three programs listed below through the Department for Children and Families: To find out which health care programs you might be eligible for go to: http://dcf.vermont.gov/esd/health_insurance.

- Medicaid for the Aged, Blind or Disabled (MABD Medicaid). To be eligible you must: 1) Be a Vermont resident; 2) Meet one of the following criteria: (aged – 65 years of age or over; Blind; or Disabled - as defined by the SSA); and 3) Met the financial criteria, including income guidelines and resource limits.
- Prescription Assistance (includes VPharm & Healthy Vermonters)
- Vermont's Long-Term Care Medicaid Program (Choices for Care) helps eligible Vermonters pay for long-term care services in the setting of their choice.

Other Health Care Plans
To learn about and apply for the following other health care plans in Vermont, call 855-899-9600 or go to Vermont Health Connect at: http://info.healthconnect.vermont.gov/.

- Dr. Dynasaur: Provides free or low-cost health coverage for children under 19 and pregnant women. Eligibility is based on household income and family size.
- Medicaid for Individuals who are not Blind, Disabled, or Age 65 or Older**: Medicaid is low-cost or free health coverage for adults.**
- Private Health Plans with and without tax credits or subsidies.

Fuel Assistance in Vermont
The Fuel Assistance Program is administered by the Economic Services Division. Fuel Assistance (also known as Home Heating Assistance) can help pay part of your home heating bills whether you:

- Own your home or rent;
- Pay for heat directly or as part of rent;
- Rent a room in someone's home; or
- Live in public, subsidized, or Section 8 housing AND rent includes the cost of heat.

To apply or reapply for Fuel Assistance you must fill out a Fuel Assistance application each and every year. You can receive an application by calling the Fuel Office at: (800) 479-6151 or go to: http://dcf.vermont.gov/esd/fuel_assistance.

Energy Assistance in Vermont
Energy Assistance helps lower-income Vermonters afford energy for their homes. Assistance is available for Green Mountain Power customers and Vermont Gas customers. If you are eligible, you'll get a 25% discount off the GMP monthly charge for the first 600 kilowatt hours of energy used. This could save you up to $300 a year! Vermont Gas customers get a 20% discount off their monthly bill. To learn more visit: http://dcf.vermont.gov/esd/eap or call (800) 775-0516 to ask for an application.

3SquaresVT
3SquaresVT is a federal USDA program that can help you stretch your food budget and put three healthy meals on your table every day. Benefits include: A monthly payment to help you buy more and better food. You may be eligible:

- If your gross household income is equal to or less than 185% of the federal poverty level, based on household size — regardless of the resources you own.
- If you have children and get the Vermont Earned Income Tax Credit.
- If your household includes someone aged 60+ or with a disability.

If you get a monthly payment, you will receive an EBT card called Vermont Express. You can use this card to buy food at most stores that sell food, much the same way you would use a bankcard or credit card. To find out if you are eligible, you need to apply by calling the Benefits Service Center at (800) 479-6151 or go to: http://dcf.vermont.gov/esd/3SquaresVT.

Phone Assistance in Vermont
The Lifeline Telephone Service Credit offers eligible Vermonters a discount of at least $9.25 off their monthly phone bills. You are eligible if you live in Vermont, have phone service through a participating company, and qualify based on your household income or based on whether you receive public benefits. To learn more and apply go to: http://dcf.vermont.gov/esd/phone or call (800) 479-6151.

Reach Up in Vermont (TANF)
Reach Up helps families with children by providing cash assistance for basic needs and services that support work and self-sufficiency.

Eligibility depends on your income, resources, living expenses, family members in your household, and other factors. If you are likely to be self-sufficient in 4 months or less AND meet eligibility requirements, you may choose to participate in the Reach First program. To apply, call the Benefits Service Center at (800) 479-6151 or go to: http://dcf.vermont.gov/esd/reach_up.

Emergency / General Assistance in Vermont
Emergency/General Assistance helps individuals and families with their emergency basic needs such as housing (e.g., mortgage, rent, room rent, temporary housing), fuel & utilities, personal need items, and medical needs. You may be eligible if you have an emergency need and do not have the income or resources to meet that need. To apply, visit your local District Office (http://dcf.vermont.gov/esd/districts). Call first to find out what documents and information you need to bring. To learn more, visit: http://dcf.vermont.gov/esd/EA-GA.

GUARDIANSHIP AND PROTECTIVE SERVICES

Sometimes, either for short periods of time or for years at a time, a person is so disabled by a mental illness that he or she is not capable of providing for personal needs such as food, clothing, shelter or safety; nor can they manage their financial affairs. Any interested person, e.g. a family member or a friend, can file a petition with the Probate Court requesting a finding of incapacity, and the appointment by the court of a guardian. This is an involuntary guardianship, and the court must have sufficient evidence to conclude that the ward is mentally disabled and incapable of independently managing either his or her personal care or financial affairs or both. Guardianship is awarded only to the extent required by the individual's actual mental and adaptive limitations, so the Court may appoint a total guardian or a limited guardian. In either case, the guardian is to encourage the ward to build independence and self-reliance.

One important benefit of guardianship is that it can allow the guardian to be part of treatment planning. Citing confidentiality, many mental health care providers will not or cannot discuss details of treatment or other matters with a family member without the prior and written consent of the person being treated. If the court so decrees, such matters can be discussed with a Court appointed legal guardian. The guardian then has the right and duty to be informed about treatments, the findings of physical exams, and any evidence of substance abuse. Asking to be included in treatment information can make a great and positive difference in the ability of a family member, as guardian, to cooperate with health providers in the treatment process.

The Court may appoint a total guardian if it has been determined that the ward is unable to manage, without the supervision of a guardian, all aspects of personal care and financial affairs. A total guardian can supervise the ward through the exercise of the following powers, but in a manner which is least restrictive of the ward's personal freedom:

- general supervision, which includes choosing or changing the residence (*with Probate Court permission, if necessary*), care, education, employment;
- approval of a contract, except for necessaries, which the ward wishes to make;
- approval of the ward's request to sell or encumber personal or real property;
- general supervision over the income and resources of the ward; consent to surgery or other medical procedures (*with Probate Court permission*) and subject to the constitutional right to refuse treatment. (Guardians cannot consent to sterilization of adults with mental retardation. Family Court handles these issues.)
- receive, sue for, and recover debts for the ward.

In an involuntary guardianship case, the Court can set up a limited guardianship if the ward is able to manage some aspects of personal care and financial affairs. The Court will specify the powers listed above that the limited guardian shall have, and may further restrict each power if the ward can assume the responsibility. The law establishes certain limits on a guardian's powers. For example a guardian may consent to non-emergency surgery or non-emergency admission to a nursing home only after specific Probate Court approval.

There are special statutes pertaining to medication. However, before a limited guardianship for medication can be ordered by the court, there must be evidence that the individual with a mental disorder is incompetent to refuse medication and/or other treatments, is incapable of caring for him or herself, and is likely to benefit from recommended and prescribed psychotropic medications (those which affect thought processes and mood).

To obtain guardianship for someone, a family member, friend, public official, or social worker files a petition in the Register of the Probate Office of the county courthouse. This person, known as the "petitioner," may recommend a particular person, including him or herself. The petitioner will be asked to testify as to the proposed ward's need for a guardian. It is vital that the petitioner makes a current physician's report available to the court. The proposed ward may also submit a report from a different physician, and is also entitled to have his or her own attorney present, paid for by the county if the person cannot afford one.

For many families, the advantage of seeking guardianship for an ill relative is that someone is responsible to the court for the basic treatment needs and proper disbursement of income for the individual. It is a step that may be taken if family members are fearful that their loved one is impaired to the point of being unable to function at a survival level.

For more information on guardianship visit the Vermont Judiciary website at https://www.vermontjudiciary.org/GTC/Family/GAL.aspx.

WILLS AND ESTATE PLANNING

Considering the lifelong support for a relative with mental illness is usually not a high priority concern during the early, crisis-filled stages of the illness. That worry develops later when the long-term aspects of the illness begin to register, and the reality of our own mortality sinks in.

As soon as your relative qualifies for SSI/SSDI benefits, it becomes very important to protect these benefits. The whole family should be aware of the need to plan ahead so that SSI/SSDI payments and Medicaid benefits will not be jeopardized.

For many of us, the search for and provision of good care ensures that there is little accumulation of wealth which could substantially change our loved one's financial situation. An inheritance from an estranged parent or a well-intentioned grandparent could quite possibly disqualify your relative for continued benefits.

Often when the subject of financial security arises, we think first of the principal sum and then, perhaps, of a financial advisor to best care for that wealth. Nevertheless, it could all be lost or seriously depleted without sound legal advice. For instance, a financial planner may direct funds from an insurance policy or from investments directly to the person with a disability thereby, disqualifying him or her from much needed entitlements. Legal advice is necessary to accommodate your relative's particular situation. Furthermore, his or her situation could change greatly if the laws of another state become applicable. There are a variety of legal documents (trusts, wills, and powers of attorney) that will enable you to leave property to your relative in a form that will permit proper management, while at the same time not endangering your relative's eligibility for governmental health and income benefits.

If the whole family understands the need for precautions to safeguard governmental benefits, ill will and misunderstandings can be minimized. Some families elect to draft a will which disqualifies the relative with a mental illness. Others have set up a trust fund with another relative or third party as trustee (or co-trustee with a financial institution) on behalf of the ill person. Such trusts are called Special Needs Trusts and there are several kinds of them.

All of these considerations dictate that you start by consulting a lawyer who specializes in estate planning. Members of your local NAMI support group or Family to Family Education Course may be able to recommend lawyers they have used.

OTHER COMMUNITY RESOURCES

HOUSING

State public housing authorities administer the federally funded House and Urban Development (HUD) Section 8 Housing Choice Voucher Program, informally known as "Section 8." This Housing Choice Voucher program provides income-eligible families and individuals with rental assistance.

Initial eligibility is based upon income. Income guidelines vary, based on where you live and how many people are in your family. In general, any person living primarily on social security payments would qualify based on their income.

Should a family member meet the income criteria, the next step is to find a rental housing opportunity in your community that will meet his or her needs. Landlords who agree to participate in the Section 8 program have a reasonable rent as established by Housing and Urban Development's (HUD) Fair Market Rent (FMR) standard. In addition, the housing unit will have to meet HUD's Housing Quality Standards (HOS). Should that threshold requirement be met, the local Housing Authority will calculate the rent payment based on income and they will pay the landlord. Typically a person receiving SSI will only pay between 30% and 40% of their annual income on the rent plus the cost of utilities. HUD funds will pay the balance of the rent payment directly to the landlord via the Housing Authority.

The Section 8 rental assistance payment is not limited to apartments only. The Section 8 subsidy can be used to rent a single family home, a multifamily apartment building, mobile home, single room occupancy (SRO) unit, a group home, or shared housing. All of these housing options must meet the FMR and HQS standards referenced above. Vermont has led the nation in applying the Section 8 subsidy toward homeownership in some instances.

The Section 8 program is limited by annual HUD appropriations to the states. There are a limited number of Section 8 vouchers. Consequently most applicants go on a waiting list. It is important to realize that Section 8 housing is not an emergency housing program, since the wait to receive a voucher can be a year or more. Housing Authorities have been known to temporarily close waiting lists, or a waiting period can be in excess of two years. However, there have been times when waiting periods have been reduced, as well. If your family member is seeking affordable housing, it is best to fill out an application as soon as possible.

In addition to the Section 8 Program, there are other housing assistance programs for which your relative may qualify. In some instances, these options may have shorter waiting periods. Such programs include:

- The Project-Based Voucher and Moderate Rehabilitation program. The subsidy is attached to the UNIT and NOT to the family. Therefore, if a family vacates a Project-Based Voucher or Moderate Rehabilitation unit and still wishes to have a subsidy, they must reapply under a different program.
- The Shelter Plus Care program provides rental assistance to homeless people with disabilities. Supportive services, at least equal in value to the rental assistance, must be funded from other sources.
- The Family Unification program promotes family unification by providing rental assistance to families for whom the lack of adequate housing is a primary factor in the separation, or threat of imminent separation, of children from their families.
- The Mainstream Housing program funds rental assistance for non-elderly disabled families. Its primary purpose is to enable disabled families to rent affordable private housing.

For additional information on these programs and availability in your area, check with your local housing authority or community mental health center. Your relative may apply at a local housing authority or the Vermont State Housing Authority in Montpelier. Applications can be mailed to the applicant as well. Completing an application requires that information is completed by your loved one and his or her family (if applicable). Basic demographic information is required, along with documentation of income and assets held by the individual applicant or family. Be sure to have financial institution(s) information regarding account numbers, and documentation on hand. If you are telephoning for an application to be mailed, it is a good time to ask what may be required. In addition you may check www.vsha.org .

Once an applicant receives a letter confirming that he or she has been placed on the Section 8 waiting list or other housing assistance waiting list, it is important to notify the housing authorities of any change in the applicant's address or telephone numbers. Periodically, housing authorities may send letters to update information, or for verification purposes. It is very important to respond to these letters. Housing Authorities may drop applicants from the waiting list(s) if they do not reply. In order to insure the required follow up, you can ask to have a duplicate sent to you.

Some housing authorities may have managed properties. These are moderate to high density rental properties. Preference may be given in these units based upon specific program eligibility requirements, such as household composition, age or disability. Not all managed properties maintain waiting lists. For information on affordable housing units in your area, see: http://housingdata.org/doarh/index.php , the statewide directory of affordable housing.

In addition, Vermont has a very sophisticated nonprofit affordable housing development sector. The Vermont Housing and Conservation Board funds nonprofit housing development in communities across the state. To learn more about these programs, go to www.vhcb.org/links.html#housing

Check directly with Vermont Housing and Conservation Board (VHCB) at (802) 828-3250 or the website www.vhcb.org to determine what housing resources are available in your community. You can then contact the not-for-profit developer to see what affordable housing options your loved one or family might apply for. The application process for affordable housing developed by these agencies is similar to the section 8 program. In fact, you may find some units that have a section 8 subsidy attached. This is another way to secure decent, safe and affordable housing. Community Mental Health Centers have direct working relationships established with these housing agencies, and their staff may be of assistance and support in this area as well.

Pathways Vermont's Housing First Program provides housing and support services for individuals with mental health challenges and who experience long episodes of homelessness. Peer support, self-directed goals, trauma informed care, and integrative services are the core values of the Housing First Program. They have regional offices in the following counties: Addison, Chittenden, Franklin, Washington, and Windham. To learn more, call (888) 492-8218 or visit www.pathwaysvermont.org.

CRIMINAL JUSTICE SYSTEM

The symptoms of mental illness distort a person's judgment, and may lead to behaviors which may draw the attention of law enforcement, or be reported to police by others. In some cases, it is the family that calls the police in response to a potentially volatile situation in the home. Thus, persons with a serious mental health disorder can sometimes find themselves in the midst of interacting with the criminal justice system.

If an individual with symptoms of a mental illness had previously refused to see a mental health professional for an evaluation, police intervention may provide the first opportunity to identify a person's serious mental health disorder. Although it is every family's nightmare for a loved one to commit a crime and be arrested by the police, it can be the step that gets your loved one into effective treatment.

Most often, individuals with mental illness are cited or arrested and taken into custody as a result of misdemeanor offenses, although felonies may also be involved. In more severe cases, an arrest may result in your family member being taken to a psychiatric hospital for a forensic evaluation. A judge may order a forensic evaluation in a criminal case, when the judge thinks that person may not be competent to understand the legal process because of symptoms of a mental illness or other disability.

A competency evaluation may occur prior to an arraignment (which is when formal charges are brought) if your relative is showing obvious symptoms. A mental health "screener" will come to the courthouse to perform the evaluation. Competency screenings are not done in jail.

Seeking legal advice maybe helpful at this time. If you have questions, the local Public Defender's Office can be helpful. If your loved one is facing criminal charges and cannot afford a lawyer, a Public Defender will be appointed by the court to represent him/her. However, if you're able to financially afford a lawyer, this may be the time to consider retaining legal representation. Vermont Legal Aid may also be helpful, as they can help provide information on potential accommodations that may be provided for your relative under the American Disability Act (ADA) as a result of their mental illness.

If your relative has been arrested and is currently in a treatment program, there may be opportunities to prevent him/her from becoming imprisoned through participation in a voluntary jail diversion program. Drug treatment courts and mental health courts are special programs (not yet available in every community in Vermont) that provide an opportunity for defendants to be diverted from typical sentencing if they agree to enter (and also complete) a treatment program. Such programs help ensure that individuals with mental illness receive treatment as well as consequences. Even where such programs are not yet available, family members can play an important role in educating the criminal justice system professionals about your relative's illness and their needs. For example, the defense attorney may be able to negotiate the defendant's participation in treatment as an alternative to jail time, if they understand the impact of mental illness on the circumstances of the alleged crime.

If your relative does end up going to jail, it is essential that he or she continue to receive medical and mental health care while incarcerated. If the individual is not in a treatment program, the contact

with the criminal justice system may well result in some sort of treatment, provided the police and/or correctional staff connect with someone at the local mental health center who is both willing and able to do an assessment.

Families must understand that jail is not a hospital, and correctional officers are not social workers. Correctional workers are primarily concerned with security. Medical and mental health services are now provided by private companies working under contracts with the VT Department of Corrections. These companies hire qualified local mental health providers, who offer support and treatment to incarcerated individuals with mental illness, as well as support for coping with being incarcerated.

Correctional officers, caseworkers, medical staff, and mental health workers must protect the confidentiality of your relative. If you have questions or concerns about your relative's medical or mental health, there are steps to take:

1. Encourage your family member to submit a sick slip for medical or mental health services.
2. Ask your relative to sign a release of information, allowing his or her caseworker to talk with you.
3. Contact the assigned caseworker with specific questions which the caseworker will communicate to medical or mental health staff.
4. An informal complaint, or grievance, can be submitted if your family member hasn't received a timely and appropriate response. Please refer to *The Health Services Handbook for Families & Friends of Inmates* for how to file an informal complaint or grievance.
5. Lastly, you may contact the Health Services Division of the Department of Corrections at (802) 241-2295.

The Health Services Handbook for Families & Friends of Inmates, published by the Department of Corrections, addresses many questions or concerns you or your relative may have regarding medical and/or mental health services. The handbooks can be found at every Vermont correctional facility or go to: www.doc.state.vt.us/about and click on the Health Services Handbook on the left navigation link.

If problems occur that cannot be resolved easily, do not hesitate to call the superintendent of the correctional facility, or the Commissioner of Corrections. They should both be able to help explain how the care and treatment of incarcerated individuals is handled. In addition, all of the policies of the Vermont Department of Corrections are made available on their website: www.doc.state.vt.us.

IF/WHEN THINGS GO WRONG

What To Do / Who To Call

Families with relatives living with serious mental illness soon discover that the road to recovery and wellness is a rocky one. Things can and will go wrong with the system of care, despite the best of

intentions. Our loved ones can be very vulnerable to stress, anxiety, ambivalence, and delays. This fact, combined with the symptoms of the illness itself can make negotiating the complex mental health delivery system nearly impossible. Individuals may not receive all the services they need and to which they are entitled. They may need your help, even if such help is not wanted.

If there is a problem with delivery or quality of services, it is generally a good idea to address the problem at the most immediate level of service: i.e. directly with your relative's caregivers, case managers or doctors. Talk to these people first. You will likely need your relative to sign a release form to allow this person to talk with you. If your relative will not sign a release, or if, after talking with the individual(s) providing the service(s) the issue is not resolved to your or your relative's satisfaction, you may contact the CRT team leader or the CRT coordinator of the relevant community mental health center. If, after talking to the people immediately involved you still have a problem you may want to file a grievance.

Some of the most effective community mental health centers have become so because of the advocacy of family members and/or peers. If you are told there is not enough money available to provide the needed and requested service(s) then go to the agency's Board meeting and learn about the allocation process. Write to your local legislators to make them aware of budget shortfalls. Work to change the funding priorities of the state. Your actions can help to make your local community mental health center as strong as it can be.

If your relative is receiving services through the private sector, you can contact the VT Secretary of State's office at (802) 828-2363 to file a complaint with the professional licensing board. For problems with getting insurance to cover mental health treatment, you can call the Vermont Department of Financial Regulation (formerly BISHCA) and lodge a complaint. The number is (802) 828-3301.

Formal Grievances

The Vermont Department of Mental Health requires each community mental health center to have a grievance procedure, or an appeal process for resolving disagreements about services. Formal grievances may be filed by any client, prospective client, or family member. Ask for an explanation of this grievance process and request the necessary form from the administrative office or receptionist of your local agency.

The above organizations provide free advocacy and, in some cases, legal services for adults with serious mental illness who are in hospitals, nursing homes, group homes, or other supervised living arrangements.

Americans with Disabilities Act (ADA)

The Americans with Disabilities Act was made law in 1990, and amended in 2008. Although flawed, it remains the most comprehensive piece of legislation affecting people with disabilities in America, and guarantees equal rights to those with physical, mental, cognitive, or sensory disabilities. It also covers individuals who have a history of a disability, such as those who have had psychiatric treatment in the past, but who are now fully recovered.

The ADA prohibits discrimination based on a relationship to, or association with, a person with a disability. For example, this provision would prohibit an employer from refusing to hire a person whose family member had a mental illness, just because the employer fears the prospective employee may be distracted at work as a result.

Employers may not discriminate against an individual with a disability, including mental illness, if the person has the necessary skills and background needed for the job, and can, with or without "reasonable accommodations," perform the essential functions of the job. The employer must list these essential functions on the written job description. It is not considered discrimination if an individual does not have the necessary skills to perform those essential functions, and the employer does not consider that person for the position. Employers must provide reasonable accommodations, or any adjustment to a job or work environment that permits a qualified person with a disability to perform the essential function of the job.

Some examples of accommodation for people with mental illnesses include part-time work or a flexible schedule, time off for therapy appointments, or moving to a quieter workspace to minimize distractions. If an employee does not disclose his or her disability, or explain what is needed, an employer is under no obligation to provide an accommodation. Employers do not necessarily have to provide the accommodation(s) requested by employees. Employers may choose a less expensive option, and may not have to provide an accommodation that proves to be an "undue hardship."

If you believe an employer has discriminated based on the employee's mental illness, contact the Equal Employment Opportunities Commission office in Boston at (800) 669-4000, or visit their web site at www.eeoc.gov.

APPENDICES

APPENDIX A

MENTAL HEALTH CRISIS HOTLINES – AVAILABLE 24/7

Please call the number below for the county in which you live. This information is also available at http://mentalhealth.vermont.gov/DAlist.

Other (non-crisis) services can be located by calling Vermont 2-1-1, a program of United Way of Vermont. (Dial 211 from any landline phone in the 802 area code.) It is a health and human services information and referral program serving the state of Vermont.

County	Provider	Telephone
Addison	Counseling Service of Addison County	(802) 388-7641
Bennington	United Counseling Service, Inc. – Bennington	(802) 442-5491
	Manchester	(802) 362-3950
Caledonia	Northeast Kingdom Human Services – St. Johnsbury	(802) 748-3181
	Mental Health, Substance Abuse and Development Services	(800) 649-0118
Chittenden	HowardCenter – Adults	(802) 488-6400
	HowardCenter – Children's Services	(802) 488-7777
Chittenden	Northeastern Family Institute	(802) 658-0040
Essex	Northeast Kingdom Human Services – Derby	(800) 334-6744
Franklin Grand Isle	Northwestern Counseling and Support Services	(802) 524-6554
Lamoille	Lamoille County Mental Health Services	(802) 888-5026
	Nights and weekends	(802) 888-8888
Orange	Clara Martin Center	(800) 639-6360
Orleans	Northeast Kingdom Human Services – Derby	(802) 334-6744
	Mental Health, Substance Abuse and Development Services	(800) 696-4979
Rutland	Rutland Mental Health Services, Inc.	(802) 775-1000
Washington	Washington County Mental Health Services, Inc.	(802) 229-0591
Windham Windsor	Health Care and Rehabilitation Services	(800) 622-4235
	Guardianship Services Emergency	(800) 642-3100
	National Suicide Prevention Lifeline	(800) 273-8255

APPENDIX B

STATE MENTAL HEALTH AGENCY:
Vermont Department of Mental Health
26 Terrace Street, Montpelier, VT
http://mentalhealth.vermont.gov

Connecting all offices (802) 828-3824
Toll Free (888) 212-4677

DIRECTORY OF VERMONT COMMUNITY MENTAL HEALTH AGENCIES

Note: *if you're unsure which program or service you need, and it's not a crisis, call the main office of the agency for your community and ask to speak with Intake. This directory does NOT include programs serving individuals living with developmental disabilities.*

Addison County

Counseling Service of Addison County (CSAC)
89 Main Street, Middlebury, VT 05753 – Main Office
www.csac-vt.org

Main Office .....(802) 388-6751
24-hour Emergency Service .....(802) 388-7641
Bristol Office, 25 Mountain View Street .....(802) 453-3009
Evergreen House, 17 Court Street. .....(802) 388-3468
Developmental Services - Community Assoc. 109 Catamount Park .....(802) 388-4021
Employment Associates .....(802) 388-4021

Bennington County

United Counseling Service of Bennington County, Inc. (UCS)
100 Ledge Hill Drive / PO Box 588
Bennington, VT 05201-0588
5312 Main St, Manchester, VT 05254
www.ucsvt.org

Main Office .....(802) 442-5491
24-hour Emergency Service
  Bennington .....(802) 442-5491
  Manchester .....(802) 362-3950
Substance Abuse Services .....(802) 442-5491
Developmental Disabilities .....(802) 442-5491
Family Emergency Services .....(802) 447-1700
Community Rehabilitation and Treatment Program .....(802) 442-5491

Chittenden County

HowardCenter for Human Services (HCHS)

208 Flynn Avenue, Burlington, VT 05401 – Administrative Office
300 Flynn Avenue, Burlington, VT 05401 – Adult Behavioral Health
102 S. Winooski Avenue, Burlington, VT 05401 – Developmental Services
www.howardcenter.org
855 Pine St., Burlington, VT 05401 - Mental Health & Substance Abuse Services
45 Clark St., Burlington, VT 05401 – Co-Occurring Disorders

Administrative Offices ..... (802) 488-6000
24-hour Adult Crisis Service ..... (802) 488-6400
24-hour Substance Abuse Crisis ACT ONE ..... (802) 488-6425
First Call for Families ..... (802) 488-7777
Adult Behavioral Health
  Program Information ..... (802) 488-6100
  Residential Programs ..... (802) 488-6200
Children Youth & Family Services ..... (802) 488-6600
Developmental Services ..... (802) 488-6500
Mental Health & Substance Abuse Services ..... (802) 488-6103
CRASH Drinking Driver Assessments ..... (802) 488-6150
Co-Occurring Disorders Treatment Program ..... (802) 488-6006
Westview House ..... (802) 488-6023
Westview Employment Services ..... (802) 488-6242
Peer Access Line (PAL) 6-9 pm Thursday-Sunday ..... (802) 321-2190

Caledonia, Essex and Orleans Counties

Northeast Kingdom Human Services (NKHS)

181 Crawford Road, Derby
Mailing address: PO Box 724, Newport, VT 05855
2225 Portland Street, St. Johnsbury, VT 05819
www.nkhs.net

Administrative Offices – Derby ..... (802) 334-6744
Mental Health and Substance Abuse Services – Derby ..... (800) 696-4979
  Developmental Services – Derby ..... (800) 696-4979
  Administrative Offices – St. Johnsbury ..... (802) 748-3181
Mental Health, Substance Abuse, and Developmental Services – St. Johnsbury ..... (800) 649-0118
24-hour Emergency Service
    Derby ..... (802) 334-6744
    St. Johnsbury ..... (802) 748-3181

Franklin and Grand Isle Counties

Northwestern Counseling and Support Services (NCSS)

107 Fisher Pond Road, St. Albans, VT 05478 – Main Office
130 Fisher Pond Road, St. Albans, VT 05478 – The Family Center
www.ncssinc.org

Main Office ..... (802) 524-6554
Main Office toll free ..... (800) 834-7793
24-hour Emergency Service ..... (802) 524-6554
Behavioral Health Services ..... (802) 524-6554
Community Support Programs ..... (802) 524-6554
Walk-In Services 107 Fisher Pond Road (M-F, 10 am – 5 pm) ..... (802) 524-6554
Children, Youth and Family Services ..... (802) 524-6554
Family Center of NW VT ..... (802) 524-6554
Developmental Services ..... (802) 524-6554
Employment Services ..... (802) 524-6554
Soar Learning Center ..... (802) 527-7514

Lamoille County

Lamoille County Mental Health Services, Inc. (LCMHS)

72 Harrel St., Morrisville, VT 05661
www.lamoille.org

Outpatient Services ..... (802) 888-5026
CRT Services ..... (802) 888-5026
24-hour Mobile Crisis Team ..... (802) 888-5026
Nights and Weekends ..... (802) 888-8888

Orange County

Clara Martin Center (CMC)

11 North Main Street / PO Box G, Randolph, VT 05060-0167
1483 Lower Plain / PO Box 278, Bradford, VT 05033-0278
39 Fogg Farm Rd / PO Box 816 Wilder, VT 05088
356 VT Route 110, Chelsea, VT 05038
www.claramartin.org

Main Office (Randolph) ..... (802) 728-4466
24-hour Emergency Service ..... (800) 639-6360
Bradford Office ..... (802) 222-4477
Safe Haven Homeless Shelter ..... (802) 728-4466 x359
Community Rehab Treatment ..... (802) 728-6000
Wilder Office ..... (802) 295-1311
Quitting Time, Come About Program ..... (802) 295-1311
Crash, Crash Weekend Program (with VA) ..... (802) 295-1311 x405

Rutland County

Rutland Mental Health Services (RMHS)

78 So. Main Street, Rutland, VT 05701 – Main Office
7 Court Square, Rutland, VT 05701
135 Granger Street, Rutland, VT 05701
www.rmhsccn.org

Main Office ..... (802) 775-2381
24-hr Emergency Services ..... (802) 775-1000
Child and Family Services ..... (802) 775-2381
Evergreen Substance Abuse Services ..... (802) 747-3588
Rutland Mental Health Services (Court Square) ..... (802) 775-4388

Washington County

Washington County Mental Health Services, Inc. (WCMHS)

174 Hospital Loop, Berlin / 885 South Barre Road, South Barre, VT 05670 – Administration
9 Heaton Street, Montpelier, VT 05602 – CRT Program
23 Jones Brothers Way, Barre, VT 05641 – Counseling Center
579 South Barre Road, Barre, VT 05670 – Children/Family Services
7 Baldwin Street, Montpelier, VT 05602 – Green Mountain Workforce
www.wcmhs.org

Administrative Offices/General Info ..... (802) 229-1399
24-hour Emergency Service ..... (802) 229-0591
Community Rehabilitation and Treatment ..... (802) 223-6328
Center for Counseling and Psychological Services ..... (802) 479-4083
Counseling Services of Washington County ..... (802) 229-0591
Children, Youth & Family Services ..... (802) 476-1480
Home Intervention ..... (802) 479-1339
J.O.B.S ..... (802) 476-1480
Green Mtn. Workforce ..... (802) 223-6328
Employment Services
  Mental Health ..... (802) 229-0591
  Developmental Services ..... (802) 479-5012 x565
Elder Treatment ..... (802) 476-0531
Community Developmental Services ..... (802) 479-2502

Windham and Windsor Counties

Health Care and Rehabilitation Services (HCRS)

390 River Street, Springfield, VT 05156 – Bellows Falls, Windsor & Springfield Office
49 School Street / PO Box 709, Hartford, VT 05047 – Outpatient Services
51 Fairview Street, Brattleboro, VT 05301 – Outpatient Services
www.hcrs.org

Main Office .....(802) 886-4500
24-hour Emergency Service .....(800) 622-4235
Outpatient Services:
- Springfield .....(802) 886-4500
- Hartford .....(802) 295-3031
- Brattleboro .....(802) 254-6028
- Bellows Falls .....(802) 463-3947

Substance Abuse Program .....(802) 886-4500
CRT Programs:
- Brattleboro .....(802) 254-7511
- Springfield .....(802) 886-4500
- Hartford .....(802) 295-9337
- The Alternatives Program .....(802) 885-7280

APPENDIX C

OTHER MENTAL HEALTH TREATMENT PROVIDERS AND RESOURCES

HOSPITALS IN VERMONT WITH PSYCHIATRIC INPATIENT UNITS

Brattleboro Retreat (Brattleboro) ..... (802) 257-7785
Central Vermont Medical Center (Berlin) ..... (802) 371-4100
University of Vermont Medical Center (Burlington)..... (802) 847-0000 – (800) 358-1144
Rutland Regional Medical Center (Rutland) ..... (800) 649-2187 - (802) 775-7111
Vermont Psychiatric Care Hospital (350 Fisher Road, Berlin)..... (802) 828-3300
Windham Center (Bellows Falls) ..... (802) 463-1346

OTHER PSYCHIATRIC INPATIENT HOSPITALS IN AND NEARBY VERMONT

Albany Medical Center (Albany, NY) ..... (518) 262-3125
Cheshire Medical Center (Keene, NH) ..... (603) 354-6670
Dartmouth Hitchcock Medical Center (Lebanon, NH) ..... (603) 650-7500
Franklin Medical Center (Greenfield, MA)..... (413) 773-2546
VA Medical Center (White River Jct.)..... (802) 295-9363
..... (866) 687-8387

PRIVATE RESIDENTIAL TREATMENT PROGRAMS IN VERMONT

Forty Seven Main (Castleton, VT) ..... (802) 468-5325
..... (800) 287-5325
Hundred Acre Homestead (Worcester, VT)..... (802) 223-9122
Merry Meadow Farm (Bradford, VT)..... (802) 222-4412
Northeastern Family Institute (NFI) – for youth, teens ..... (802) 658-3924
Spring Lake Ranch (Cuttingsville, VT)..... (802) 492-3322
Spruce Mountain Inn (Plainfield, VT)..... (802) 454-8353

INTENSIVE RESIDENTIAL

Hilltop Recovery Residence (Westminster) ..... (802) 886-4567
Meadowview Recovery Residence (Brattleboro) ....Email: Emily at emegasrussell@newperspectives.org
Rutland Mental Health Services (Rutland)..... (802) 775-7381
Second Spring (Williamstown) ..... (802) 433-6183
Second Spring North (Westford)..... (802) 433-6183
Soteria ..... (888) 492-8218
Middlesex Secure Residential Program (MSRP) - Middlesex ..... (802) 828-5800

CRISIS BEDS

Alyssum (2 beds) – North Rochester .....(802) 767-6000

Alternatives (6 beds) – Springfield .....(802) 885-7280

Assist HC (6 beds) – Burlington .....(802) 488-6412

Battelle House UCS (6 beds) – Bennington.....(802) 442-5491

Bayview NCSS (2 beds) – Saint Albans .....(802) 393-0620 - (800) 834-7793

Care Beds (2 beds) – St. Johnsbury.....(802) 748-6960 - (802) 748-6961 - (800) 649-0118

Chris' Place (1 bed) – Randolph .....(802) 728-4466 - (800) 639-6360

Home Intervention (5 beds) – Barre.....(802) 479-1339

Oasis (2 beds) – Morrisville .....(802) 888-5026
evenings and weekends .....(802) 888-4231

CSID RMHS (4 beds) – Rutland ..... (802) 747-3587 – (877) 430-2273

Robinson House (1 bed) – Middlebury .....(802) 388-6754

Second Spring – Williamstown and Westford .....(802) 433-6183

APPENDIX D

OTHER LOCAL/STATE AGENCIES, DEPARTMENTS AND ORGANIZATIONS

(PUBLIC AND PRIVATE)

General information on all health and human services programs in Vermont:
Vermont Statewide Information & Referral Service: dial 211* (toll-free)
* (from any landline in VT; cell phones call 1-866-652-4636)

OTHER PUBLIC AND PRIVATE AGENCIES:

Adult Protective Services (State of Vermont) .....(800) 564-1612
American Foundation for Suicide Prevention – Vermont .....(802) 272-6564
Disability Law Project - Vermont Legal Aid.....(800) 747-5022
(Burlington, Montpelier, Rutland, Springfield, St. Johnsbury)
Disability Rights Vermont.....(800) 834-7890
Friends of Recovery – Vermont .....(800) 769-2798
Health Care Ombudsman .....(800) 917-7787
Medicare Help Line .....(800) 633-4227
Mental Health Law Project – Vermont Legal Aid .....(800) 265-0660
Mind Freedom International .....(877) 623-7743
National Association for Rights Protection and Advocacy .....(256) 650-6311
National Empowerment Center.....(800) 769-3728
Prevent Child Abuse – Vermont.....(800) 244-5373
Senior Helpline.....(800) 642-5119
Stern Center for Language and Learning .....(802) 878-2332
Suicide Prevention Lifeline .....(800) 273-8255
Vermont Association for Mental Health .....(802) 223-6263
Vermont Center for Independent Living .....(800) 639-1522
Vermont Coalition for Disability Rights .....(800) 639-1522
Vermont Department for Children & Families (Medicaid Info) .....(800) 250-8427
Vermont Department of Disabilities, Aging and Independent Living.....(802) 871-3350
Vermont Department of Financial Regulation .....(802) 828-3301
Vermont Department of Health
Division of Alcohol and Drug Abuse Programs.....(802) 651-1550
Vermont Family Network.....(800) 800-4005
Vermont Federation of Families for Children's Mental Health.....(802) 876-7021
.....(800) 639-6071
Vermont Human Rights Commission.....(800) 416-2010
Vermont Legal Aid .....(800) 889-2047
Vermont Psychiatric Survivors .....(802) 775-6834
Vermont Psychological Association .....(802) 229-5447
Vermont Suicide Prevention Center..... (802) 254-6590
Vermont Support Line: free, anonymous, non-judgmental 3-11 pm .....(888) 604-6412
Vermont Tenants, Inc. .....(802) 864-0099
Voices for Vermont's Children .....(802) 229-6377

STATE AND NATIONAL POLITICAL REPRESENTATIVES

Vermont Legislature/State House.....(802) 828-2228
Governor Peter Shumlin .....(802) 828-3333 - (800) 649-6825
Senator Bernie Sanders .....(202) 224-5141 - (800) 339-9834
Senator Pat Leahy .....(202) 224-4242 - (800) 642-3193
Congressman Peter Welch .....(202) 225-4115 - (888) 605-7270

APPENDIX E

VERMONT COALITION OF CLINICS FOR THE UNINSURED

CLINICS AROUND THE STATE

Bennington Free Clinic (Bennington) ..... (802) 447 3700
Good Neighbor Health Clinic (White River Junction).....(802) 295-1868
The Health Assistance Program University of Vermont Medical Center
(Burlington).....(802) 847-6985
Health Connections at Gifford Medical Center (Randolph) .....(802) 728-2323
Open Door Clinic (Middlebury and Vergennes) .....(802) 388-0137
People's Health and Wellness Clinic (Barre).....(802) 479-1229
Putney Walk-In Clinic (Putney) .....(802) 387-2120
Rutland Free Clinic (Rutland) .....(802) 775-1360
Valley Health Connections (Springfield).....(802) 885-1616
Windsor Community Health Clinic at Mt. Ascutney Hospital (Windsor).....(802) 674-7213
Red Logan Dental Clinic at Good Neighbor Health Clinic (White River Jct.) .....(802) 295-7573

OTHER CLINICS:

Burlington Safe Harbor (Homeless Services).....(802) 860-4310

Community Health Center (Burlington).....(802) 864-6309

APPENDIX F

VOCATIONAL REHABILITATION OFFICES

http://vocrehab.vermont.gov/home

VocRehab Vermont has offices around the state to make their services available to anyone with a disability who can benefit from their help to prepare for, obtain and maintain meaningful employment. Office locations:

Barre-Montpelier Regional Office
McFarland State Building
5 Perry Street, Ste. 100
Barre, VT 05641
Voice/TTY: (802) 479-4210

Bennington District Office
150 Veterans Memorial Drive, Ste. 15
Bennington, VT 05201-1998
Voice/TTY: (802) 447-2780
TTY: (802) 447-2805

Brattleboro District Office
Marlboro Technology Center
28 Vernon Street, Ste. 400
Brattleboro, VT 05301
Voice: (802) 257-0579

Burlington Regional Office
110 Cherry Street, Suite 201
Burlington, VT 05401
Voice: (802) 863-7500

Middlebury District Office
156 South Village Green
Middlebury, VT 05753-1105
Voice: (802) 388-4666

Morrisville District Office
63 Professional Drive
Morrisville, VT 05661-9724
Voice: (802) 888-5976

Newport District Office
100 Main Street, Ste. 120
Newport, VT 05855
Voice/TTY: (802) 334-6794

Rutland Regional Office
190 Asa Bloomer Building
Rutland, VT 05701-9408
Voice/TTY: (802) 786-5866

Springfield Regional Office
100 Mineral Street, Ste. 308
Springfield, VT 05156
Voice/TTY: (802) 885-2279

St. Albans District Office
State Office Bldg.
27 Federal Street, Ste. 200
St. Albans, VT 05478
Voice: (802) 524-7950

St. Johnsbury District Office
67 Eastern Avenue, Ste. 3
St. Johnsbury, VT 05819
Voice/TTY: (802) 748-8716

White River Jct. District Office
220 Holiday Drive, Suite A
White River Junction, VT 05001
Voice/TTY: (802) 295-8850

Central Office (Mailing Address):
103 So Main St., Wks 1A Blding, Waterbury, VT 05671, Voice/TTY: (866) 879-6757

APPENDIX G

OTHER LOCAL AND STATE RESOURCES

(Please note that these resources change frequently; for best results, call ahead.)

PEER SUPPORT RESOURCES:

Vermont Psychiatric Survivors: VPS is a statewide peer-run organization that offers peer support groups. Office phone: 802-775-6834 or visit www.vermontpsychiatricsurvivors.org

Brain Injury Association: Offering peer support groups for individuals with a brain injury. Contact the Brain Injury Association at (877) 856-1772 for more information or visit www.biavt.org

NAMI Vermont: NAMI offers Family Support Groups and Connection Recovery Support Groups. Contact their Warm Line at (800) 639-6480. For information on meeting locations and schedules call (802) 876-7949 or visit www.namivt.org.

Friends of Recovery VT: Promotes education and an understanding of recovery from both mental health conditions and addictions and inspires hope for recovery. Phone: (800) 769-2798 or visit www.friendsofrecoveryvt.org/

Pathways Vermont: Promotes dignity and equal opportunity for all. Some of their services include: The Vermont Support Line: free, anonymous and non-judgmental support to anyone who calls from 3 pm to 11 pm, 7 days a week. Call (888) 604-6412; The Wellness Co-op: a peer-run community center in Chittenden County; Housing First places people experiencing chronic homelessness into permanent, independent housing; and Soteria: a five bed residence for individuals experiencing a first break of psychosis. Visit www.PathwaysVermont.org.

PEER SUPPORT LINES AND DROP-IN PEER SUPPORT CENTERS

Vermont Support Line: free, anonymous, non-judgmental 3pm-11pm.....(888) 604-6412
Another Way - 125 Barre St., Montpelier.....(802) 229-0920
Brattleboro Area Drop-In Center - 60 South Main Street, Brattleboro.....(802) 257-2005
Our Place Drop in Center - 4 Island Street, Bellows Falls .....(802) 463-2217
COTS Daystation – 113 Elmwood Ave., Burlington..... (802) 862-5418
The Wellness Co-op - 279 N Winooski Ave., Burlington..... (888) 492-8218 ext 300

CO-OCCURRING RESOURCES:
VERMONT RECOVERY CENTER NETWORK:

Helping people find, maintain, and enhance their recovery experience through peer support, sober recreation, and educational opportunities. (802) 738-8998. website: www.vtrecoverynetwork.org email: vtrecoverynetwork@gmail.com

Barre:
Turning Point Center of Central Vermont
489 Main Street
Barre, VT 05641
(802) 479-7373
tpccvbarre@gmail.com

Bennington:
Turning Point Center of Bennington
465 Main Street, PO Box 454
Bennington, VT 05201
(802) 442-9700
turningpointbennington@comcast.net

Brattleboro:
Turning Point Center of Windham County
14 Elm Street, Brattleboro, VT 05301
(802) 257-5600
tpwc.1@hotmail.com

Burlington:
Turning Point Center of Chittenden County
191 Bank St., Suite 200 Burlington, VT 05401
(802) 861-3150
garyd@turningpointcentervt.org

Middlebury:
Turning Point Center of Addison County
228 Maple Street, Space 31B, PO Box 405
Middlebury, VT 05753
(802) 388-4249
tcacvt@yahoo.com

Morrisville:
North Central Recovery Center
275R Brooklyn St., P.O. Box 862
Morrisville, VT 05661
(802) 851-8120
recovery@ncvrc.com

Rutland:
Turning Point Recovery Center of Rutland
141 State Street
Rutland, VT 05701
(802) 773-6010
turningpointcenterrutland@yahoo.com

Springfield:
Turning Point Center of Springfield
7 Morgan Street
Springfield, VT 05156
(802) 885-4688
spfldturningpoint@gmail.com

St. Albans:
Turning Point Center of Franklin County
182 Lake Street, P.O. Box 1187
St. Albans, VT 05478
(802) 782-8454
tpfcdirector@gmail.com

St. Johnsbury:
Kingdom Recovery Center
297 Summer Street
St. Johnsbury, VT 05819
(802) 751-8520
n.bassett@stjkrc.org

White River Junction:
Upper Valley Turning Point
200 Olcott Road
White River Jct., VT 05001
(802) 295-5206
mhelijas@secondwindfound.org

RESOURCES FOR MILITARY VETERANS AND THEIR FAMILIES:

Vermont Vet to Vet: Free peer support groups for veterans, led by trained veteran volunteers. Call a Veteran at 1-802-485-4534 for the latest information and updated meeting information. Website: www.vtvettovet.org.

Federal Mental Health Resources for Veterans and Families: Find mental health services for vets and families; publications about coping with trauma and more. Veterans Crisis Line: (800) 273-8255, press 1 or visit www.samhsa.gov/MilitaryFamilies/

Free Transportation to Appointments: Contact Disabled American Veterans at (877) 426-2838, (802) 295-9363 x5394 for more information or visit www.dav.org.

Services for Veterans and Family Members in Need
In Vermont dial 2-1-1 and ask for info about a variety of services for vets and families
Vermont Veteran and Family Outreach Program: (888) 607-8773
Visit the Vermont Veterans Services Online Directory, at www.veterans.vermont.gov.

Suicide Prevention for Veterans: The Department of Veterans Affairs (VA) and Substance Abuse and Mental Health Services Administration (SAMHSA) teamed up to launch the Veterans Suicide Prevention Hotline, to ensure that veterans in emotional crisis have free, 24/7 access to trained, professional counselors. Veterans can call the National Suicide Prevention Lifeline number, (800) 273-TALK (8255), and press "1" to be routed to the Veterans Hotline.

Vermont National Guard Family Program: provides assistance to military members and their families. Call them toll free at (888) 607-8773 or visit http://www.vtguard.com/resources/organization/family_programs/default.html.

VA Medical Center, White River Jct.: Offering mental health services to veterans. Call the VA Medical Center toll free at (866) 687-8387 for more information.

VA Medical Center Community Outpatient Clinics:
Bennington .....(802) 447-6913
Brattleboro .....(802) 251-2200
Burlington ..... (802) 657-7000
Newport .....(802) 334-9777
Rutland .....(802) 772-2300
Keene, NH .....(603) 358-4900
Littleton, NH .....(603) 444-9328

VA's National Center for Post-Traumatic Stress Disorders: www.ptsd.va.gov/.

National Coalition for Homeless Veterans: Call (800) VET-HELP or (202) 546-1969. www.nchv.org/.

VA's National Call Center for Homeless Veterans: 1-877-4AID-VET or (877) 424-3838

APPENDIX H
RECOMMENDED READING

NAMI Vermont has many books that members can borrow from our office. The following is a list of books that may be of interest to you:

Help for Families

Adamec, C. (1996). *How to live with a mentally ill person: A handbook of day-to-day strategies.*

Amador, X. and Johanson, A. (2000). *I am not sick, I don't need help: Helping the seriously mentally ill accept treatment: A practical guide for families and therapists.*

Amador, X. & Rosen, L.E. (1997). *When someone you love is depressed: How to help your loved one without losing yourself.*

Backlar, Patricia. (1994). *The family face of schizophrenia: Practical counsel from America's leading experts.*

Bernheim, Kayla, Lewine, Richard & Beale, Caroline (1982). *The caring family: Living with chronic mental illness.*

Campbell, Bebe Moore (2003). *Sometimes my mommy gets angry.*

Carter, Rosalynn and Susan Ma Golant, *Helping Someone with Mental Illness: A Compassionate Guide for Family, Friends, and Caregivers*

Earley, Pete. *Crazy: A Father's Search Through America's Mental Health Madness*

Hine, Robert V. *Broken Glass: A Family's Journey Through Mental Illness*

Jamison, K. (1999). *Night falls fast: Understanding suicide.*

Johnson, Julie Tallard (1989). *Understanding mental illness (for teenagers).*

Karp, David A.(2000), *The Burden of Sympathy: How Families Cope With Mental Illness*

Lachenmeyer, Nathaniel (2000). *The outsider: A journey into my father's struggle with madness.*

Woolis, Rebecca (1992). *When someone you love has a mental illness: A handbook for family, friends and caregivers.*

Depression

Copeland, Mary Ellen (1992). *The depression workbook: A guide to living with depression and manic depression.*

Cronkite, Kathy (1994). *On the edge of darkness: Conversations about conquering depression*

Fassler, M.D., David, and Lynne S. Dumas (1997). *Help Me I'm Sad*

Papolos, Dimitri and Papolos, Janice (1997). *Overcoming Depression.* (3rd Edition).

Solomon, Andrew (2001). *The noonday demon: An atlas of depression.*

Styron, William (1990). *Darkness visible.*

Schizophrenia

Torrey, E. Fuller (2001). *Surviving schizophrenia: A manual for families, consumers and providers*

Steele, Ken and Claire Berman (2001). *The Day the Voices Stopped: A Schizophrenic's Journey from Madness to Hope*

Wagner, Pamela Spiro, and Carolyn Spiro. *Divided Minds: Twin Sisters and Their Journey Through Schizophrenia*

Bipolar

Berger, Diane and Lisa (1991). *We heard the angels of madness: One family's struggle with manic depression.*

Goodwin, Frederick K. and Kay Redfield Jamison. *Manic-Depressive Illness: Bipolar Disorders and Recurrent Depression, 2nd Edition*

Jamison, Kay Redfield (1995). *An unquiet mind: A memoir of moods and madness.*

National Depressive and Manic Depressive Association (1997). *Living with manic-depressive illness: A guidebook for patients, families and friends.* National DMDA

Papolos, D. & J. (1999). *The bipolar child: The definitive and reassuring guide to childhood's most misunderstood disorder*

Torrey, E. Fuller & Knable, M. (2002). *Surviving manic depression: A manual on bipolar disorder for patients, families and providers.*

Borderline Personality Disorder

Linehan, Marsha (1993). *Cognitive-behavioral treatment of borderline personality disorder.*

Kreisman Jerold J. and Hal Straus. *I Hate You, Don't Leave Me: Understanding the Borderline Personality*

Anxiety and OCD

Griest, John H. & Jefferson, J.W. (1998). *Panic disorder and agoraphobia: A guide.*

Jenike, Michael, Baer, Lee, & Minichiello, William, (Eds.) (1990). *Obsessive compulsive disorders: Theory and management.* (2nd Edition).

Osborn, I. (1999). *Tormenting thoughts and secret rituals: The hidden epidemic of obsessive-compulsive disorder.*

Rapoport, Judith (1989). *The boy who couldn't stop washing.*

BECOME A MEMBER OF NAMI VERMONT

If you would like to help us continue to provide this resource, please consider joining us. Feel free to copy and share this page with others.

NAMI Vermont needs YOU! Please become a member and/or consider making a tax-deductible donation. Your contribution will help us support and educate individuals and family members living with serious mental illness in Vermont, and strengthen our efforts to improve Vermont's system of mental health care.

Your contact information:

Name

Address

City State Zip Code

Home Phone Cell Phone

E-mail Address

☐ I have email access, and would prefer to receive the quarterly newsletter electronically instead of through the mail. *Please Note:* **be sure to enter your email address above if you choose this option.**

☐ I would like to be added to your e-mail Action Alert list, to keep me up to date on upcoming legislative issues and NAMI Vermont educational opportunities.

☐ I would like to make a donation but DO NOT wish to receive mail / email from NAMI Vermont.

Benefits of NAMI Membership

- Our flagship magazine, the NAMI Advocate
- Discounts on resources at www.NAMIstore.com
- Discounts at the National NAMI Convention and the Vermont Pathways to Wellness Conference
- Full access to all the information and features on the NAMI website
- Invitations and discounts to NAMI Vermont events
- NAMI VT e-news and bi-annual newsletter
- Membership in your local Vermont Affiliate
- Voting rights on NAMI VT bylaws and board members

I would like to become a member of NAMI Vermont:

☐ Individual $ 35.00
☐ Open Door member 3.00
(limited income)

I would like to ADD A DONATION:

☐ $25 ☐ $50 ☐ $100 ☐ $500
☐ Other $ _____

I would like to make a monthly pledge of:

☐ $5 ☐ $10 ☐ $25 ☐ $50
☐ Other $ _____

Total $ _____

Payment Method:

☐ Check enclosed *(make payable to NAMI Vermont)*
☐ VISA
☐ MasterCard
☐ American Express
☐ Discover

Account # Expiration Date

Address from your credit card billing statement

CID # *(The last 3 digits on the signature panel; For American Express cards: the CID # is the 4 Digit # printed above the account number.)*

Please return with your payment to:
NAMI Vermont, 600 Blair Park Road, Suite 301, Williston, VT 05495

Thank you for your support!

NAMI Vermont
600 Blair Park Road, Suite 301
Williston, VT 05495
(802) 876-7949
(800) 639-6480 (toll-free)
email: info@namivt.org
website: www.namivt.org