Crisis File

Mental Health and Crisis Services in Your Community

Crisis team phone # _____

Local mental health agency phone # _____

Local mental health caseworker services phone # _____

Local hospital phone # _____

Local law enforcement phone # _____

State law enforcement phone # _____

Psychiatrist phone # _____

Internist phone # _____

Counselor/Therapist phone # _____

Case manager phone # _____

Other Contacts

NAMI State Organization phone # _____

NAMI Affiliate office phone # _____

Local NAMI support group facilitator phone # _____

State Department of Mental Health phone # _____

National Mental Health Crisis and Support Services

National Suicide Prevention Lifeline: (800) 273-TALK (8255)

A free national network of local crisis centers that provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week. The Lifeline offers specialized assistance for the following: Attempt Survivors, Disaster Survivors, Deaf/Hard of Hearing, Loss Survivors, LGBTQ+, Native Americans, Veterans, Youth.

Ayuda En Español: (888) 628-9454

Lifeline ofrece 24/7, gratuito servicios en español, no es necesario hablar ingles si usted necesita ayuda.

Veterans Suicide Prevention Hotline: (800) 273-8255 and Press 1

A free 24-hour hotline and online chat available to Service Members and Veterans of all branches of the military and their loved ones in suicidal crisis or emotional distress: 1-800-273-TALK (800-273-8255) and press "1" to be routed to the Veterans Suicide Prevention Hotline. In Germany, Belgium, United Kingdom, Italy and the Netherlands call 001-800-273-8255. Individuals on military bases can access the Lifeline with a 3-digit access code (118) through their DSN system. http://www.veteranscrisisline.net

Veterans Affairs' Caregiver Support Line: (855) 260-3274

A free support line answered by licensed professionals who can tell you about the services available from VA, how you can access them and how you can reach the Caregiver Support Coordinator at a VA Medical Center near you. VA's Caregiver Support Line is toll-free Monday through Friday 8:00 am-8:00 pm ET. www.caregiver.va.gov

NAMI HelpLine: (800) 950-NAMI (6264) or info@nami.org

Staff and volunteers are available Monday through Friday, 10:00 am-6:00 pm ET to answer your questions about mental health issues.

Crisis Text Line: Text NAMI to 741-741

Connect with a trained counselor to receive free, 24/7 crisis support via text message.

National Domestic Violence Hotline: (800) 799-SAFE (7233)

Trained expert advocates are available 24/7 to provide confidential support to anyone experiencing domestic violence or seeking resources and information. Help is available in Spanish and other languages.

National Sexual Assault Hotline: (800) 656-HOPE (4673)

Connect with a trained staff member from a sexual assault service provider in your area that offers access to a range of free services. Crisis chat support is available at the Online Hotline: online.rainn.org. Free help, 24/7.

Dealing with the Criminal Justice System

When people with a mental health condition or their families interact with the criminal justice system, the pressure and intimidation can be overwhelming. This fact sheet offers basic information to help you navigate the legal system. More detail can be found on the NAMI website.

What should you know first about criminal law?

In criminal law, the outcome of a case depends as much on the facts of the case and the procedures followed in building it as it does on the actual law. It is, therefore, essential to have a good criminal lawyer to direct you through any encounter with the criminal justice system.

What is the difference between a misdemeanor and a felony?

Criminal violations come in two varieties, misdemeanors and felonies. There is no universal rule among the states to determine what is a misdemeanor and what is a felony. Generally, crimes that are punishable by incarceration of one year or less are misdemeanors, and crimes punishable by incarceration of more than one year are felonies. Beyond the maximum period of incarceration, whether a crime is a felony or a misdemeanor is significant because it will impact criminal procedures and constitutional rights.

When does an arrest take place?

An arrest occurs when the police take a person into custody in order to charge that person with a crime. To make a lawful arrest, a police officer must believe that the person to be arrested committed a crime. This is important in the context of mental illness because an arrest does not occur every time a person with a mental health condition is picked up or taken into custody by police.

What is booking?

Booking is the process of fingerprinting and photographing a person who has been arrested. In some instances, it may be important for the police to be notified quickly that they have a person with a mental health condition in custody. However, families should be cautioned that the disclosure that a person has a mental illness could make the police view the situation more seriously. Therefore, whenever possible, before family members make disclosures to the authorities concerning the psychiatric history of a family member, they should discuss it with their attorney.

What should the family do during the interrogation?

Family members should try to prevent the police from questioning a family member with a mental health condition without a lawyer present. Any person who is questioned by the police and is not free to end the questioning and leave the place where he or she is being questioned must be given a Miranda warning (the right to remain silent, etc.). The police must immediately stop questioning anyone who asks for a lawyer.

How do you find a lawyer?

Competent criminal lawyers are almost always available, even if your budget is limited. The first places to seek a lawyer if you cannot afford to pay a full fee for a private lawyer is through public defender services, court-appointed attorneys, local criminal defense lawyers' associations or local bar associations.

The United States Constitution guarantees legal representation to every defendant in a felony criminal case. Therefore, if a defendant to a felony charge cannot afford a lawyer, the state must provide him or her with one.

What are your constitutional rights?

- The Fourth Amendment guarantees the right against unreasonable searches and seizures. Usually a warrant is required. The exclusionary rule prevents the prosecution from placing into evidence any evidence that was obtained unreasonably.
- The Fifth Amendment guarantees the right against self-incrimination, which is the well-known right to remain silent.
- The Sixth Amendment guarantees the right to a speedy trial. Every defendant in a criminal case has a constitutional right to have the charges against him or her decided quickly so that he or she can move on with life. The Sixth Amendment also guarantees the right to a public trial and a jury trial. The right to confront witnesses, a compulsory process for obtaining witnesses, and the right to assistance of counsel are also protected by this amendment.
- The Eighth Amendment protects people from cruel and unusual punishment. In addition, it protects the right to treatment for acute medical problems, including psychiatric problems.

Who decides to file charges?

The decision to file charges is often made by the police and the prosecutor's office together.

What is jail diversion?

Jail diversion is a procedure in which a person with a mental health condition who has been charged with a crime agrees to participate in voluntary treatment. This treatment is generally provided in the community. In exchange for participating in treatment, the charges are either dropped or deferred, pending satisfactory compliance with treatment. Jail diversion must be distinguished from probation and a suspended sentence (which are similar), which entail a conviction being entered onto the defendant's criminal record, either by guilty plea or by a verdict.

Can a person stand trial if he or she is viewed as incompetent?

No person can be tried or sentenced for a crime if — because of a mental disease or defect — he or she cannot understand the nature of the proceedings against him or her or assist his or her lawyer in preparing a defense. A criminal found not competent to stand trial is usually subject to civil commitment for an indefinite period.

If a person is found competent to stand trial, can he or she invoke the insanity defense?

Yes. A determination of competency does not prevent a defendant from raising the insanity defense.

Other justice resources may be available for Service Members and civilians dealing with mental illness including:

- Specialty courts or dockets that address various issues and populations including: Veterans, Mental Health, Drugs/Substance Abuse and SAMI (Substance Addiction and Mental Illness).
- Diversionary programs that allow the individual who has been charged with a crime to opt into a special program that will require rigorous mental health and/or addiction treatment in order to avoid to serving time. These programs may not be available to those charged with serious crimes.
- Reentry programs that provide specialized supervision as individuals with mental health needs transition back into the community following incarceration.

Source: A Guide to Mental Illness and the Criminal Justice System (NAMI, out of print)

Take Warning Signs of Suicide Seriously

Recognize signs of suicide risk:

- Feeling like a burden
- Isolating
- Increased anxiety
- Feeling trapped or in unbearable pain
- Increased substance use
- Looking for a way to access lethal means
- Increased anger or rage
- Extreme mood swings
- Expressing hopelessness
- Sleeping too little or too much
- Talking or posting about wanting to die
- Making plans for suicide
- Change in personality — sad, withdrawn, irritable, anxious, tired, indecisive, apathetic
- Change in behavior — unable to concentrate on school, work, routine tasks
- Change in eating habits — loss of appetite and weight, or overeating
- Loss of interest in friends, sex, hobbies, and activities previously enjoyed
- Worry about money, illness (either real or imaginary)
- Fear of losing control, “going crazy” or harming self or others
- Feelings of overwhelming guilt, shame, self-hatred
- Recent loss — death, divorce, separation, broken relationship, job, money, status, self-confidence, self-esteem
- Loss of religious faith
- Agitation, hyperactivity, restlessness may indicate masked depression

Five steps to help someone at risk:

- Ask
- Keep them safe
- Be there
- Help them connect
- Follow up

Sources: Center for Disease Control & Prevention (CDC), American Foundation for Suicide Prevention (AFSP)

Preventing Suicide through Communication

A Checklist for Parents and Families of People Living with Mental Illness to Assist in Communicating with Treatment Providers**

Created by the Oregon Council of Child and Adolescent Psychiatry in 2013, national statistics added by NAMI

Purpose

Statistics from the Centers for Disease Control and Prevention (CDC) indicate that more than 47,000 people died by suicide in 2017 (the most recent year for which full data are available) making suicide the 10th leading cause of death in the U.S. The highest rates of suicide occur among people ages 45-54 years and second highest among people aged 85 and older. While unintentional injury is the leading cause of death among young people ages 10-14 years, suicide was the second leading cause of death among youth ages 15-19 years and those ages 20-34 years. In 2017 50.6% of deaths by suicide involved a firearm, 27.7% were by suffocation and 13.9% were by poisoning *(CDC website)*.

According to the American Foundation for Suicide Prevention (AFSP), no complete count is kept of suicide attempts in the U.S.; however, each year the CDC gathers data from hospitals on non-fatal injuries from self-harm. 575,000 people visited a hospital for injuries due to self-harm. This number suggests that approximately 12 people harm themselves for every reported death by suicide. However, because of the way these data are collected, we are not able to distinguish intentional suicide attempts from non-intentional self-harm behaviors. Many suicide attempts, however, go unreported or untreated. In 2017, an estimated 1.4 million people in the U.S. each year engage in intentionally inflicted self-harm. Females attempt suicide three times more often than males. As with suicide deaths, rates of attempted suicide vary considerably among demographic groups. While males are 4 times more likely than females to die by suicide, females attempt suicide 3 times as often as males. The ratio of suicide attempts to suicide death in youth is estimated to be about 25:1, compared to about 4:1 in the elderly *(AFSP website)*.

Communication between family members of persons seeking treatment for mental illness and primary care providers and/or mental health practitioners improves the quality of care provided to these persons, reduces the risk of suicide and self-harm behaviors, and encourages the use of community resources to improve overall outcomes for these persons. While confidentiality is a fundamental component of a therapeutic relationship, it is not an absolute, and the safety of the patient overrides the duty of confidentiality. Misunderstandings by clinicians about the limitations created by HIPAA, FERPA, and state laws for preserving confidentiality of patients has caused unnecessary concern regarding disclosure of relevant clinical information. Communication between family members or identified significant others and providers needs to be recognized as a clinical best practice and deviations from this should occur only in rare and special circumstances.

To address a perceived deficit of communication, the Oregon Council of Child and Adolescent Psychiatry published a checklist for health providers in 2012. This

companion checklist is designed to help family members access information that might be essential to preserving the life of their loved one.

Definitions

Person involved in treatment — a person receiving care for a mental illness, which may include a child, sibling, parent, or other person whom you wish to support in treatment services, herein abbreviated to "person."

Treatment services — may include outpatient therapy, medication management, support groups, or other treatment supports, partial hospitalization, hospitalization, or therapeutic residential treatment programs.

Provider — may include primary care providers, emergency room physicians, psychiatrists, nurse practitioners, licensed clinical social workers, licensed professional counselors, or other qualified mental health professionals.

Family — may include first-degree biological relatives, adoptive family, foster parent(s), spouse, or other individuals who occupy a similar position in the life of the person involved in treatment.

> **NOTE: If patient is a minor, parents may consult state statutes to determine when the provider may or must disclose patient's information to parents.

For all persons with mental health issues, families should request the following:

- ☐ Has the provider requested that the person sign an authorization to speak with the family? If not, why not? If yes and the person refused, did the provider explain the therapeutic value of speaking with the family?
- ☐ Has a comprehensive risk assessment including personal interview with the person, record review, and solicitation of information from the family been completed by the provider or another qualified professional?
- ☐ Has the provider or any other professional concluded that the person is at elevated risk of suicide?
- ☐ Has the provider reviewed the records of previous mental health providers, and communicated with all others who are involved with the persons' treatment and care (e.g., therapist, family physician, case manager, et al.)?
- ☐ You should offer to provide additional history to the provider and tell the provider what you already know about the family member's illness and need for treatment, especially any episode that suggests the potential for self-harm.

Where an elevated risk of suicide is identified in persons involved in treatment, families have a compelling interest to learn the following:

- ☐ What are the diagnoses and treatment recommendations? How can the family best support the provider's recommendations? Where can one learn more about the illness which has been diagnosed?

- ☐ What is the provider's evaluation of suicide risk in this case? What are the particular warning signs (not the same as risk factors) for suicide in this person's situation? What steps should the family take if they see these signs occurring, such as taking the person to the hospital for reassessment? You may wish to ask the provider to help create a plan to monitor and support the family member. What protective factors exist, and how can these be expanded or enhanced for this person?
- ☐ What community resources are available to help the family and the person involved in treatment, including resources for case management, peer and family support groups, and improving mental health at home?
- ☐ What type of ongoing care is required? Who should provide that care? How can the family access that care?
- ☐ What can the family do to best help the person involved in treatment? What should the family not do?
- ☐ When the person transitions from one level of care to another or from one provider to another, how will provision of care be coordinated? You may wish to request that the provider assures that follow up is in place with a specific timely appointment, that the accepting provider has full knowledge of history and risk issues/records, and that the original provider confirms that family member has attended the follow up appointment.

Where the person is at university or similar setting, the family may wish to ask the Dean of Students:

- ☐ What systems are in place to support students living with mental illness and avoid self-harm? Is peer counseling available for the student with mental illness? Are the health service and/or counseling services on call 24/7; if not what are their hours? Is there a 24-hour number to call in case of emergency?
- ☐ Is there an office to intercede with instructors for the student who feels overwhelmed or highly stressed? Will use of these resources imperil any scholarships the student might have?

Identifying a Good Psychiatrist

Check with other families who have relatives with mental health conditions to see if they have had good experiences with a particular psychiatrist, one who:

- Will make special efforts to communicate with the family; can speak using terms you can understand.
- Won't insist that your loved one makes the first contact and recognizes that they may be in crisis and unable to do so.
- Will make special efforts to communicate. For instance, taking five minutes in the middle or at the end of a session to ask for patient's family to share their views on how things are going.
- Recognizes the condition is a no-fault brain disorder.
- Is strong enough not to be threatened by views of the family or the individual about treatment; willing to discuss openly symptoms, medications and side effects, and the limits of his/her knowledge, while remaining in command of the treatment. While psychiatrists are trained to be vigilant about boundaries, any psychiatrist who communicates the idea that there is a special mystique in psychiatry that you can't understand isn't the kind of doctor you want.
- Is flexible enough to customize treatment for your relative and to enlist families as part of the treatment team when that is indicated, e.g., as observers and reporters on the response to changes in treatment.
- Is innovative enough to consider alternative ways to engage with people who don't think they have a mental health condition.
- Is accommodating enough to schedule visits at less frequent intervals to match the family's financial ability; communicates that he/she is more concerned about finding outcomes that satisfy the entire family than about maximizing their own income.
- Takes seriously and respects the information communicated by the family regarding the status of the patient.

Modified by: Carol Howe, NAMI Threshold, Bethesda, MD

Questions to Ask the Psychiatrist

1. What is the diagnosis? What is the nature of this condition from a medical point of view?
2. What is known about how we can avoid future episodes or making this disorder worse in the future?
3. How certain are you of this diagnosis? If you're not certain, what other possibilities do you consider most likely, and why?
4. Did the physical examination include a neurological exam? If so, how extensive was it, and what were the results?
5. Are there any additional tests or exams that you would recommend at this point?
6. Would you advise an independent opinion from another psychiatrist at this point?
7. What program of treatment do you think would be most helpful? How will it be helpful?
8. Will this program involve services by other specialists (i.e., neurologist, psychologist, allied health professionals)? If so, who will be responsible for coordinating these services?
9. Who will be able to answer our questions at times when you're not available?
10. What kind of therapy do you plan to use, and what will be the contribution of the psychiatrist to the overall program of treatment?
11. What do you expect this program to accomplish? About how long will it take, and how frequently will you and the other specialists be seeing my loved one?
12. What will be the best evidence that my loved one is responding to the program, and how soon will it be before these signs appear?
13. What do you see as the family's role in this program of treatment? In particular, how much access will the family have to the individuals who are providing the treatment?
14. If your current evaluation is a preliminary one, how soon will it be before you will be able to provide a more definite evaluation of my loved one's condition?
15. What medication do you propose to use? (Ask for name and dosage level). What is the biological effect of this medication, and what do you expect it to accomplish? What are the risks associated with the medication? How soon will we be able to tell if the medication is effective, and how will we know?
16. Are there other medications that might be appropriate? If so, why do you prefer the one you have chosen?
17. Are you currently treating other patients with these symptoms? (Psychiatrists vary in their level of experience with severe or long-term mental health conditions, and it

is helpful to know how involved the psychiatrist is with treatment of the kind of problem that your relative has).

18. When are the best times, and what are the most dependable ways for getting in touch with you?
19. How do you monitor medications and what symptoms indicate that they should be raised, lowered or changed?
20. How familiar are you with the activities of NAMI and of our NAMI State Organization?

Getting Satisfactory Results: Some Dos and Don'ts

Families need to know how to be effective in getting help for a person with a mental health condition. They need to know what questions to ask, what people to see and where to go. They need to understand the various parts of the mental healthcare system and how best to interact with each part.

Frequently, when a parent, relative or close friend becomes involved — especially during the early phases of the condition — each person is so overwhelmed by the experience that vague information and "jargon" is accepted as substantive. Families, at the time, want and need honest, direct information about the disorder. They want specific, practical suggestions about how to cope during the acute as well as the stable phases of the condition. To get this kind of information, there are some things which you must do. Following are some hints to obtain positive results from the mental health system.

Things to do:

- Keep a record of everything. List names, addresses, phone numbers, etc. Nothing is unimportant. Every date, time, etc., may come in handy. Make notes of what went on during conferences. Keep all notices, letters, etc. Make copies of everything you mail. Keep a notebook or file of all contacts. Don't throw anything away.
- Be polite. Keep all conversations to the point. Ask for specific information.
- If your loved one is 18 years of age or older, request their permission to review all documents. Many places will request written permission from the person with the condition, so consider asking your relative for this before symptoms affect their ability to cooperate with signing a release of information.
- If your loved one is hospitalized, get the name of the physician who is coordinating the care. In some cases, you may have the right to request a different doctor who has privileges at that hospital. Get the name of the staff member on the unit who is working most closely with your loved one. This is usually a psychiatric nurse, but may be a therapist, a social worker, a psychiatric resident or a case manager. Ask for an appointment to meet with this person; make it at their convenience. Come prepared with a list of specific questions. Some sample questions are:
    - "What are the specific symptoms about which you are most concerned?"
    - "What do these indicate? How are you monitoring them? Who is documenting in the chart? How often is the medication being monitored? What, specifically, is he/she getting? How much? How often? Has my loved one been informed on medication side-effects? When can I look at the record book or chart? When can we meet to plan the transition back home?"
- Keep the meeting short. If you come with a list of questions you will be able to get all the information you need in less than half an hour.
- Write letters of appreciation when warranted; write letters of criticism when necessary. Send these to the head of the hospital (or unit, or both), and send copies

to anyone else who may be involved, including the Governor. Just as there are certain actions to take in order to be effective, there are some things that tend to be counter-productive. Keep in mind that most professionals want to do a good job. Most of the frontline staff (people who work directly with the patients — social workers, case managers, hospital attendants, practical nurses, doctors, nurses, therapists, etc.) are over-scheduled. Usually, there are too few staff for the number of community mental health centers, jails, etc. Thus, it is important to maintain some perspective on what one can reasonably expect.

There are, however, some specific responsibilities for which you can hold staff accountable. The following “don’ts” will help both you and the helping professionals.

- Don’t come late to appointments.
- Don’t accept repeated “cancellations.”
- Don’t make excessive demands on staff, i.e., don’t harass the staff with special requests, don’t have long phone conversations filled with unnecessary details, etc.
- Don’t accept vague answers or statements that seem confusing. If a clinician says, “we are observing your daughter carefully,” recognize that this is a statement which provides you with no information. Don’t accept it without further clarification. Ask who is doing the observing, what is being observed (exactly), how is the information being documented, when can you view the progress of the observation, etc.
- Don’t feel that you “should know” and therefore inhibit yourself from asking for substantive information.
- If your loved one is in a state psychiatric hospital and you have permission to look at the record book, set up an appointment with a staff member who can review what information they have recorded. Be clear that you are not trying to find fault with their care, and that your only goal is to make sure that they have the correct and complete information about your family member.
- Ask to review your loved one’s Individualized Treatment Plan. This is legally mandated and must be carried out. You can ask to participate in the development of the plan. As a patient, your loved one has the right to have his/her wishes considered.
- When you ask how the staff is implementing the treatment plan, don’t accept answers which imply that the patient is responsible for his/her own progress. Persist in finding out exactly what actions staff are taking, i.e., how often my loved one gets exercise or recreation time, which staff person oversees group therapy, how consistent is the treatment, i.e., does each staff member know what others are doing?
- Don’t allow yourself to be intimidated.
- If your relative is in a group home, critical care facility (CCF), individual care facility (ICF) or any facility receiving public funds, you are entitled to inquire about personnel qualifications, etc. Don’t permit unqualified personnel to continue to work

without a formal complaint to the Department of Social & Health Services.

- Don’t be afraid or ashamed to acknowledge that you are related to a person with brain disorder.
- Keep your loved one informed about everything you plan to do. He/she might disapprove of your action or may wish to modify your plan.
- Be assertive! As a taxpayer, you are entitled to information, respect, and courtesy. Your taxes go to public employees. You’re not asking for freebies. You are simply helping to get the job done.

Source: Eleanor Owen, NAMI Washington Connections

Co-occurring Disorders

Co-occurring disorder (also referred to as dual diagnosis) is a term for when someone experiences a mental illness and a substance use disorder simultaneously. Either disorder — substance use or mental illness — can develop first. People experiencing a mental health condition may turn to alcohol or other drugs as a form of self-medication to improve the mental health symptoms they experience. However, research shows that alcohol and other drugs worsen the symptoms of mental illnesses.

The professional fields of mental health and substance use recovery have different cultures, so finding integrated care can challenging. A national effort led by psychiatrist Ken Minkoff helps systems integrate these cultures and services on every level of care.

How Common are Co-occurring disorders?

According to a 2014 National Survey on Drug Use and Health, 7.9 million people in the U.S. experience both a mental disorder and substance use disorder simultaneously. More than half of those people — 4.1 million to be exact — are men.

Symptoms

Because many combinations of co-occurring disorders can occur, the symptoms vary widely. Mental health clinics are starting to use alcohol and drug screening tools to help identify people at risk for drug and alcohol abuse. Symptoms of substance use disorder may include:

- Withdrawal from friends and family
- Sudden changes in behavior
- Using substances under dangerous conditions
- Engaging in risky behaviors
- Loss of control over use of substances
- Developing a high tolerance and withdrawal symptoms
- Feeling like you need a drug to be able to function

Symptoms of a mental health condition can also vary greatly. Warnings signs, such as extreme mood changes, confused thinking or problems concentrating, avoiding friends and social activities and thoughts of suicide may be reason to seek help.

How Are Co-occurring Disorders Treated?

The best treatment for co-occurring disorders is integrated intervention, when a person receives care for both their diagnosed mental illness and substance use disorder. The idea that “I cannot treat your depression because you are also drinking” is outdated — current thinking requires *both* issues be addressed.

You and your treatment provider should understand the ways each condition affects the other and how your treatment can be most effective. Treatment planning will not be the same for everyone, but here are the common methods used as part of the treatment plan:

Detoxification. Inpatient detoxification is generally more effective than outpatient for initial sobriety and safety. During inpatient detoxification, trained medical staff monitor a person 24/7 for up to seven days. The staff may administer tapering amounts of the substance or its medical alternative to wean a person off and lessen the effects of withdrawal.

Inpatient Rehabilitation. A person experiencing a mental illness and dangerous/dependent patterns of substance use may benefit from an inpatient rehabilitation center where they can receive medical and mental health care 24/7. These treatment centers provide therapy, support, medication and health services to treat the substance use disorder and its underlying causes.

Supportive Housing, like group homes or sober houses, are residential treatment centers that may help people who are newly sober or trying to avoid relapse. These centers provide some support and independence. Sober homes have been criticized for offering varying levels of quality care because licensed professionals do not typically run them. Do your research when selecting a treatment setting.

Psychotherapy is usually a large part of an effective dual diagnosis treatment plan. Cognitive behavioral therapy (CBT) helps people with dual diagnosis learn how to cope and change ineffective patterns of thinking, which may increase the risk of substance use.

Medications are useful for treating mental illnesses. Certain medications can also help people experiencing substance use disorders ease withdrawal symptoms during the detoxification process and promote recovery.

Self-Help and Support Groups. Dealing with a dual diagnosis can feel challenging and isolating. Support groups allow members to share frustrations, celebrate successes, find referrals for specialists, find the best community resources and swap recovery tips. They also provide a space for forming healthy friendships filled with encouragement to stay clean. Here are some groups NAMI likes:

- Double Trouble in Recovery is a 12-step fellowship for people managing both a mental illness and substance abuse.
- Alcoholics Anonymous and Narcotics Anonymous are 12-step groups for people recovering from alcohol or drug addiction. Be sure to find a group that understands the role of mental health treatment in recovery.
- Smart Recovery is a sobriety support group for people with a variety of addictions that is *not* based in faith.

Source: nami.org

Limit Setting

Behaviors that shouldn't be tolerated:

Even if they are a result of the mental health condition, the following behaviors shouldn't be tolerated:

- Physical abuse
- Sexual abuse
- Destruction of property (example: punching holes in walls)
- Setting fires or creating fire hazards (example: smoking in bed)
- Stealing
- Abuse of illegal and/or prescription drugs
- Severely disruptive or tyrannical behaviors (examples: walking around the house with a weapon, blasting the stereo, intolerably loud screaming)

Allowing yourself or other members of your family to become a victim of any of these behaviors not only poses danger but sets up an atmosphere that is extremely stressful for everyone, especially your loved one.

Behaviors that are typical symptoms of a mental health condition:

- Trying to stop any of the following behaviors in someone with a mental health disorder can be like trying to stop someone with a cold from sneezing:
  - Periodic departure from normal eating habits
  - Unusual sleep/wake cycles (example: sleeping all day and staying up all night)
  - Delusions or disordered thinking
  - Hallucinations
  - Withdrawal to a quiet, private place
  - Exhibiting behaviors that fall outside social norms
- The reasons for these behaviors are much more complicated than attempts to manipulate. They are symptoms of a disorder or attempts to cope with symptoms in which manipulation may play only a small role, if any.
- Even if a behavior is a symptom or attempt to cope with a symptom, you shouldn't tolerate it if it's destructive or severely disruptive (see above), or if it is driving you or someone else in the house to absolute distraction.

What you can do to manage violent or disruptive behavior:

- When you and your relative are BOTH calm, explain to him/her what kinds of behaviors you will not tolerate, as well as the specific consequences upon which you (and other family members) have decided (and agreed) for specific violent or disruptive behaviors.

  Example: "Next time you threaten to harm any of us, law enforcement will be called."

- Get to know and recognize cues that your relative is becoming violent or disruptive (your own uneasiness or fear is usually a good cue).
- Tell your relative that his/her behavior is scaring you or upsetting you. This feedback can defuse the situation but proceed with the next suggestion if it doesn't. Saying you are scared doesn't mean you act scared.
- If you (and other family members) have made a limit-setting plan, now is the time to carry out the consequences. If you haven't already warned your relative of the consequences when he/she was calm, use your judgment and past experience to decide whether to warn him/her or to just go ahead with the plan without saying anything.
- Give your relative plenty of space, both physical and emotional. Never corner a person who is agitated or whose symptoms are escalating unless you can safely restrain them. Verbal threats or hostile remarks constitute emotional cornering and should be avoided.
- Give yourself an easy exit and leave the scene immediately if they are scaring you or becoming violent.
- Get help! Bringing in other people, including law enforcement if necessary, can quickly defuse the situation.
- If you or someone else has witnessed your relative recently committing or planning a violent or dangerous act, that is grounds for involuntary commitment.

What you should NOT do:

- Don't ignore violent or disruptive behavior. Ignoring only leads your loved one to believe that this kind of behavior is acceptable and "repeatable."
- Don't give your loved one what they want if they are bullying you. Giving in reinforces this bullying behavior and makes it likely that your loved one will use it again. Give in if it is the ONLY way out of a dangerous situation.
- Don't try to lecture or reason with your loved one when they are agitated or losing control.
- NEVER be alone with someone you fear.

  Example: Don't drive them to the hospital by yourself

Source: The Training and Education Center Network, Mental Health Association of Southeastern Pennsylvania, Philadelphia, Pennsylvania