

# ROADMAP TO MENTAL HEALTH

Navigating the System in Puget Sound





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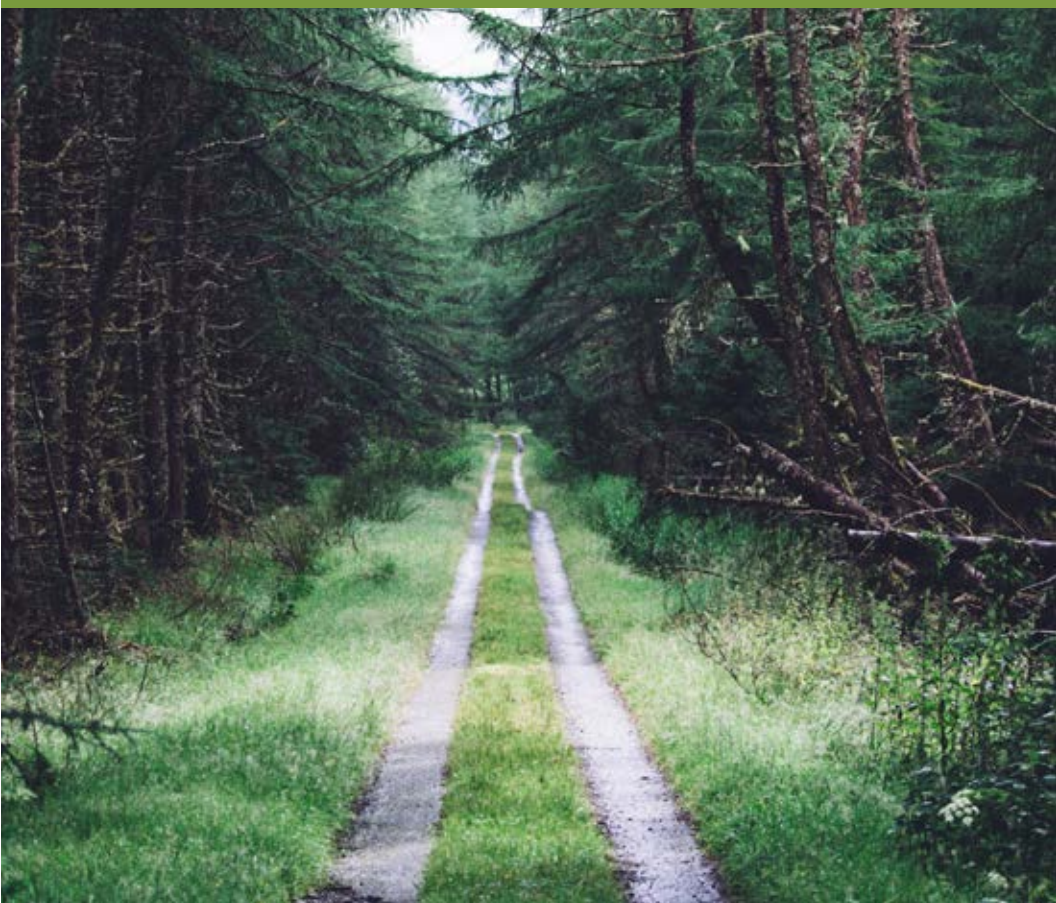
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# INTRODUCTION



# THE PURPOSE OF THIS ROADMAP

Living with mental illness is a challenge, and often the effects of living with mental health challenges extend to friends and family. A person affected by mental health conditions faces the ups and downs on the road to recovery—from diagnosis and treatment to managing their wellness to balancing work, school and mental health. But more often than not, the journey on that road to recovery can involve parents, siblings, partners, grandparents and children, too.

Some families can be completely overwhelmed by the experience, while others deny the situation entirely. Many times families are strengthened and unified, which can even extend to the community beyond the family and generate understanding for others who face the road to recovery.

This “roadmap” is meant to provide families and individuals with mental health conditions help and hope for living in a world affected by

mental health challenges, from an overview of symptoms to navigating the health system in the Puget Sound area. People in recovery who live with mental illness and their families can be an influential force that can inspire their communities, fight stigma and transform the state of mental health care. Together, we can advocate for an array of readily available resources designed to meet the diverse needs of persons with mental health conditions and their families.

“I first came to NAMI support groups after seeing an In Our Own Voice presentation while in the hospital. They inspired me. They showed me there was a life after diagnosis of mental illness. The groups I went to and led gave me support and structure in a time when I had very little. Ten years later, I enjoy assisting people with problem solving on the NAMI Seattle Helpline.” —Rachel



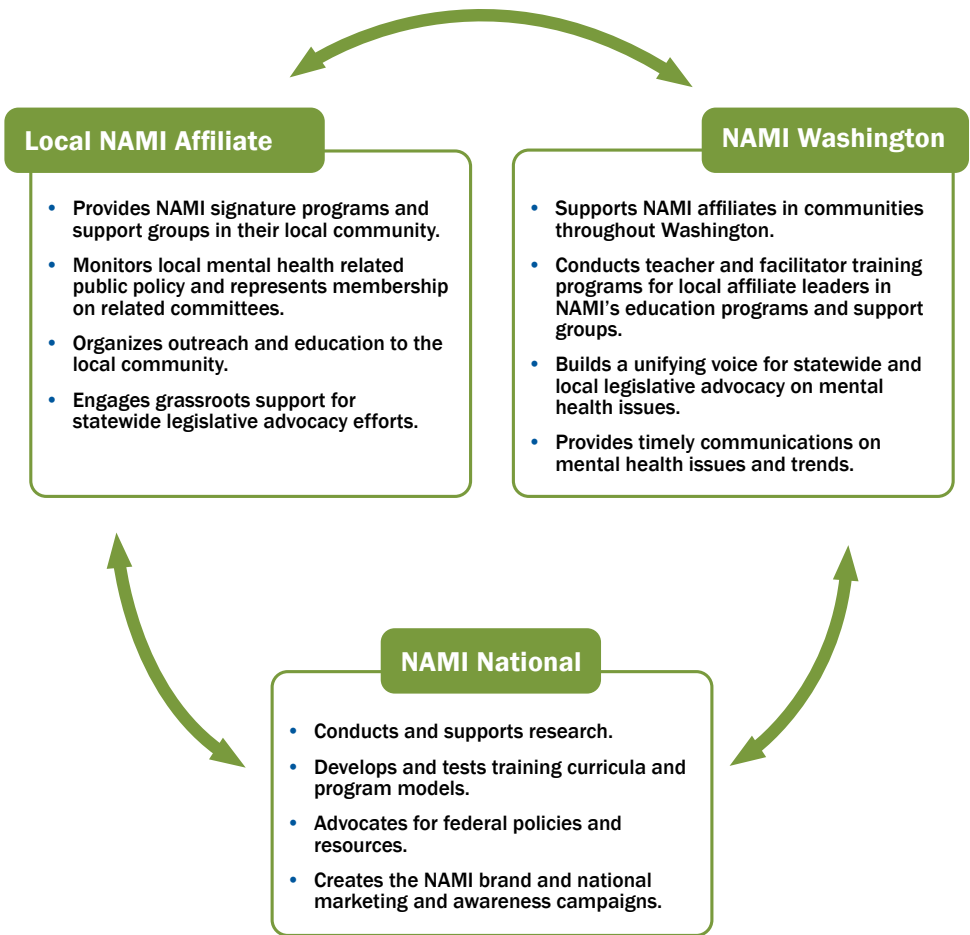
# HOW CAN NAMI HELP?

NAMI Seattle is a chapter of the National Alliance on Mental Illness, the nation's largest grassroots organization that focuses on mental health conditions.

We are a non-partisan 501(c)(3) nonprofit organization and join hundreds of other NAMI affiliates across the country in fighting discrimination against people with mental health conditions and building a community of hope. We offer free presentations, classes and peer support groups for individuals, families, friends, and providers whose lives are impacted by mental illness. For information on our support groups and groups offered by other organizations and affiliates in the Puget Sound area, visit the NAMI Seattle website at [www.namiseattle.org](http://www.namiseattle.org) or call 206.783.9264.

NAMI's national website, [www.nami.org](http://www.nami.org), is a great resource full of information on mental health, treatment resources, and other useful guides for people affected by mental health conditions.

“When I’m in the support group I feel completely present. The universe outside disappears, and that room and everyone in it is all that exists. Being around people who can understand and empathize with you creates a sense of unity and hope.” —TJ



# PROGRAMS OVERVIEW



**FAMILY-TO-FAMILY EDUCATION PROGRAM** is for families, caregivers and friends of individuals with mental illness. The course is designed to facilitate a better understanding of mental illness, increase coping skills, and empower participants to advocate for their family members. NAMI Family-to-Family was designated as an evidence-based program by SAMHSA (Substance Abuse and Mental Health Services Administration). Offered in English and Spanish.



**ENDING THE SILENCE** is a presentation designed to teach middle and high school students, school staff, and family members about the signs and symptoms of mental illness, how to recognize the early warning signs and the importance of acknowledging those warning signs. Ending the Silence is a 50-minute presentation, free of cost, led by a team of trained presenters including a young adult living with mental health conditions.



**PEER-TO-PEER** NAMI Peer-to-Peer is a unique, recovery education course open to any individual living with mental health conditions who is interested in establishing and maintaining their wellness and recovery. Classes are designed to encourage growth, healing and recovery among participants. It is taught by a team of two trained mentors who are personally experienced at living well with mental health conditions.

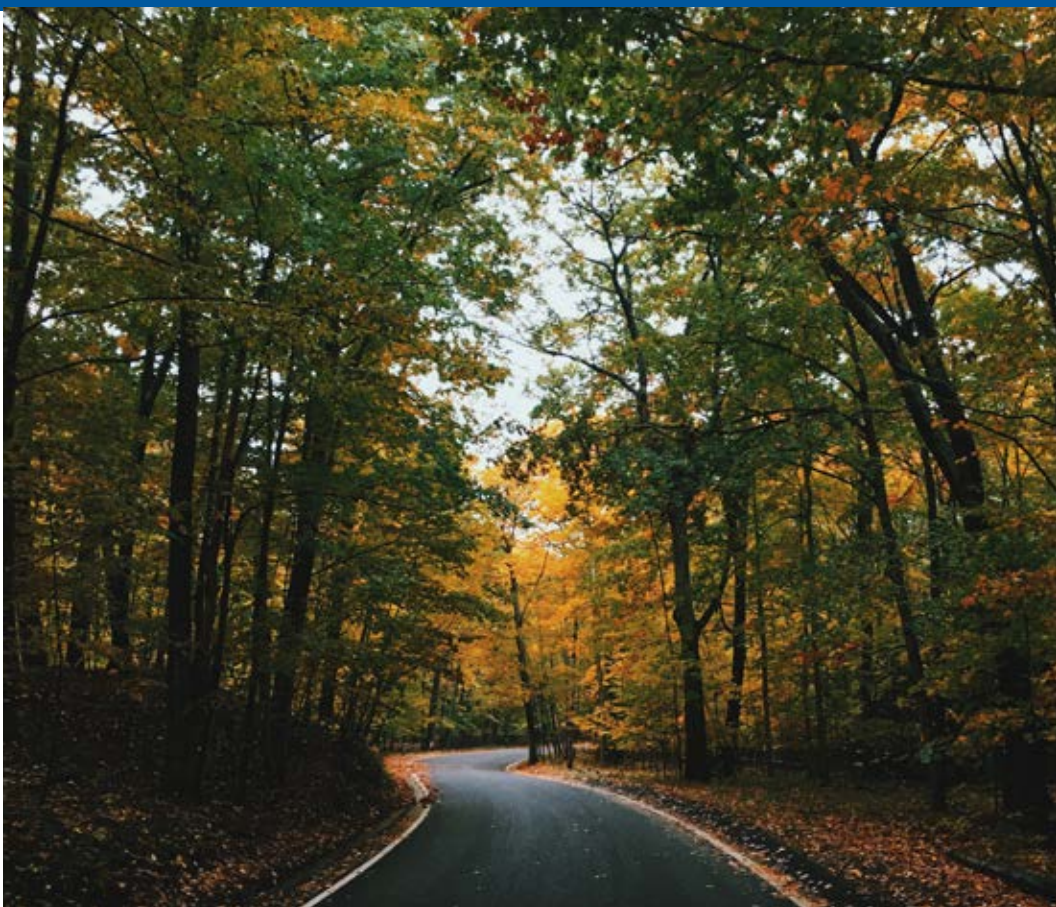


**IN OUR OWN VOICE** unmask mental illness, using speaker stories to illustrate the individual realities of living with mental illness. In Our Own Voice is a 60-90 minute presentation that can change attitudes, preconceived notions and stereotypes. Trained IOOV speakers are individuals living with mental health conditions.

**NAMI SEATTLE SUPPORT GROUPS** We offer peer-led support groups for family members, friends, and people living with a mental health condition. Each group is led by someone who is on their own journey as a supporter or person in recovery, and provides an opportunity to share struggles, tips, tools, and successes.



# AN OVERVIEW OF MENTAL HEALTH CONDITIONS



# AN OVERVIEW

In the United States, one in five people will face a mental health condition in their lifetime. Diagnosing mental illness can be a complicated process that can take years, as there is no uniform medical test. Health care providers consult the Diagnostic and Statistical Manual of Mental Disorders (DSM) to identify symptoms to diagnose mental health conditions. Treatment varies from illness to illness and person to person, but it is critical to have a good system of care in place and a holistic approach to recovery.

*A note about language: NAMI recognizes that other organizations have drawn distinctions between what diagnoses are considered “mental health conditions” as opposed to “mental illnesses.” We intentionally use the terms “mental health conditions” and “mental illness/es” interchangeably.*

## **WHAT IS MENTAL ILLNESS?**

Mental illnesses are conditions that disrupt a person’s thinking, feeling, mood, ability to relate to others and/or daily functioning. Although we often use the term “mental illness” to refer to all mental health challenges, it is important to remember that this term refers to many different conditions and diagnoses, and that each person’s experience with mental health issues is unique. Preferences range widely about the language we use to talk about those experiences, and many people who use mental health services do not identify with a particular diagnosis.

## **WHAT CAUSES MENTAL ILLNESS?**

Modern science cannot yet pinpoint the cause of mental illness. However, researchers generally agree that multiple factors play a role, rather than a single cause. Mental illnesses have nothing to do with personal weakness or lack of character. Examples of possible factors: “trauma (including generational trauma), genetic predispositions, environment, biochemistry, chronic stress and serious loss.

## **WHERE CAN I LEARN MORE?**

This guide gives a brief overview of several serious mental health conditions. This is due to space limitations, not because other illnesses are less serious or more important than the ones discussed here. To learn about other illnesses, please visit [nami.org/About-Mental-Illness](http://nami.org/About-Mental-Illness)

# ANXIETY DISORDERS

Everyone experiences anxiety. Speaking in front of a group makes most of us anxious, but that motivates us to prepare and do well. Driving in heavy traffic is a common source of anxiety, but it keeps us alert and cautious to better avoid accidents. However, when feelings of intense fear and distress are overwhelming and prevent us from doing everyday activities, an anxiety disorder may be the cause.

Anxiety disorders are the most common mental health concern in the United States. Over 40 million adults in the U.S. (19.1%) have an anxiety disorder. Meanwhile, approximately 7% of children aged 3-17 experience issues with anxiety each year. Most people develop symptoms before age 21 and women are twice as likely to be diagnosed with an anxiety disorder than men.

## COMMON SYMPTOMS

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

### Emotional symptoms

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

### Physical symptoms

- » Pounding or racing heart and shortness of breath
- » Sweating, tremors and twitches

- » Headaches, fatigue and insomnia
- » Upset stomach, frequent urination or diarrhea

## TYPES OF ANXIETY DISORDERS

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

### Panic Disorder

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

to avoid having an attack, including social isolation.

### **Phobias**

Everyone tries to avoid certain things or situations that make us uncomfortable or even fearful. However, for someone with a phobia, certain places, events or objects create powerful reactions of strong, irrational fear. Most people with specific phobias have several things that can trigger those reactions. To avoid panicking, someone with specific phobias will work hard to avoid their triggers. Depending on the type and number of triggers, this fear and the attempt to control it take over a person's life.

### **Generalized Anxiety Disorder (GAD)**

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

### **Social Anxiety Disorder**

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

### **Other anxiety disorders include:**

- » Agoraphobia
- » Selective mutism
- » Separation anxiety disorder
- » Substance/medication-induced anxiety disorder, involving intoxication or withdrawal or medication treatment

To learn more about anxiety disorders, their treatment, and resources available through NAMI, visit <https://nami.org/About-Mental-Illness/Mental-Health-Conditions/Anxiety-Disorders>.



# BIPOLAR DISORDER

Affecting at least 6 million Americans, bipolar disorder is characterized by dramatic shifts in a person's mood, energy and ability to think clearly. People with bipolar have high and low moods, known as mania and depression, which differ from the typical ups and downs most people experience. Not everyone's symptoms are the same and the severity can vary. Because of its irregular patterns, bipolar disorder can be difficult to diagnose. Although bipolar disorder can occur at any point in life, the average age of onset is 25.

## COMMON SYMPTOMS

### Symptoms of mania

- » Irritable mood
- » Overconfidence or 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
- » Unpredictable behavior
- » Impaired judgement

### Symptoms of depression

- » 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
- » Changes in eating, sleeping, or other daily habits
- » Thoughts of death and/or suicide attempts
- » Decision-making feels overwhelming

## EARLY WARNING SIGNS OF BIPOLAR DISORDER IN CHILDREN AND TEENS

Children may experience severe temper tantrums when told “no.” Tantrums can last for hours while the child continues to become more volatile. They may also show odd displays of happy or silly moods and behaviors. A new diagnosis, Disruptive Mood Dysregulation Disorder (DMDD), was added to the DSM 5 in 2014.

Teenagers may experience a drop in grades, quit sports teams or other activities, be suspended from school or arrested for fighting or drug use, engage in risky sexual behavior or talk about death or even suicide. These kinds of behaviors are worth evaluating with a health care provider.

## BRENDA'S STORY

As an individual who was diagnosed with bipolar disease in 1979, I've seen many sides of the mental health field in those past several decades. My forte? Mania, not so much depression. When manic, I lose all sense of what's right and proper and safe. I've been hospitalized many, many times because of mania and have experienced all the local psychiatric hospitals and have also done stays at Western State Hospital. During this time, I've felt hopeless, scared, out of control and negative about myself.

I've been treated with many different meds and have dealt with many professional providers. For much of that time, there's been no treatment that would stop the episodes. My family and I were all desperate for something that would work. Because of the manic episodes, I lost my home and my job of 35 years. I felt at the mercy of this disease.

During 2013, I was an inpatient in a geriatric psychiatry unit. Somehow, I finally arrived at the right combination of therapies and medications. I started a group therapy program using Cognitive Behavioral Therapy (CBT) for older adults with mood disorders. One of the key concepts of CBT is that how we think affects how we feel. Through that regular therapy, I learned that I am not my disease. I am more than that. With group help, I began to think positively about myself. I still refer to notes from that period. They help.

This recovery, for me, is a miracle. I've not had an episode for over three years. I feel safe and healthy with all these supports. I feel positive about myself and feel I can be a help for others. It is good to feel so empowered. I'd like to urge others who are in the throes of mental emergencies, or their aftermath, to reach out and avail themselves of the multitude of aids that may help in a recovery. I don't think it is something to do alone. Instead "It takes a village..." Outside support is vital!

# BORDERLINE PERSONALITY DISORDER

**Borderline personality disorder (BPD)** is a condition characterized by difficulties in regulating emotion. This difficulty leads to severe, unstable mood swings, impulsivity, instability, poor self-image and stormy personal relationships. People may make repeated attempts to avoid real or imagined situations of abandonment. The combined result of living with BPD can manifest into destructive behavior, such as self-harm (cutting) or suicide attempts.

It's estimated that 1.4% of the adult U.S. population has BPD. Nearly 75% of people diagnosed with BPD are women, but recent research suggests that men may be almost as frequently affected by BPD. In the past, men with BPD were often misdiagnosed with PTSD or depression.

## COMMON SYMPTOMS

People with BPD experience wide mood swings and can display a great sense of instability and insecurity.

### **Signs and symptoms may include:**

- » Frantic efforts to avoid being abandoned by friends and family.
- » Unstable personal relationships that alternate between idealization—"I'm so in love!"—and devaluation—"I hate her." This is also sometimes known as "splitting."
- » Distorted and unstable self-image, which affects moods, values, opinions, goals and relationships.
- » Impulsive behaviors that can have dangerous outcomes, such as excessive spending, unsafe sex, substance abuse or reckless driving.
- » Suicidal and self-harming behavior.
- » Periods of intense depressed mood, irritability or anxiety lasting a few hours to a few days.
- » Chronic feelings of boredom or emptiness.
- » Inappropriate, intense or uncontrollable anger—often followed by shame and guilt.
- » Dissociative feelings—disconnecting from your thoughts or sense of identity, or "out of body" type of feelings—and stress-related paranoid thoughts. Severe cases of stress can also lead to brief psychotic episodes.

Borderline personality disorder is ultimately characterized by the emotional turmoil it causes. People who have it feel emotions intensely for longer periods of time, and it is harder for them to return to a stable baseline after an emotionally intense event. Suicide threats and attempts are very common for people with BPD. Self-harming acts,

such as cutting and burning, are also common.

To learn more about borderline personality disorder, its treatment, and resources available through NAMI, visit <https://nami.org/About-Mental-Illness/Mental-Health-Conditions/Borderline-Personality-Disorder>.

### ANNA'S STORY

As someone with BPD, I see the world in black and white polarities—it is difficult for me to reconcile two opposing feelings or concepts. Because of this, I struggle to understand how I can be both a successful student and an individual struggling with a relatively debilitating disorder at the same time. This has caused somewhat of a rift in my understanding of where I stand in society and who I am as a person. I often feel like a counterfeit. I wonder if the people I work with can tell that I have BPD. I worry that they have figured out why I know so much about Dialectic Behavioral Therapy (DBT), the main treatment for BPD, self-injury, and suicidal ideation.

Thankfully, I have a very supportive family who has the means to send me to therapy twice a week. I know this is a rare commodity, especially in the BPD community, so I am continuously grateful for that. If anyone with BPD is reading this, I want to remind you that this disorder is not a guaranteed barrier between you and your hopes for the future, whether it be college or a different venture. You are not a stereotype, but rather a person with a beautifully unique mind who is capable of achieving whatever it is that you set that beautifully unique mind to.

# POST-TRAUMATIC STRESS DISORDER

PTSD affects about 9 million Americans. Traumatic events, such as assault, sexual assault, military combat, an accident or a natural disaster, can have long-lasting negative effects. Sometimes our biological responses and instincts, which can be life-saving during a crisis, leave people with ongoing psychological symptoms because they are not integrated into consciousness.

Because the body is busy increasing the heart rate, pumping blood to muscles for movement and preparing the body to fight off infection and bleeding in case of a wound, all bodily resources and energy get focused on physically getting out of harm's way. This resulting damage to the brain's response system is called posttraumatic stress response or disorder, also known as PTSD.

## COMMON SYMPTOMS

**The symptoms of PTSD fall into the following categories:**

- » Intrusive Memories, which can include flashbacks of reliving the moment of trauma, bad dreams and intrusive thoughts.
- » Avoidance, which can include staying away from certain places or objects that are reminders of the traumatic event.
- » Cognitive and mood symptoms, which can include trouble recalling the event and negative thoughts about one's self. A person may also feel numb, guilty, worried or depressed and have difficulty remembering the traumatic event. Cognitive symptoms can in some instances

extend to include out-of-body experiences or feeling that the world is "not real" (derealization).

- » Hypervigilance, which can include being startled very easily, feeling tense, trouble sleeping or outbursts of anger.

Research on 1–6 year olds found that young children can develop PTSD, and the symptoms are quite different from those of adults. These findings also saw an increase in PTSD diagnoses in young children by more than 8 times when using the newer criteria.

## Symptoms in young children can include:

- » Acting out scary events during playtime
- » Forgetting how/being unable to talk
- » Being excessively clingy with adults
- » Extreme temper tantrums, as well as overly aggressive behavior
- » Developmental achievements in an impacted child might slip back (e.g. reversion to not being toilet trained in a 4-year-old)

To learn more about post-traumatic stress disorder, its treatment, and resources available through NAMI,

visit <https://nami.org/About-Mental-Illness/Mental-Health-Conditions/Posttraumatic-Stress-Disorder>.

## HEATHER'S STORY

Ever since I developed delayed-onset PTSD from childhood abuse, “flakiness” has been a problem for me. It plagues me a lot. I have done what I’m supposed to do—therapy, journaling, yoga, mindfulness, getting out and doing social things, reading books about trauma recovery and implementing the suggestions—but the fact remains that it’s a lot easier for people to refrain from doing things that can break other people than it is to repair complex PTSD.

It was actually only once my life was in a pretty good place that I ever got really bad symptoms, learned that I had PTSD, that the internal walls keeping things in emergency mode working order (all I’d ever known) had fallen down and I now had to integrate these pieces, learn a new way to live. It changed me. Imagine trying to take the flooded out city of New Orleans after Katrina and turn it into Venice. That’s a good analogy for what recovery from PTSD feels like. The beautiful parts and the horrible parts. There is such thing as post-traumatic resilience. The human mind and body are amazing things. I have a good life now, a much more integrated understanding of what happened and why, and an ability to enjoy my own company, but sometimes I still have good days and bad days.

I can promise to be somewhere or do something and figure it’s simple, fun, or not a big deal, and then find it’s not compatible with flashbacks and concentration issues. I don’t like to talk about it. I will probably never tell my friends at the time that this is why I flaked out or missed a deadline.

I love my friends. The warmth of caring people and caring for people is what’s got me through most hard times - love and telling myself that there were better things ahead if I just kept going. So if I flake out, it’s not that I don’t care about my friends or the activities I seemed excited about. It is not me being lazy. It is me having a difficult time, trying to deal with the basics while struggling for words within my own self as to what’s going on. Instead of figuring I’m flaky, just try to imagine I’m home with a really bad hangover after a crummy night out I’d rather not talk about. Because it is kind of like that. And most people already know how to be there for friends dealing with that.

# DEPRESSION

Depression affects almost 25 million Americans each year. It is more than just feeling sad or going through a rough patch. It's a serious mental health condition that requires understanding and a good treatment plan. With early detection, diagnosis and a treatment plan consisting of medication, psychotherapy and lifestyle choices, many people can get better at managing their symptoms.

People with depression often experience periods of wellness that alternate with periods of illness. Without treatment, episodes may last a few months to several years. People with severe depression can feel so hopeless that they become at risk for suicide.

Just like with any mental health condition, people with depression or those who are going through a depressive episode (also known as major or clinical depression) experience symptoms differently. But for most people, depression changes how they function day-to-day.

## COMMON SYMPTOMS

- » Changes in sleep
- » Changes in appetite
- » Lack of concentration
- » Loss of energy and ability to perform daily routines
- » Lack of interest in activities the person used to enjoy
- » Low self esteem. During periods of depression, people dwell on losses or failures and feel excessive guilt and helplessness
- » Hopelessness. Depression can make a person feel that nothing good will ever happen. Physical aches and pains. Instead of talking about their emotions or sadness, some people may complain about a headache or an upset stomach.

- » Suicidal thoughts
- » Changes in movement (less activity or agitation)

How a person describes the symptoms of depression often depends on the cultural lens they are looking through. In Western cultures, people generally talk about their moods or feelings, whereas in many Eastern cultures, people may refer more often to physical pain.

## Major Depressive Disorder with a Seasonal Pattern

Major Depressive Disorder with a Seasonal Pattern (formerly known as seasonal affective disorder, or SAD) is characterized by recurrent episodes of depression in late fall

and winter, alternating with periods of normal mood the rest of the year.

Researchers at the National Institute of Mental Health were the first to suggest this condition was the result of decreased light and experimented with the use of bright light to address the symptoms. Research has shown that people who experience this disorder may not have optimal levels of a working neurotransmitter known as serotonin.

The prevalence of this condition appears to vary with latitude, age and sex:

- » Prevalence increases among people living in higher/northern latitudes.
- » Younger persons are at higher risk.
- » Women are more likely than men to experience this condition.

### **SYMPTOMS**

This disorder's most common presentation is atypical of depression. With Major Depressive Disorder with a Seasonal Pattern people tend to gain weight and sleep more.

Although not everyone experiences all the following symptoms, the classic characteristics of Major Depressive Disorder with a Seasonal Pattern include:

- » Hypersomnia (or oversleeping)
- » Daytime fatigue
- » Decreased sexual interest
- » Lethargy
- » Hopelessness
- » Suicidal thoughts
- » Lack of interest in usual activities and decreased socialization

### **DIAGNOSIS**

The key to an accurate diagnosis of this condition is recognizing its pattern. Symptoms usually begin in October/November and subside in March/April. Some people begin to experience a “slump” as early as August, while others remain well until January. Regardless of the time of onset, most people don't feel fully “back to normal” until early May.

For a diagnosis to be made, this pattern of onset and remission must have occurred during at least a two-year period, without the occurrence of any non-seasonal episodes during that same period.

This means you will not receive this diagnosis the first time you experience symptoms. If you believe you may have a seasonal depressive pattern, it's important to pay attention to the pattern. Track your symptoms, noting when they begin and when they subside. Mental health professionals will ask you about your observations and



also your family history since mood disorders tend to run in families.

### TREATMENT

As with most depressive disorders, the best treatment includes a combination of antidepressant medications, cognitive behavioral therapy and exercise. Unlike other depressive disorders, this condition can also be treated with light therapy. Light therapy consists of regular, daily exposure to a “light box” (also known as a “happy light”), which artificially simulates high-intensity sunlight. Be aware that ordinary indoor light is not sufficient to treat this condition.

Some primary care doctors have experience treating this disorder. Remember that this condition is a subset of major depression. If your primary care doctor prescribes you an antidepressant, orders you a light box and sends you to a social worker—and you have trouble the following year—consider seeking consultation from a psychiatrist. Treatment planning needs to match the severity of the condition for each individual.

For more information on MDD with a Seasonal Pattern, visit <https://nami.org/About-Mental-Illness/Mental-Health-Conditions/Depression/Major-Depressive-Disorder-with-a-Seasonal-Pattern>.

### Major Depressive Disorder with Peripartum Onset

Major Depressive Disorder (MDD) with Peripartum Onset (also known as postpartum depression) is different from a temporary mood disturbance after childbirth. Up to 6% of pregnant people will experience a major depressive episode during pregnancy or in the first year following delivery. It is also estimated that 50% of all MDD episodes actually begin prior to delivery or postpartum. For this reason, all episodes are referred to collectively as “peripartum.”

Any child-bearing person can experience postpartum depression and it has no relationship to a person’s capacity to be a good parent. With treatment, they can feel better.

### SYMPTOMS

Symptoms can present themselves differently depending on the person but some of the most common symptoms include:

- » Extreme difficulty in day-to-day functioning
- » Feelings of guilt, anxiety and fear
- » Loss of pleasure in life
- » Insomnia
- » Bouts of crying
- » Thoughts of hurting oneself or the infant

Psychotic symptoms in the peripartum timeframe are less common after childbirth and are characterized by seeing things that don't exist, confusion, rapid mood swings and thoughts of harming oneself or the infant. These symptoms only occur in about 1 of every 1,000 births. People who have bipolar disorder or schizoaffective disorder are at increased risk of having psychotic symptoms, but they can also occur in women with no prior history of these disorders.

### CAUSES

Previous depressive episodes and/or a family history of depression, lack of social support, anxiety, marriage or money problems, stress and substance use disorders are risk factors for MDD with Peripartum Onset. The risk of developing symptoms of depression has also been associated with being a stay-at-home parent and unwanted pregnancy.

People who have experienced one episode of postpartum depression have an increased chance of experiencing it again. Preparing with your doctor for onset can make a significant difference in many cases.

### DIAGNOSIS

One of the criteria used to diagnose depression is appetite change.

However, appetite change may not be suitable for the diagnosis of depression in the perinatal period, five months before and one month after giving birth.

Dramatic hormone changes—like those that happen during the perinatal period—can replicate symptoms of depression. During pregnancy, estrogen and progesterone levels increase. In the first 24 hours after childbirth, these hormone levels abruptly return to normal. Thyroid hormones may also decrease after childbirth. A blood test can determine if thyroid/hormone levels are abnormal.

### TREATMENT

The key to recovery is to seek help as soon as symptoms are recognized. Treatment plans vary by individual and can include options such as individual, family or group psychotherapy and medication.

### RESOURCES

Studies suggest that people who experience postpartum depression have often had earlier episodes of depression that were not diagnosed or treated. If you have experienced an episode of depression and are planning to become pregnant, you can reduce your risk and improve your outcomes by consulting your doctor. Talk with your obstetrician

or primary care provider about whether they can help you—if not, a mental health professional can be of help. Local academic departments of psychiatry also often have resources in this field.

For more information on MDD with a Peripartum Onset, visit <https://nami.org/About-Mental-Illness/Mental-Health-Conditions/Depression/Major-Depressive-Disorder-with-Peripartum-Onset>.

# SCHIZOAFFECTIVE DISORDER

Schizoaffective disorder is characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression. Reading about schizophrenia and bipolar disorder will offer many overlapping resources for schizoaffective disorder. Because schizoaffective disorder is less well-studied than the other two conditions, many interventions are borrowed from their treatment approaches.

Many people with schizoaffective disorder are often incorrectly diagnosed at first with bipolar disorder or schizophrenia because it shares symptoms of multiple mental health conditions.

## COMMON SYMPTOMS

- » Hallucinations, which are seeing or hearing things that aren't there.
- » Delusions—which are false, fixed beliefs that are held regardless of contradictory evidence.
- » Disorganized thinking. A person may switch very quickly from one topic to another or provide answers that are completely unrelated.
- » Depressed mood. If a person has been diagnosed with schizoaffective disorder depressive type they will experience feelings of sadness, emptiness, feelings of worthlessness or other symptoms of depression.
- » Manic behavior. If a person has been diagnosed with schizoaffective disorder: bipolar type they will experience feelings of euphoria, racing thoughts, increased risky behavior and other symptoms of mania.

To learn more about schizoaffective disorder, its treatment, and resources available through NAMI, visit <https://nami.org/About-Mental-Illness/Mental-Health-Conditions/Schizoaffective-Disorder>.

# 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. It is a complex, long-term medical illness. Although schizophrenia can occur at any age, the average age of onset tends to be in the late teens to the early 20s for men, and the late 20s to early 30s for women. It is uncommon for schizophrenia to be diagnosed in a person younger than 12 or older than 40. It is possible to live well with schizophrenia.

It can be difficult to diagnose schizophrenia in teens. This is because the first signs can include a change of friends, a drop in grades, sleep problems, and irritability—common and nonspecific adolescent behavior. Other factors include isolating oneself and withdrawing from others, an increase in unusual thoughts and suspicions, and a family history of psychosis. This period is known as the “prodrome” or “prodromal” stage and most people with schizophrenia will have experienced this stage prior to the onset of a psychotic episode. *Understanding the schizophrenia prodrome (nih.gov)*

## COMMON SYMPTOMS

- » Hallucinations. These include a person hearing voices, seeing things, or smelling things others can't perceive. The hallucination is very real to the person experiencing it, and it may be very confusing for a loved one to witness. The voices in the hallucination can be critical or threatening. Voices may involve people that are known or unknown to the person hearing them.
- » Delusions. These are false beliefs that don't change even when the person who holds them is presented with new ideas or facts. People who have delusions often also have problems concentrating, confused thinking, or the sense that their thoughts are blocked.
- » Negative symptoms are ones that diminish a person's abilities. Negative symptoms often include being emotionally flat or speaking in a dull, disconnected way. People with the negative symptoms may be unable to start or follow through with activities, show little interest in life, or sustain relationships. Negative symptoms are sometimes confused with clinical depression.

To learn more about schizophrenia, its treatment, and resources available through NAMI, visit <https://nami.org/About-Mental-Illness/Mental-Health-Conditions/Schizophrenia>.

# WHAT IS PSYCHOSIS?

Psychosis is a symptom, not an illness, and it is more common than you may think. In the U.S., approximately 100,000 young people experience psychosis each year. As many as three in 100 people will have an episode at some point in their lives.

Early or first-episode psychosis (FEP) refers to when a person first shows signs of beginning to lose contact with reality. Acting quickly to connect a person with the right treatment during early psychosis or FEP can be life-changing and radically alter that person's future.

Most people think of psychosis as a break with reality. In a way it is. Psychosis is characterized as disruptions to a person's thoughts and perceptions that make it difficult for them to recognize what is real and what isn't. These disruptions are often experienced as seeing, hearing and believing things that aren't real or having strange, persistent thoughts, behaviors and emotions. While everyone's experience is different, most people say psychosis is frightening and confusing.

## IDENTIFYING PSYCHOSIS

Early psychosis rarely comes suddenly. Usually, a person has gradual, non-specific changes in thoughts and perceptions, but doesn't understand what's going on. Early warning signs can be difficult to distinguish from typical teen or young adult behavior. While such signs should not be cause for alarm, they may indicate the need to get an assessment from a doctor.

Encouraging people to seek help for early psychosis is important. Families are often the first to see early signs of psychosis and the first to address the issue of seeking treatment. However, a person's willingness to accept help is often complicated by

delusions, fears, stigma and feeling unsettled. In this case, families can find the situation extremely difficult, but there are engagement strategies to help encourage a person to seek help.

It's important to get help quickly since early treatment provides the best hope of recovery by slowing or stopping psychosis. Early warning signs include the following:

- » A worrisome drop in grades or job performance
- » Trouble thinking clearly or concentrating
- » Suspiciousness or uneasiness with others
- » A decline in self-care or personal hygiene

- » Spending a lot more time alone than usual
- » Strong, inappropriate emotions or having no feelings at all

### Types of Psychosis

Psychosis includes a range of symptoms but typically involves one of these two major experiences:

Hallucinations are seeing, hearing or feeling things that aren't there, such as the following:

- » Hearing voices (auditory hallucinations)
- » Strange sensations or unexplainable feelings
- » Seeing glimpses of objects or people that are not there or distortions.

Delusions are strong beliefs that are not consistent with the person's culture, are unlikely to be true and may seem irrational to others, such as the following:

- » Believing that you are being spied on, poisoned, or that others are plotting against you.
- » Believing external forces are controlling thoughts, feelings and behaviors
- » Believing that trivial remarks, events or objects have personal meaning or significance
- » Thinking you have special powers, are on a special mission or that you are a very powerful/famous person. (Grandiose delusion)

### CAUSES OF PSYCHOSIS

Some people are genetically vulnerable to developing psychosis or conditions that include psychosis (e.g. schizophrenia). However, not everyone with a genetic risk develops psychosis unless they experience a major stressor or trauma which can trigger the development of psychosis.

- » **Genetics.** Many genes can contribute to the development of psychosis, but just because a person has a gene doesn't mean they will experience psychosis. Ongoing studies will help us better understand which genes play a role in psychosis. (After Genes and Trauma we could add in the stress diathesis explanation of their relation)
- » **Trauma.** A traumatic event such as a death, war or sexual assault can trigger a psychotic episode. The type of trauma—and a person's age—affects whether a traumatic event will result in psychosis.
- » **Substance use.** The use of marijuana, LSD, amphetamines and other substances can increase the risk of psychosis in people who are already vulnerable.
- » **Physical illness or injury.** Traumatic brain injuries, brain tumors, strokes, HIV and some brain diseases such as Parkinson's, Alzheimer's and

dementia can sometimes cause psychosis.

- » **Mental health conditions.** Sometimes psychosis is a symptom of a condition like schizophrenia, schizoaffective disorder, bipolar disorder or depression.

To learn more about psychosis, its treatment, and resources available through NAMI, visit <https://nami.org/About-Mental-Illness/Mental-Health-Conditions/Psychosis>.



# DISSOCIATIVE DISORDERS

Dissociative disorders are defined by an involuntary escape from reality characterized by a disconnection between thoughts, identity, consciousness and memory. People from all age groups and racial, ethnic and socioeconomic backgrounds can experience a dissociative disorder.

Up to 75% of people experience at least one dissociative episode in their lives, with only 2% meeting the full criteria for chronic episodes. Women are more likely than men to be diagnosed with a dissociative disorder.

The symptoms of a dissociative disorder usually first develop as a response to a traumatic event, such as abuse or military combat. Stressful situations can worsen symptoms and cause problems with functioning in everyday activities. However, the symptoms a person experiences will depend on the type of dissociative disorder that a person has.

Treatment for dissociative disorders often involves psychotherapy and medication. Though finding an effective treatment plan can be difficult, many people are able to live healthy and productive lives.

## SYMPTOMS

Symptoms and signs of dissociative disorders include:

- » Significant memory loss of specific times, people and events
- » Out-of-body experiences, such as feeling as though you are watching a movie of yourself
- » Co-occurring mental health symptoms such as depression, anxiety and thoughts of suicide
- » A sense of detachment from your emotions, or emotional numbness
- » A lack of a sense of self-identity

The symptoms of dissociative disorders depend on the type of disorder that has been diagnosed. There are three types of dissociative disorders defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM):

### **Dissociative Amnesia**

The main symptom is difficulty remembering important information about one's self. Dissociative amnesia may surround a particular event, such as combat or abuse, or more rarely, information about

identity and life history. The onset for an amnesic episode is usually sudden, and an episode can last minutes, hours, days, or, rarely, months or years. There is no average for age onset or percentage, and a person may experience multiple episodes throughout their life.

### **Depersonalization disorder**

This disorder involves ongoing feelings of detachment from actions, feelings, thoughts and sensations as if someone is watching a movie of themselves (depersonalization). Sometimes other people and things may feel like they are unreal (derealization). A person may experience depersonalization, derealization or both. Symptoms can last just a matter of moments or return at times over the years. The average onset age is 16, although depersonalization episodes can start anywhere from early to mid childhood. Less than 20% of people with this disorder start experiencing episodes after the age of 20.

### **Dissociative identity disorder**

Formerly known as multiple personality disorder, this disorder is characterized by alternating between multiple identities.

A person may feel like one or more voices are trying to take control in their head. Often these identities may have unique names, characteristics, mannerisms and voices. People with DID will experience gaps in memory of every day events, personal information and trauma. Women are more likely to be diagnosed, as they more frequently present with acute dissociative symptoms. Men are more likely to deny symptoms and trauma histories, and commonly exhibit more violent behavior, rather than amnesia or fugue states. This can lead to elevated false negative diagnosis.

To learn more about dissociative disorders, their treatment, and resources available through NAMI, visit <https://nami.org/About-Mental-Illness/Mental-Health-Conditions/Dissociative-Disorders>.

# EATING DISORDERS

When you become so preoccupied with food and/or weight that you find it harder to focus on other aspects of your life, it may be an early sign of an eating disorder. Without treatment, eating disorders can take over a person's life and lead to serious, potentially fatal medical complications. Eating disorders can affect people of any age or gender, but rates are higher among women. Symptoms commonly appear in adolescence and young adulthood.

## **SYMPTOMS**

Eating disorders are a group of related conditions that cause serious emotional and physical problems. Each condition involves extreme food and/or weight issues; however, each has unique symptoms that separate it from the others. These are three of the most common types of eating disorders, but there are other types as well.

### **Anorexia Nervosa**

People with anorexia will deny themselves food to the point of self-starvation as they obsess about weight loss. With anorexia, a person will deny hunger and refuse to eat, practice binge eating and purging behaviors or exercise to the point of exhaustion as they attempt to limit, eliminate or “burn” calories.

The emotional symptoms of anorexia include irritability, social withdrawal, lack of mood or emotion, inability to understand the seriousness of the situation, fear of eating in public and obsessions with food and exercise. Often food rituals are developed

or whole categories of food are eliminated from the person's diet, out of fear of being “fat”.

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

### **Bulimia Nervosa**

People living with bulimia will feel out of control when bingeing on very large amounts of food during short periods of time, and then desperately try to rid themselves of the extra calories using forced vomiting, abusing laxatives or excessive exercise. This becomes a repeating cycle that controls many aspects

of the person's life and has a very negative effect both emotionally and physically.

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

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

### **Binge Eating Disorder (BED).**

A person with BED loses control over their eating and eats a very large amount of food in a short period of time. They may also eat large amounts of food even when they aren't hungry or after they are uncomfortably full. This causes them to feel embarrassed, disgusted, depressed or guilty about their behavior. A person with BED, after an episode of binge eating, does not attempt to purge or exercise excessively like someone living with anorexia or bulimia would.

To learn more about eating disorders, their treatment, and resources available through NAMI, visit <https://nami.org/About-Mental-Illness/Mental-Health-Conditions/Eating-Disorders>.

# OBSESSIVE-COMPULSIVE DISORDER

Obsessive-compulsive disorder (OCD) is characterized by repetitive, unwanted, intrusive thoughts (obsessions) and irrational, excessive urges to do certain actions (compulsions). Although people with OCD may know that their thoughts and behavior don't make sense, they are often unable to stop them. Symptoms typically begin during childhood, the teenage years or young adulthood, although males often develop them at a younger age than females. 1.2% of U.S. adults experience OCD each year.

Most people have occasional obsessive thoughts or compulsive behaviors. In an obsessive-compulsive disorder; however, these symptoms generally last more than an hour each day and interfere with daily life.

**Obsessions** are intrusive, irrational thoughts or impulses that repeatedly occur. People with these disorders know these thoughts are irrational but are afraid that somehow they might be true. These thoughts and impulses are upsetting, and people may try to ignore or suppress them.

Examples of obsessions include:

- » Thoughts about harming or having harmed someone
- » Doubts about having done something right, like turning off the stove or locking a door
- » Unpleasant sexual images
- » Fears of saying or shouting inappropriate things in public

**Compulsions** are repetitive acts that temporarily relieve the stress brought on by an obsession. People with these disorders know that these rituals don't make sense but feel they must perform them to relieve the anxiety and, in some cases, to prevent something bad from happening. Like obsessions, people may try not to perform compulsive acts but feel forced to do so to relieve anxiety.

Examples of compulsions include:

- » Hand washing due to a fear of germs
- » Counting and recounting money because a person can't be sure they added correctly
- » Checking to see if a door is locked or the stove is off
- » "Mental checking" that goes with intrusive thoughts is also a form of compulsion

To learn more about OCD, its treatment, and resources available through NAMI, visit <https://nami.org/About-Mental-Illness/Mental-Health-Conditions/Obsessive-compulsive-Disorder>.



# TREATMENT AND RECOVERY



# WHAT IS RECOVERY?

Recovery is often a lifelong wellness plan when someone is living with mental illness. Treatment can include diet and exercise, work, sleep, mental health and an overall treatment plan. Evidence-based medications, therapy and psychosocial services such as psychiatric rehabilitation, housing, employment and peer supports have made wellness and recovery a reality for people living with mental health conditions.

Choosing the right mix of treatments and supports that work for you or your family member is an important step in the recovery process. Treatment choices for mental health conditions will vary from person to person. Even people with the same diagnosis will have different experiences, needs, goals and objectives for treatment. There is no “one size fits all” treatment. When people are directly involved in designing their own treatment plan, including defining recovery and wellness goals, choosing services that support them and evaluating treatment decisions and progress, the experience of care and outcomes are improved.

There are many tools that can improve the experience on the road to wellness including medication, counseling (therapy), social support and education. Therapy, for example, can take many forms, from learning relaxation skills to intensively reworking your thinking patterns. Social support, acceptance and encouragement from friends,

family and others can also make a difference. Education about how to manage a mental health condition along with other medical conditions can provide the skills and supports to enrich the unique journey toward overall recovery and wellness. Together with a treatment team you can develop a well-rounded and integrated recovery plan that may include counseling, medications, support groups, education programs and other strategies that could work for you or your loved one.

Recovery is also a mindset. It requires dedication and discipline as well as support from family, loved ones, and/or friends. Everyone can craft the recovery journey differently. Research shows that a variety of approaches to treatment and recovery can work it is up to the individual living with mental illness and their treatment team whether those approaches include medication, therapy, supplements, meditation or other types of alternative therapy.



# THE ELEMENTS OF RECOVERY

Looking at an array of research, models and experience, NAMI believes there are core elements to recovery. William Anthony, director of the Boston Center for Psychiatric Rehabilitation, developed the recovery model in 1993. Anthony believed, “Recovery is 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 effects of mental illness.”

NAMI Seattle is a big champion of individual, family and peer support programs, and we offer free courses for all families and individuals in the Seattle area. Read more about our programs on page 9. The elements of recovery may include:

**1. ACCEPTANCE.** Acceptance that you or a loved one has mental illness is often the most difficult hurdle in recovery. When individuals or family members first hear that they or someone they love has a diagnosis, they frequently find themselves experiencing a wide range of emotions including denial, fear, relief, embarrassment, guilt, frustration. With a diagnosis, you start to wonder what life will look like from now on, and that can be daunting. Acceptance can come immediately or it can take a long time. Once acceptance has been reached, you can then make plans based on the diagnosis, and the individual with a mental illness and their family can better map out specific options.

**2. HOPE.** Individuals with mental illness must believe that there is hope for recovery. Those who have previous episodes of mental illnesses can look back and realize that because they recovered once, they can do it again. Those who are experiencing an episode for the first time can gain much by having contact with other people who have been through it before and can share their experiences and journey.

**3. MEDICATION.** Finding the right medication that works—with side effects that are minimal or absent—can be tricky and extremely stressful. If you can find a good fit, medications can be important to your recovery process. Some people may work toward being medication

free, and others may need to change medications many times over the course of their mental health journey.

**4. TREATMENT.** Mental health care providers are valuable to recovery. Whether they are a psychiatrist, psychologist, counselor or therapist, these professionals can provide a safe environment to discuss symptoms and issues related to mental illness and receive support.

**5. HOUSING.** Stable, safe and affordable housing is one of the most crucial elements of recovery. Sometimes, housing can further recovery by enhancing autonomy and preventing future hospitalizations.

**6. FAMILY SUPPORT.** For most families, confronting a loved one's mental illness is very difficult. Fortunately, there are numerous resources available to help families. Families can learn coping and stress reduction techniques to assist both their loved ones and themselves in specialized support programs, such as NAMI's Family-to-Family program. Family-to-Family is a designated evidence-based program aimed at family members, significant others and friends of people living with mental illness. The free program consists of 8 weekly sessions and is taught by trained

volunteers who have completed a 26-hour intensive workshop. Also available in Spanish as De Familia a Familia. Check [www.nami.org](http://www.nami.org) to see if your local NAMI offers NAMI Family to Family or De Familia a Familia de NAMI.

**7. PEER SUPPORT AND RELATIONSHIPS.** Peer support provides a person experiencing mental illness with the strength, hope and wisdom others have gained through recovery. Individuals share what has worked for them in overcoming the impact that a mental health condition has had on their lives. There is a level of community and comfort connecting with people who share your situation—in this case, recovering from a mental health condition. NAMI's Peer-to-Peer is an eight-week program, taught by trained individuals who are living well in recovery from their own mental illnesses. Check for NAMI Peer-to-Peer near you at [www.nami.org](http://www.nami.org).

**8. RESILIENCY.** Resiliency is the ability to recover from, overcome or “bounce forward” from hardship, misfortune, change or shock. Whether experiencing an episode for the first time or experiencing a repeat episode, individuals often lose hope, thinking that they will never be themselves again. Resiliency is the ability to remain flexible and hold

onto life, while not catastrophizing or overanalyzing changing conditions. It is about having hope that the future can offer something better or different. Resiliency is learned through insight, adversity, creativity, humor, morality, taking initiative and relationships with others.

**9. MEANINGFUL ACTIVITY AND/OR WORK.** Working or hobbies can provide opportunities to regain a positive identity, including a sense of purpose and value. It can provide both financial benefits and psychological benefits that can contribute greatly to the recovery process.

**10. COMMUNITY INVOLVEMENT.** Individuals recover more quickly if they are active in their communities. Ideally, communities will have created programs to assist in maintaining an individual's social integration and affiliation with the community. Joining a church or social group and volunteering can be great opportunities to be active in your community and to make friends.

**11. EDUCATION AND KNOWLEDGE.** It is very important to learn about your own or your loved one's mental illness. The more information you have, the better you can move toward recovery.

Knowing the ins and outs of the mental health system helps to better navigate the system. There are countless sources of information available on mental health, from the web (mentalhealth.gov, www.nimh.nih.gov and nami.org are great resources), to your local library, NAMI affiliate or your health care provider's office. Schools, community centers and churches also sometimes have groups, counselors and activities around mental health. You can always call or text the NAMI HelpLine at 800-950-6264 or email at info@nami.org for a wealth of information.

**12. EMPOWERMENT.** Empowerment is defined as having the means, opportunities and authority to take personal responsibility for attaining one's objectives. As individuals begin their recoveries, they begin to see that they don't need to be passive observers of events and decisions in their lives; they begin to learn that they can have a say in what affects them.

**13. SELF-ADVOCACY.** This element naturally follows empowerment. People can ask for what they want, say yes or no and can freely change their minds. They can have choices in their lives. They can follow their own values, standards and spiritual beliefs. This element is based on

## ETHAN'S STORY

“I feel that recovery is a never ending process - but the turning point for me was getting together with my friend and playing music and realizing that I still had something to live for. My friend Mike was a huge, huge part of uplifting my life. Just by helping me create, being there and caring for me. And like he has told me: you aren't alone and there will be brighter days.”

the concept of taking personal responsibility in the recovery process.

### **14. ACCESS TO RESOURCES.**

Access to resources is the ability to make contact with various people and places and to use products, services, and technologies that promote recovery. People can research mental health services online and call for information. In Washington State, each of the Behavioral Health Networks (BHN) can be contacted for information. Local mental health clinics have information available. NAMI Seattle hosts a person-to-person information and referral line, available during business hours, at (425) 298-5315. Questions are answered by a

knowledgeable person who can direct you where to get the help.

### **15. COPING SKILLS.**

Coping skills enable everyone to reduce stress. These skills vary case by case and person to person, but can include taking medications as prescribed, keeping appointments with service providers, deep breathing exercises, eating properly and getting enough sleep.

### **16. SPIRITUALITY.**

A broad definition of spirituality is: a partnership with one's higher power. For many individuals, spirituality provides hope, solace during illness, peace, understanding, community and can contribute much on the road to recovery.

# WHAT DOES SUPPORT FROM FAMILY MEMBERS LOOK LIKE?

When someone has a mental health condition, support from family can make a big difference. However, it may be hard for family members to know what approach is best. It's particularly difficult to balance showing support with caring for their own health and encouraging others to be responsible for their actions.

## **REMEMBER: YOU'RE IN THE PROCESS OF LEARNING**

Helping a family member can be difficult, even if you do everything "right." No book, therapist or website can tell you how to prepare for the situations that may arise. It

helps to think of this experience as a learning process. Every person with a mental health condition experiences it slightly differently. One person may fear losing a job, while another may be more worried about how relationships will

## **JEN'S STORY**

Our family was given contact information for NAMI by a nurse during our first hospital visit with my brother Alex. We were so scared, it felt like in the blink of an eye we were dropped onto a deserted island all alone. Until recent years, conversation on the subject of mental illness has been little to none, it has been an almost taboo topic of conversation. This being said, there really is no point of reference on what to do when mental illness turns your world upside down. Where do we go to get help for him? What is Schizophrenia? What are people going to say, and think about him, and how will they treat him? How did this happen? Will my brother ever get better?

One of the first things that we did was join a NAMI Family-to-Family class, and NAMI provided us with the roadmap that we so desperately needed. We were given a wealth of knowledge, names of mental health providers, social services, groups, education on Schizophrenia and other mental illnesses, and most of all we were able to connect with other families dealing with the same thing. We felt supported and understood, no longer stranded on that deserted island. The class was life-changing for our family, and that is why I am now so committed to helping make sure that NAMI programs continue to be available to other families in need as well.

change. If you ask questions and listen to the answers, you can learn about your family member's unique concerns.

You can also acquire better skills for offering support. If you come from a family that's uncomfortable talking about mental illness or emotions you can try to change this. Similarly, even if you feel like you don't know how to offer encouragement right now, you can develop and improve through practice.

### **SUPPORT IS NOT CONTROL**

We can support and encourage our family members; however, we can't make treatment decisions for them. We should offer suggestions and input, but be ready to accept and support their decisions.

They may not choose the same treatment options we would, but by acknowledging their right to decide, we create a respectful, healing environment within the family. We improve their immediate quality of life by treating them with respect by supporting them through the decisions they decide to make.

The reality is that we can only control our own actions. We have to learn to give the people around us responsibility for decisions that only they can make. It's ultimately up to them to decide on their goals

and strategies. You can encourage your family members, but you must let go of the feeling that you have to solve their problems for them.

### **TIPS ON BEING SUPPORTIVE**

One of the most important ways to support a family member is to maintain our own mental health. The healthier we are, the more energy we have for offering encouragement. We can then offer practical support, such as the following:

- » Learn as much as possible about mental health and your family member's condition. Knowledge gives you practical insight and understanding. Learn about available treatments. What therapies and medications can help?
- » Show interest in your family member's treatment plan. Doctors and other medical providers cannot talk to family members without a patient's permission, so ask your family member if they are interested in allowing this permission. Talk to the medical team about what to expect from the treatment plan. In particular, ask about possible side effects of medication. Find out how to call the provider if you notice behavioral or emotional changes you're concerned about.

## WHAT DOES SUPPORT FROM FAMILY MEMBERS LOOK LIKE?

- » Encourage your family member to follow their treatment plan. This might mean offering transportation to therapy sessions, or reminders to take medications as prescribed. Because daily prodding about medication can be insulting to a person, handle this carefully. Talk to your family member about preferences. Try to set up a simple system to ensure that recovery is on track.
- » Strive for an atmosphere of cooperation, which means communicating with everyone in the family and distributing responsibility equally. Assign everyone in the household roles to play according to their abilities. Include your family member with the illness as well, making their responsibilities clear.
- » Listen carefully. Simply listening is one of the best ways to show your support. If your family member says hurtful things, it helps to listen for the emotion behind the words rather than focusing on the words themselves. Try to recognize and acknowledge the pain, anxiety or confusion rather than getting into unnecessary arguments.
- » Resume “normal” activities and routines. Don’t let life revolve around your family member’s mental health condition. Return to a regular routine within the family. Spend time together on activities unconnected from illness, such as watching a movie, going to a restaurant or visiting a park. Practice living life with a mental health condition, rather than struggling against mental illness.
- » Don’t push too hard. At the same time, remember that it takes time to heal from an acute episode. Allow your family member to rest. Offer them opportunities to ease back into routine activities rather than requiring participation. A gentle approach encourages recuperation.
- » Find support. Outside support and encouragement is critical for everyone in the family, not only the person with the mental health condition. Whatever your role in the family, stress is easier to handle when you regularly talk to people who understand your experience. Peer-led support groups are available for people living with mental illnesses and also for their family members.
- » Express your support out loud. Spoken encouragement can reduce stress levels. You don’t need to say anything fancy. Practice a few simple, gentle

statements: “I’m sorry you feel bad and I want to help,” “It isn’t your fault. It’s an illness that can happen to anyone,” “How can I best support you?,” “What do you need from me?”

- » Keep family members and yourself physically and emotionally safe. A caring, compassionate, and supportive environment helps in recovery. If there is abuse in the family, such as violence or emotional abuse, seeking help, such as individual or family therapy, may help improve dynamics.
- » Prepare a crisis plan that includes important phone numbers such as the local crisis intervention team.

Include your family member in the planning of this document. Make everyone in the family aware of what they should do in case of an emergency. (See creating a CARE Kit on page 118.)

- » Don’t give up. A person with a mental health condition benefits enormously from having social support. Remind your family member that you’re there to help and you’re not giving up. When setbacks occur with one treatment strategy, look for alternative strategies. Try something new, and encourage your family member not to give up. A good life is possible.



# MENTAL HEALTH RESOURCES FOR VETERANS AND SERVICE MEMBERS

## VETERANS AND ACTIVE DUTY

According to a 2014 study in JAMA Psychiatry, nearly 1 in 4 active duty members showed signs of a mental health condition. There are three primary mental health concerns that you may encounter serving in the military:

- » **Postraumatic Stress Disorder (PTSD).** Traumatic events, such as military combat, assault, disasters or sexual assault can have long-lasting negative effects such as trouble sleeping, anger, nightmares, being jumpy and alcohol and drug abuse. When these troubles don't go away, it could be PTSD. The 2014 JAMA Psychiatry study found the rate of PTSD to be 15 times higher than civilians.
- » **Depression.** It is more than just experiencing sadness, depression interferes with daily life and normal functioning and may require treatment.
- » **Traumatic Brain Injury (TBI).** A traumatic brain injury is usually the result of a significant blow to the head or body. Symptoms can include headaches, fatigue or drowsiness, memory problems, mood changes and mood swings.

## Active Duty: Who Should I Tell?

Service members work better together when they and their fellow

service members are experiencing good mental and physical health. If you're concerned about a possible mental health condition—or if you enter the armed forces with a past or present mental health condition—know that the armed forces does not require service members to disclose mental health problems to their chain of command. The responsibility for deciding whether to disclose your condition does fall on the medical officers and care providers you consult. They receive training on military policies concerning the confidentiality of protected health information (PHI). Here are some people to consider speaking with:

- » Confidential counselors are available for service members and their families through Military One Source at 1-800-342-9647. If you're unsure whether to seek treatment or if you know someone who might need treatment, they are an excellent first stop for information and advice.
- » Primary care providers can be helpful for discussing concerns and treatment options.
- » Behavioral health care providers working at primary care clinics are available on many military bases so you can seek a specialist's advice without leaving base. And at some bases, you can find convenient

Embedded Behavioral Health teams—clinics separate from traditional medical facilities.

If you, a colleague or a family member are experiencing an immediate crisis—particularly if it's a life-threatening mental health crisis—you should proceed immediately to a military or civilian emergency room for acute care or call 911.

### **Will Asking for Mental Health Treatment Affect My Career?**

Military personnel have always taken care of their physical health, but in today's armed forces, mental health is equally essential to a successful career. The military has changed many of its policies in recent years to encourage better mental health. The Department of Defense acknowledges that untreated mental health conditions pose a greater safety threat than mental health conditions for which you're seeking treatment. Under 2014 rules, talking to a doctor about your concerns, asking if you need a diagnosis or seeking treatment does not affect your career. If your doctor needs to disclose your condition, your career is not at risk from this disclosure. In addition, with changes to security clearance procedures, you no longer risk losing clearance by consulting a doctor. If you seek help for combat-related issues or receive marital counseling, you do

not have to worry about “question 21” regarding treatment for mental or emotional conditions.

### **The Dangers of Not Disclosing**

Untreated mental illness can, however, damage your career. If the symptoms are severe, your commanding officer may require duty limitations or recommend separation from the military for medical reasons. Military records show that talking to a doctor is a good career move. According to a 2006 study in *Military Medicine*, 97% of personnel who sought mental health treatment did not experience any negative career impact. The same study showed that it's risky to ignore a mental health condition. If it worsens, a commanding officer can require a mental health evaluation, which is much more damaging to your career. Among people who had command-directed evaluations, 39% had a negative career impact.

### **Military Policy and Your Privacy**

When you seek mental health care, your care provider will inform you that the Department of Defense follows the privacy guidelines set down by HIPAA and the Privacy Act. These guidelines ensure the privacy of your mental health records in most situations. If your care provider discovers that your mental health condition may

endanger yourself, others or the mission, however, they are obligated to disclose this information to the chain of command.

Military policy states that care providers can only share certain information and only in those situations involving safety. The precise definition of those circumstances is different for each of the branches of the armed forces.

In the Army, for example, PHI policy states that information can only be released in situations involving an acute threat of harm to self, others or a mission; upon admission or discharge from inpatient hospitalization; when entering formal substance abuse treatment; and when enrolling in personnel reliability programs.

If a medical officer or military care provider observes that your health condition poses a danger, the officer will share your medical profile with commanding officers. The information they are allowed to share includes your diagnosis and the medically recommended duty limitations. Unit commanders will decide what duties to assign you until your condition improves.

You can avoid situations requiring disclosure by discussing your concerns with providers when they first arise. Ignoring symptoms may

allow them to worsen. A mental health condition may affect only you at first, but if your condition doesn't improve, your ability to perform your duties may suffer.

If commanders or supervisors observe behaviors that appear to compromise safety or job performance, they can request a command-directed behavioral health evaluation. A command-directed evaluation doesn't guarantee as much confidentiality as a medical consultation you seek yourself.

### **VETERANS: MAKING A STRONG TRANSITION TO CIVILIAN LIFE**

Returning to civilian life can be a time of joy, but also a time of emotional upheaval. Your experiences in the service may have changed the way you look at life. You may have new abilities, new friendships or new concerns.

If you were in combat or similarly stressful situations, it's possible some of the habits that helped you stay strong during traumatic events will be less useful in civilian life. Keeping strong in civilian life might require developing new habits. You may also be at increased risk of PTSD and other symptoms because your brain is recovering from trauma. Some veterans find they miss the structure that the military life provides. Some miss feeling a sense of purpose

## ERICA'S STORY

“Being a warrior, no matter which branch you serve in, comes with the attitude that you just need to “get over” whatever your mental health issue is. The stigma of mental health issues can make a service member a pariah. When we can't discuss these problems and bottle it up, it can lead to domestic violence, self-harm, the inability to connect with your spouse or children and makes it hard to function in a “normal” way. In layman's terms, stuff it down, adapt and overcome ... but that doesn't make the problem go away. Veterans and our families need more support.” —Erica, United States Marine Corps Veteran

in their daily work. Others may feel isolated because civilians don't understand the experience of serving. The memories of your experiences also may take time to deal with. Remember that readjusting takes time. Give yourself opportunities to maintain your physical and mental health during the transition.

The important thing to remember is that you're not alone. There

are many people who want to support you. You can start preparing now, by looking at VA website ([www.va.gov](http://www.va.gov)) or the MilitaryOneSource website (<http://www.militaryonesource.mil>) offering assistance with the transition to civilian life. If you are having thoughts of suicide, the Veterans Crisis Line is available 24/7 by dialing 1-800-273-8255 and pressing 1.

# DUAL DIAGNOSIS

Dual diagnosis is a term for when someone experiences a mental illness and a substance abuse problem simultaneously. Dual diagnosis is a very broad category. It can range from someone developing depression because of binge drinking, to someone's symptoms of bipolar disorder becoming more severe when that person abuses heroin during periods of mania.

Either substance abuse or mental illness can develop first. A person experiencing a mental health condition may turn to drugs and alcohol as a form of self-medication to improve the troubling mental health symptoms they experience. Research shows that drugs and alcohol make the symptoms of mental health conditions worse. Abusing substances can also lead to mental health problems because of the effects drugs have on a person's moods, thoughts, brain chemistry and behavior.

## HOW COMMON IS A DUAL DIAGNOSIS?

About one-third of all people experiencing mental illness and about one-half of people living with severe mental illness also experience substance abuse. These statistics are mirrored in the substance abuse community, where about a third of all alcohol abusers and more than half of all drug abusers report experiencing a mental illness.

Those who have a higher risk of dual diagnosis include individuals of lower socioeconomic status, military veterans and people with more general medical illnesses.

## Symptoms

The defining characteristic of dual diagnosis is that both a mental health

and substance abuse disorder occur simultaneously. Because there are many combinations of disorders that can occur, the symptoms of dual diagnosis vary widely. The symptoms of substance abuse may include:

- » Withdrawal from friends and family.
- » Sudden changes in behavior.
- » Using substances under dangerous conditions.
- » Engaging in risky behaviors when drunk or high.
- » Loss of control over use of substances.
- » Doing things you wouldn't normally do to maintain your habit.
- » Developing tolerance and withdrawal symptoms.
- » Feeling like you need the drug to be able to function.

### TREATMENT

The most common method of treatment for dual diagnosis today is integrated intervention, where a person receives care for both a specific mental illness and substance abuse. Because there are many ways in which a dual diagnosis may occur, treatment will not be the same for everyone.

### DETOXIFICATION

The first major hurdle that people with dual diagnosis will have to pass is detoxification. During inpatient detoxification, a person is monitored 24/7 by a trained medical staff for up to 7 days. The staff may administer tapering amounts of the substance or its medical alternative in order to wean a person off and lessen the effects of withdrawal.

Inpatient detoxification is generally more effective than outpatient for initial sobriety. This is because inpatient treatment provides a consistent environment and removes the person battling addiction from exposure to people and places associated with using.

### INPATIENT REHABILITATION

A person experiencing a serious mental illness and dangerous or

dependent patterns of abuse may benefit most from an inpatient rehabilitation center where they can receive concentrated medical and mental health care 24/7. These treatment centers provide them with therapy, support, medication and health services with the goal of treating their addiction and its underlying causes.

### MEDICATIONS AND PSYCHOTHERAPY

Certain medications are also helpful for people experiencing substance abuse. These medications are used to help ease withdrawal symptoms or promote recovery. Medications to ease withdrawal are used during the detoxification process. They produce similar effects in the body as certain addictive drugs. Psychotherapy is almost always a large part of an effective dual diagnosis treatment plan. Education on a person's illness and how their beliefs and behaviors influence their thoughts has been shown in countless studies to improve the symptoms of both mental illness and substance abuse. Cognitive behavioral therapy (CBT) in particular is effective in helping people with dual diagnosis learn how to cope and to change ineffective patterns of thinking.

# TREATING MENTAL ILLNESS

Treatment choices for mental health conditions will vary from person to person. There is no “one size fits all” treatment. There are many tools that can improve the experience on the road to wellness: medication, counseling (therapy), social support and education are just a few of them. Therapy, for example, can take many forms, from learning relaxation skills to intensively reworking your thinking patterns. Social support, acceptance and encouragement from friends, family and others can also make a difference. Education about how to manage a mental health condition along with other medical conditions can provide the skills and supports to enrich the unique journey toward overall recovery and wellness. Together with a treatment team you can develop a well-rounded and integrated recovery plan that may include counseling, medications, support groups, education programs and other strategies that work for you.

## BRENDA'S STORY

The public's overall impression of ECT (electroconvulsive therapy) is often quite negative. Hollywood, in the influential movie “One Flew Over the Cuckoo's Nest” with Jack Nicholson, helped create this negative paradigm. The truth is, the techniques used now are much more benign than when it was depicted in the movie. ECT has played a role in helping me recover from a truly disabling bipolar illness and in maintaining my mental health. It is no way as awful as my pre-conceived ideas made it out to be! After nearly forty years of frequent manic breakdowns, I have experienced three years of great mental health, which I attribute to ECT, an anti-psychotic medication, and intensive group therapy at my local hospital.

# DEVELOPING A RELATIONSHIP WITH YOUR PROVIDER

## Issues to Consider When Choosing a Provider

**1) GENDER, AGE, CULTURAL BACKGROUND, SEXUAL ORIENTATION/ IDENTITY, ETC.** Do you have strong preferences about these characteristics?

**2) RESPECT & EMPATHY:** A good mental health care provider should make you feel like they are on your side, truly listening to your input and seeing you as an equal. If you do not feel this, especially after several meetings, talk to them about it in a direct, and respectful way. You deserve to feel heard and respected.

**3) FAMILY MEMBER INPUT:** Does the provider have experience with and see value in meeting with family members? Do they respect your preferences in this regard?

**4) TRAINING AND SPECIALIZATION:** With what kinds of issues is your provider most experienced? For example, some providers specialize in certain diagnoses (including substance use), behaviors or age groups.

## Tips for Developing an Effective Partnership

**COMMUNICATE GOALS AND EXPECTATIONS.** Of course, we all want to feel better. But the more specific you can be, the more your provider can help.

**DESCRIBE PAST EXPERIENCES.** If you have had an especially positive OR negative experience with mental health services, try to describe what did or did not work and what you did or did not like. Don't be afraid to express your preferences! Your provider will not be offended.

**EXAMPLES:** therapeutic strategies, focus areas, general style, mannerisms, etc.

**BE HONEST AND OPEN.** It takes time to be open and honest with a provider. Some people feel comfortable sharing everything right away, others may take multiple meetings. If you want to share but can't, let your provider know. Together, you can explore possible reasons and solutions.



**ADDRESS PROBLEMS.** If you feel overwhelmed, like you're not making progress or you're dreading meeting with your provider, talk to your provider about it. An open discussion can build trust and give your provider a better understanding of your needs and preferences.

**TRUST YOUR GUT.** Even if the provider looks great on paper, if the connection doesn't feel right and you have expressed your concerns and nothing has changed—go with another choice, if you can. The provider will respect this choice and should never make you feel guilty.

**KEEP AN EYE ON PROGRESS.** *Mental health services are rarely a quick fix* and there will be times when you'll feel challenged. Nonetheless, mental health services should be helpful over time. Some questions to ask yourself if you aren't sure if therapy is helping:

- » Is one or more area of your life changing for the better? (work, family, social life, etc.)
- » Is therapy stretching you beyond your comfort zone?
- » Do you feel like you're starting to understand yourself better?
- » Do you feel more confident and empowered?
- » Are your relationships with people improving?

## EVERYONE HAS DIFFERENT PREFERENCES...

“Making therapy all about goals really stresses me out. Sometimes I just need to talk it out to gain clarity.”

—Anonymous

“I like to set concrete goals and strategies for change, not just discuss WHY I feel how I feel.”

—Anonymous

### **MARGINALIZATION IN THE MENTAL HEALTH SYSTEM**

Trust is paramount when it comes to treatment, mental health and your well-being. It's important to feel comfortable with your provider. While today, the climate of our culture is moving towards acceptance, intolerance and mistreatment toward marginalized groups is still present and can lead to higher rates of mental health issues for some people and can often leave individuals uncomfortable when it comes to seeking health care. With our health systems largely centered on the experiences and needs of white communities, cisgender people, and straight people, there are additional challenges for people who are part of marginalized groups.

### **BLACK, INDIGENOUS, AND PEOPLE OF COLOR (BIPOC) COMMUNITIES**

A person's beliefs, norms, values and language affect how we perceive and experience mental health conditions. Experiencing racism – whether directly (e.g. microaggressions) or indirectly (e.g. lack of access to resources due to structural bias) – negatively impacts mental health conditions. The cultural awareness and competence of providers directly impacts access to mental health care for BIPOC communities. When providers do not have experience with and sensitivity to the cultural framework and needs of the people

they serve, it increases barriers and compounds problems like stigma and misinformation about mental health conditions and treatments. As a result, people of color often receive poorer quality care due to lack of cultural competence, racism, and implicit bias. This results in misdiagnosis, dropping out of care, and a longer time to achieve recovery. When a mental health professional takes into account cultural needs and differences, outcomes for BIPOC are significantly improved.

### **LESBIAN, GAY, BISEXUAL, TRANSGENDER AND QUEER (LGBTQ+) COMMUNITIES**

People in LGBTQ+ communities face additional challenges when it comes to living with a mental health condition. Historically, in the U.S., LGBTQ+ people have experienced discrimination, both in and outside of health care settings, and at times even within their own community. Prejudice, abuse, violent attacks, bullying and even legislation have affected members of the various LGBTQ+ groups, sometimes in very negative ways. It's important to remember there are big differences between people who identify as lesbian, gay, bisexual and/or are unsure of their gender or sexuality. Every person's experience is unique—no two are alike. Each group and individual faces specific challenges.

### QUEER AND TRANS PEOPLE OF COLOR (QTPOC) COMMUNITIES

Queer and Trans People of Color (QTPOC) face an additionally layer of challenges than their BIPOC-only or white LGBTQ+ counterparts as they navigate the mental health system with multiple marginalized identities. QTPOC have disproportionately higher rates of mental health concerns and suicide attempts than their white LGBTQ+ counterparts. It's important to remember the compounded challenges that people face when their race intersects with their other identities and honor their unique stories.

### FINDING A CULTURALLY COMPETENT PROVIDER

You can improve your odds of getting culturally sensitive care. If you do not feel comfortable with going to a mental health provider first, you may prefer to start with your primary care doctor, who can often start the assessment to help refer you to a mental health provider or resources. When meeting with your provider, ask questions to get a sense of their level of cultural sensitivity. Here are some questions you could ask:

- » What kind of cultural competency training have you had?
- » How do you see our cultural backgrounds influencing our communication and my treatment?

- » How do you plan to integrate my beliefs and practices in my treatment?

Additionally, if having appointments in a language other than English would be helpful to you or your loved one, you contact provider's offices beforehand to inquire if they speak that language. You can also search providers by language on Psychology Today's website.

As an individual or caregiver, don't be afraid to advocate for yourself or the needs of your loved one. While it's not always possible, finding the right provider is essential to ensure the dimensions of culture and language do not get in the way of healing or recovery. Instead, those shared community values and experiences, along with dimensions of faith and spirituality, resiliency, key relationships, family bonds and pride in where you came from—your culture—becomes a source of strength and support.

### FINDING AN LGBTQ+-FRIENDLY PROVIDER

Finding an LGBTQ+ identified provider, or one that has experience specific to your situation, can go a long way in making your treatment successful. Here are some additional tools and tips:

- » Find a list of inclusive providers at the Gay and Lesbian Medical Association's Provider Directory.

- » Check out the Healthcare Equality Index to find the LGBTQ+ inclusive policies of organization leaders in healthcare.
- » Review resources on the rights and experiences of LGBTQ+ people in mental health care, including the Center for American Progress and the National Transgender Discrimination Survey.
- » Call ahead and ask if a provider has any or has worked with LGBTQ+ clients.
- » If you are uncomfortable about being open with your provider, bring a trusted friend or family member with you to your appointment.
- » QTPOC can search the National Queer & Trans Therapists of Color Network Directory to find a QTPOC therapist in their area.

### FOR PROVIDERS WORKING WITH MARGINALIZED COMMUNITIES

Therapists, especially those who are not part of marginalized groups, should recognize how their attitudes and knowledge about marginalized communities are relevant to assessment and treatment, seek consultation if they feel biased or unequipped, understand the ways in which stigma affects the mental health and well-being of marginalized individuals, and understand how prejudice may affect a client's presentation of symptoms and the therapeutic

process. Listening to the ways in which discrimination is affecting a client's life can help guide their treatment and improve outcomes.

Therapists working with LGBTQ+ clients are also encouraged to recognize the importance of relationships, understand the challenges faced by LGBTQ+ parents, recognize that family may be defined in a broader sense than legal or biological relatives, and understand that a client's sexual orientation may have an impact on relationships within the family of origin. Providers who lack knowledge and experience working with members of LGBTQ+ communities may inappropriately link a client's mental health condition to their sexual orientation or gender identity. These APA guidelines can help mental health providers provide the proper care to people in LGBTQ+ communities.

Therapists need regular continuing education to stay up-to-date on best practices for working with marginalized communities. Providers should pay special attention to how they can provide relevant and

culturally informed care, staying up to date on current research and actively seeking education about the perspectives and challenges of the populations they serve.

Psychotherapy, also known as “talk therapy,” is when a person speaks with a trained therapist in a safe and confidential environment to explore and understand feelings and behaviors and gain coping skills. During individual talk therapy sessions, the conversation is often led by the therapist and can touch on topics such as past or current problems, experiences, thoughts, feelings or relationships experienced by the person while the therapist helps make connections and provide insight.

Studies have found individual psychotherapy to be effective at improving symptoms in a wide array of mental illnesses, making it both a popular and versatile treatment. It can also be used for families, couples or groups. Best practice for treating many mental health conditions includes a combination of medication and therapy.

## Types of Psychotherapy

### COGNITIVE BEHAVIORAL THERAPY

Cognitive behavioral therapy (CBT) focuses on exploring relationships among a person’s thoughts, feelings and behaviors. During CBT a therapist will actively work with a person to uncover unhealthy patterns of thought and how they may be causing self-destructive behaviors and beliefs. By addressing these patterns, the person and therapist can work together to develop constructive ways of thinking that will produce healthier behaviors and beliefs. For instance, CBT can help someone replace thoughts that lead to low self-esteem (“I can’t do anything right”) with positive expectations (“I can do this most of the time, based on my prior experiences”).

The core principles of CBT are identifying negative or false beliefs and testing or restructuring them. Oftentimes someone being treated with CBT will have homework in between sessions where they practice replacing negative thoughts with with more realistic thoughts based on prior experiences or record their negative thoughts in a journal. Studies of CBT have shown it to be an effective treatment for a wide variety of mental illnesses, including depression, anxiety disorders, bipolar disorder, eating disorders and schizophrenia. Individuals who undergo CBT show changes in brain activity, suggesting that this therapy actually improves your brain functioning as well.

Cognitive behavioral therapy has a considerable amount of scientific

data supporting its use and many mental health care professionals have training in CBT, making it both effective and accessible. However, more CBT therapists are needed to meet the public health demand.

### **DIALECTICAL BEHAVIOR THERAPY (DBT)**

Dialectical behavior therapy (DBT) was originally developed to treat chronically suicidal individuals with borderline personality disorder (BPD). Over time, DBT has been adapted to treat people with multiple different mental illnesses, but most people who are treated with DBT have BPD as a primary diagnosis. DBT is heavily based on CBT with one big exception: it emphasizes validation, or accepting uncomfortable thoughts, feelings and behaviors instead of struggling with them. By having an individual come to terms with the troubling thoughts, emotions or behaviors that they struggle with, change no longer appears impossible and they can work with their therapist to create a gradual plan for recovery. The therapist's role in DBT is to help the person find a balance between acceptance and change. They also help the person develop new skills, like coping methods and mindfulness practices, so that the person has the power to improve unhealthy thoughts and behaviors.

Similar to CBT, individuals undergoing DBT are usually instructed to practice these new methods of thinking and behaving as homework between sessions. Improving coping strategies is an essential aspect of successful DBT treatment.

Studies have shown DBT to be effective at producing significant and long-lasting improvement for people experiencing a mental illness. It helps decrease the frequency and severity of dangerous behaviors, uses positive reinforcement to motivate change, emphasizes the individual's strengths and helps translate the things learned in therapy to the person's everyday life.

### **EYE MOVEMENT DESENSITIZATION AND REPROCESSING THERAPY (EMDR)**

EMDR is used to treat PTSD. A number of studies have shown it can reduce the emotional distress resulting from traumatic memories. EMDR replaces negative emotional reactions to difficult memories with less-charged or positive reactions or beliefs. Performing a series of back and forth, repetitive eye movements for 20-30 seconds can help individuals change these emotional reactions.

Therapists refer to this protocol as "dual stimulation." During the

therapy, an individual stimulates the brain with back and forth eye movements (or specific sequences of tapping or musical tones). Simultaneously, the individual stimulates memories by recalling a traumatic event. There is controversy about EMDR—and whether the benefit is from the exposure inherent in the treatment or if movement is an essential aspect of the treatment.

### **EXPOSURE THERAPY**

Exposure therapy is a type of cognitive behavioral therapy that is most frequently used to treat obsessive-compulsive disorder, posttraumatic stress disorder and phobias. During treatment, a person works with a therapist to identify the triggers of their anxiety and learn techniques to avoid performing rituals or becoming anxious when they are exposed to them. The person then confronts whatever triggers them in a controlled environment where they can safely practice implementing these strategies. There are two methods of exposure therapy. One presents a large amount of the triggering stimulus all at once (“flooding”) and the other presents small amounts first and escalates over time (“desensitization”). Both help the person learn how to cope with what triggers their anxiety so they can apply it to their everyday life.

### **INTERPERSONAL THERAPY**

Interpersonal therapy focuses on the relationships a person has with others, with a goal of improving the person’s interpersonal skills. In this form of psychotherapy, the therapist helps people evaluate their social interactions and recognize negative patterns, like social isolation or aggression, and ultimately helps them learn strategies for understanding and interacting positively with others. Interpersonal therapy is most often used to treat depression, but may be recommended with other mental health conditions.

### **MENTALIZATION-BASED THERAPY (MBT)**

MBT can bring long-term improvement to people with borderline personality disorder (BPD), according to randomized clinical trials. MBT is a kind of psychotherapy that engages and exercises the important skill called mentalizing. Mentalizing refers to the intuitive process that gives us a sense of self. When people consciously perceive and understand their own inner feelings and thoughts, it’s mentalizing. People also use mentalizing to perceive the behavior of others and to speculate about their feelings and thoughts. Mentalizing thus plays an essential role in helping us connect with other people.

BPD often causes feelings described as “emptiness” or “an unstable self-image.” Relationships with others tend to be unstable as well. MBT addresses this emptiness or instability by teaching skills in mentalizing. The theory behind MBT is that people with BPD have people with BPD are less able to mentalize about their own selves, leading to lower feelings of self, over-attachment to others, and difficulty empathizing with the inner lives of other people.

In MBT, a therapist encourages a person with BPD to practice mentalizing, particularly about the current relationship with the therapist. Since people with BPD may grow attached to therapists quickly, MBT takes this attachment into account. By becoming aware of attachment feelings in a safe therapeutic context, a person with BPD can increase their ability to mentalize and learn increased empathy.

Compared to other forms of psychotherapy such as cognitive-behavioral therapy, MBT is less structured and should typically be long-term. The technique can be carried out by non-specialist mental health practitioners in individual and group settings.

## PSYCHODYNAMIC PSYCHOTHERAPY

The goal of psychodynamic therapy is to recognize negative patterns of behavior and feeling that are rooted in past experiences and resolve them. This type of therapy often uses open-ended questions and free association so that people have the opportunity to discuss whatever is on their minds. The therapist then works with the person to sift through these thoughts and identify unconscious patterns of negative behavior or feelings and how they have been caused or influenced by past experiences and unresolved feelings. By bringing these associations to the person’s attention they can learn to overcome the unhelpful behaviors and feelings, which they caused.

Psychodynamic therapy is often useful for treating depression, anxiety disorders, borderline personality disorder, and other mental illnesses.

## THERAPY PETS

Spending time with domestic animals can reduce symptoms of anxiety, depression, fatigue and pain for many people. Hospitals, nursing homes and other medical facilities sometimes make use of this effect by offering therapy animals.



Trained therapy pets accompanied by a handler can offer structured animal-assisted therapy or simply visit people to provide comfort.

Dogs are the most popular animals to work as therapy pets, though other animals can succeed as well if they are docile and respond to training. Hospitals make use of therapy pets particularly for patients with cancer, heart disease and mental health conditions. The pets that are certified to visit medical facilities meet a high standard of training and are healthy and vaccinated.

For people with a mental health condition, research has shown that time with pets reduces anxiety levels more than other recreational activities. Pets also provide a non-judgmental form of interaction that can motivate and encourage people, especially children. Veterans with PTSD have also found therapy pets helpful. A session with a therapy

pet and its handler may focus on specific goals such as learning a skill through human-animal interaction. Alternatively, simply spending time holding a therapy pet can have benefits such as lower anxiety levels.

Though more research is necessary to establish why animal therapy is effective, one theory is that humans evolved to be highly aware of our natural environment, including the animals around us. The sight of a calm animal reassures us that the environment is safe, thus reducing anxiety and increasing our own feelings of calm. Therapy animals are not the same as service animals, who receive a higher level of training and learn specific tasks for assisting one person on a long-term basis. Service animals are considered working animals, not pets. They have shown some promise in helping people with mental health conditions, particularly PTSD and panic disorders.

# WORKING WITH YOUR PROVIDERS

No matter what type of mental health services work best for you or your loved one, knowing how to work with the people who provide mental health care is essential.

Here's a few tips for people living with mental health conditions (this page) and family members (opposite page) to have productive relationships with mental health professionals.

**DON'T BE AFRAID**  
to express your preferences.

*You should never feel like your opinion is unimportant—you are the expert on your experience.*

Bring a family member, partner or friend to the appointment to be your ally, advocate and a second set of ears.

*If you need written instructions, request them.*

If you are being discharged from an inpatient (hospital) stay, keep in mind that you have the right to important services before you leave:

- » Assistance in securing appropriate housing
- » Applying for appropriate benefits
- » Obtaining community services

*If you feel too intimidated, confused or tired to ask all your questions, ask if you can follow up later. Or request an information release so that a loved one can follow up for you.*

## TIPS FOR EVERYONE!

**ASK QUESTIONS** and if you don't understand the answer, don't just let it go. Ask your provider to repeat the information or explain it differently. Do this until you **TRULY** understand.

**ASK ABOUT "PERSON-CENTERED" CARE.** Does the provider value person-centered care? How will they ensure that their work with you is person-centered? For more info on person-centered care, see page 41.

# WORKING WITH A LOVED ONE'S PROVIDERS

*Understand that your involvement has limitations due to privacy laws. Generally, adults need to sign a “release of information” to allow providers to speak with family/friends. However, there are exceptions to this rule. Learn more at [hhs.gov/ocr/privacy/hipaa/understanding/special/mhguidance.html](https://www.hhs.gov/ocr/privacy/hipaa/understanding/special/mhguidance.html)*

**Your loved one can request an information release AT ANY POINT during their care.**

If you are involved in your loved one's care (they have signed an information release), keep them informed about any *communication* you have with their providers.

YOU CAN SHARE INFORMATION that you believe will benefit your loved one's care at any time. You might say:

**“I know you can't share information with me, but as a family member, I have important information to share with you. I think you should be aware that\_\_\_\_\_.”**

The therapist can choose to tell your loved one that you shared information about them.

**DON'T ASSUME** that providers will not want to partner with you. Many providers feel that it is good practice to work with well-meaning, calm family members.

Do not “vent” to providers about your loved one. Instead, get connected with NAMI family support groups or consider finding a therapist of your own. **MANY** family members do this.

## REPORT BACK YOUR UNDERSTANDING

“What I'm hearing is \_\_\_\_\_. Is that correct?”

“As I understand it, you mean\_\_\_\_\_.”

**MAKE A LIST** of your top questions/ideas and bring it to the appointment (find a sample appointment prep sheet on page 146).

**MAKE SURE YOU HAVE COPIES** of any document that seems important or official-looking. Keep these documents in one place.

“Mental health professionals are people too, and respond well to encouragement, guidance and patience.”

—Psychiatrist

# PSYCHOSOCIAL TREATMENTS

Psychosocial treatments include different types of psychotherapy and social and vocational training, and aim to provide support, education and guidance to people with mental illness and their families. Psychosocial treatments are an effective way to improve the quality of life for individuals with mental illness and their families. They can lead to fewer hospitalizations and less difficulties at home, at school and at work.

Check with your local NAMI affiliate, your community mental health center or health care provider to see what psychosocial services are available in your community and what may be provided under your health insurance plan.

## TYPES OF PSYCHOSOCIAL TREATMENTS

### **Psychotherapy**

Often called talk therapy, psychotherapy is when a person, family, couple or group sits down and talks with a therapist or other mental health provider. Psychotherapy helps people learn about their moods, thoughts, behaviors and how they influence their lives. They also provide ways to help restructure thinking and respond to stress and other conditions.

### **Psychoeducation**

Psychoeducation teaches people about their illness and how they'll receive treatment. Psychoeducation also includes education for family and friends where they learn things like coping strategies, problem-solving skills and how to recognize the signs of relapse. Family

psychoeducation can often help ease tensions at home, which can help the person experiencing the mental illness to recover. Many of NAMI's education programs are examples of psychoeducation.

### **Self-help and Support Groups**

Self-help and support groups can help address feelings of isolation and help people gain insight into their mental health condition. Members of support groups may share frustrations, successes, referrals for specialists, where to find the best community resources and tips on what works best when trying to recover. They also form friendships with other members of the group and help each other on the road to recovery. As with psychoeducation, families and friends may also benefit from support groups of their own.

**Psychosocial Rehabilitation**

Psychosocial rehabilitation helps people develop the social, emotional and intellectual skills they need in order to live happily with the smallest amount of professional assistance they can manage. Psychosocial rehabilitation uses two strategies for intervention: learning coping skills so that they are more successful handling a stressful environment and developing resources that reduce future stressors.

Treatments and resources vary from case to case but can include medication management,

psychological support, family counseling, vocational and independent living training, housing, job coaching, educational aide and social support.

**Assertive Community Treatment (ACT)**

Assertive community treatment (ACT) is a team-based treatment model that provides multidisciplinary, flexible treatment and support to people with mental illness 24/7. ACT is based around the idea that people receive better care when their mental health care providers work together. ACT team members help the person address



every aspect of their life, whether it be medication, therapy, social support, employment or housing.

ACT is mostly used for people who have transferred out of an inpatient setting but would benefit from a similar level of care and having the comfort of living a more independent life than would be possible with inpatient care.

Studies have shown that ACT is more effective than traditional treatment for people experiencing mental illnesses such as schizophrenia and schizoaffective disorder and can both reduce hospital stays and improve housing stability.

### **Is ACT available in Seattle?**

In King County, we have the Program for Assertive Community Treatment (PACT). See the resource section at the end of this book for contact information at PACT.

### **Supported Employment**

Supported employment improves the employment opportunities for adults with serious mental illness. Supported employment is one type of psychosocial rehabilitation (PSR). PSR includes independent living and social skills training, client psychological and social support services, family support services, access to recreational

activities, housing, and vocational rehabilitation as well as supported employment services. Supported employment is the placement of individuals with mental illness in competitive employment with ongoing supports. This practice, which integrates individuals with disabilities with nondisabled people as much as possible, is very different from vocational rehabilitation programs that require assessment, skills training, vocational counseling, or sheltered work experiences that segregate people with disabilities.

Supported employment assumes that someone with a serious mental illness, when given job support services, will gain the skills needed for successful employment on the job, just as most other adults do. Adults with serious mental illness who are placed into competitive employment and who receive ongoing supports are more likely to be successful in achieving good work outcomes than adults in traditional vocational programs. A primary distinction between supported employment and traditional vocational programs is that supported employment programs provide ongoing support to individuals after they have been hired. Traditional vocational programs do not provide ongoing help.

Supported employment programs can be implemented from a variety of settings, including community mental health centers, community rehabilitation programs, clubhouses, and psychiatric rehabilitation centers. However, services must be provided out in the community, where there are job searches and employment opportunities. Outcomes for supported employment programs include increased levels of competitive employment, about 21 percent in traditional programs compared to 58 percent in supported employment programs.

Work can be an essential step on the path to wellbeing and recovery, but challenges that come with mental illness can make it more difficult. There are programs, however, designed specifically to help with work readiness, searching for jobs and providing support in the workplace.

### **Vocational Rehabilitation (VR)**

VR provides career counseling and job search assistance for people with disabilities, including mental illness. VR program structures vary from state to state. To learn more about your specific state program, visit [dshs.wa.gov/dvr](http://dshs.wa.gov/dvr).

### **Individual Placement and Support (IPS) Supported Employment**

IPS programs are evidence-based programs that help people with mental illness locate jobs that match their individual strengths and interests. Once an individual locates a job, IPS programs provide continuous support to help the person succeed in the workplace. IPS Supported Employment teams include employment specialists, health care providers and the individual with mental illness. If the individual agrees, family members or a significant other may be part of the team.

### **Clubhouses**

Clubhouses are community-based centers open to individuals with mental illness. Clubhouse members have the opportunity to gain skills, locate a job, find housing, and pursue continuing education. Members work side-by-side with staff to make sure the program operates smoothly. Members also have the opportunity to take part in social events, classes and weekend activities.

# MEDICATION

There are now many medicines prescribed to relieve symptoms of schizophrenia, depression, bipolar disorders, obsessive-compulsive disorders, anxiety, and panic disorder.

Medications can play an important part of a treatment plan. Medicines are usually more effective when combined with psychotherapy.

Medications may work better for one person than for another. It is difficult to predict exactly who will respond to what medication. Doctors usually review clinical records and see if there is an evidence base for recommending one type of medicine over another. Family history and side effects also come into play when prescribing medication.

Be persistent until you find the medication or combination of medications that works for you. A few psychiatric medications work quickly and you will see improvements within days, but many work more slowly. You may need to take a medication for several weeks before you see improvement. If you feel a medication doesn't work, or you are having side effects, consult with a provider to adjust the treatment plan. Individuals with a mental health condition should monitor their own symptoms and reactions to medication as much as possible.

Some medications can be prescribed "off-label," which means they haven't been approved by the FDA for a given condition. A doctor should justify their thinking in recommending any treatment as well as be clear about the limits of the

research around that medication and if there are any alternate options.

Medication may be a short-term aid that only needs to be taken for a few months. In other cases, medication may be a long-term, or even life-long, treatment approach. Some people are afraid that taking a medication will change their personality, but most people find that treatment allows them to take charge of their personality and make decisions about treatment and their quality of life.

Knowing the benefits and risks of all treatment decisions is crucial. NAMI has brief summaries of mental health medications provided by the College of Psychiatric and Neurologic Pharmacists available at [nami.org](http://nami.org). **You can also visit [medlineplus.gov](http://medlineplus.gov), a website of the National Institute of Health.**



### TYPES OF MEDICATION

Psychiatric medications work by influencing the brain chemicals regulating emotions and thought patterns. Treatment typically consists of pills or capsules taken daily. A few medications are available as liquids, injections or tablets that dissolve in the mouth. For most medications, your provider will start at a low dose and slowly increase dosages to therapeutic levels. Following these instructions will reduce side effects and discomfort. Whenever stopping a medication, it's necessary to work with a doctor to taper off the dosage while brain chemicals get used to the change. Stopping medication abruptly can result in uncomfortable side effects. Medications for mental illness fall into the following categories:

#### **Antipsychotics**

These medications reduce or eliminate the symptoms of psychosis (delusions and hallucinations) by impacting the brain chemical called dopamine. Antipsychotics play an important role in treating schizophrenia and schizoaffective disorder.

Newer antipsychotics can also treat acute mania and depression in bipolar disorder and treatment-resistant depression. The antipsychotics developed in the

middle of the 20th century are often referred to as first-generation or typical antipsychotics. Second-generation antipsychotics are known as atypical antipsychotics.

Second-generation drugs aren't necessarily better or worse than first-generation, but do have different side effects. First-generation antipsychotics are more likely to cause movement disorders. For example, tardive dyskinesia. This is an uncomfortable condition in which the brain misfires and causes random, uncontrollable muscle movements or tics. These most typically affect the arms, fingers, legs, toes or facial muscles. Second-generation antipsychotics are more likely to result in weight gain. This increase in weight to other health complications such as metabolic syndrome. The important thing is to find the medication that works best for you.

People who have difficulty remembering to take daily pills, or people who have a history of discontinuing medication, may have better results by taking medication as a shot at the doctor's office once or twice a month. This shot is called a long-acting injectable antipsychotic medication (LAI) and it has the same effects as medication taken in pill form.

### **Antidepressants**

These medications improve the symptoms of depression by impacting the brain chemicals associated with emotion, such as serotonin, norepinephrine and dopamine.

Newer medications, SSRIs and SNRIs (selective serotonin reuptake inhibitors and selective norepinephrine reuptake inhibitors), have fewer side effects than older drugs, but no medication is side-effect-free.

### **Side effects of SSRIs and SNRIs include:**

- » Nausea
- » Nervousness, agitation or restlessness
- » Dizziness
- » Reduced sexual desire or difficulty reaching orgasm or inability to maintain an erection
- » Drowsiness
- » Insomnia
- » Weight gain or loss
- » Headache
- » Dry mouth
- » Vomiting
- » Diarrhea

Many people won't experience these side effects, or will see them go away within a few weeks. But if they continue, changing medications or adjusting the dosage will often resolve the problem.

One antidepressant (bupropion) mostly affects the brain chemical dopamine and thus forms a category of its own.

Older types of antidepressants, which include tricyclics and MAOIs (monoamine oxidase inhibitors), may be prescribed by a mental health professional if newer medications do not seem to be effective. The most common side effects of tricyclics (and tetracyclics) include:

- » Dry mouth
- » Blurred vision
- » Constipation
- » Urinary retention
- » Drowsiness
- » Increased appetite leading to weight gain
- » Drop in blood pressure when moving from sitting to standing, which can cause lightheadedness
- » Increased sweating

Monoamine oxidase inhibitors (MAOIs) are the least prescribed antidepressants because they can cause dangerously high blood pressure if combined with certain foods or medications. People taking MAOIs must watch their diets carefully to avoid potentially life-threatening complications. The foods that are off-limits include aged cheese, sauerkraut, cured meats, draft beer and fermented

## ASHLEY'S STORY

“For years I was doing well and had been off of my anti-depressant and seeing a therapist as needed. Then my recovery took a bit of a dip and I fought going back on medication because it felt like failure, like weakness. When I finally decided to go back on my medication, after months of unbearable anxiety and depression, I was mentally kicking myself for waiting as long as I did. I felt so much better after just a few weeks. I didn't need to suffer for months on end out of some misguided stigma about medication being for weak people. There is nothing weak about acknowledging when you aren't well and you need help.”

soy products such as miso, tofu or soy sauce. For some individuals, wine and all forms of beer may be contraindicated.

Many antidepressants may also be useful for treating depression that is mixed with anxiety. Some antidepressants may be useful for PTSD, generalized anxiety disorder and OCD, but may require higher doses.

Depression that is part of bipolar disorder requires more careful assessment, as antidepressants may worsen the risk of mania and provide little help for depression associated with bipolar disorder.

### **Anti-anxiety Medications**

Certain medications work solely to reduce the emotional and

physical symptoms of anxiety. Benzodiazepines such as alprazolam (Xanax) can treat social phobia, generalized anxiety disorder and panic disorder. Heart medications known as beta-blockers are also effective at treating the physical trembling and sweating that people with phobias experience in difficult situations.

Benzodiazepines work quickly and are very effective in the short-term; however, people who are prone to substance abuse may become dependent on them because they are addictive. It also may be necessary to increase the dosage over time. The body becomes accustomed to these medications over time and may require larger doses for the same therapeutic effect. People who stop taking benzodiazepines

abruptly may experience unpleasant withdrawal symptoms. Other side effects can include:

- » Low blood pressure
- » Decreased sex drive
- » Nausea
- » Lack of coordination
- » Disinhibition
- » Depression
- » Unusual emotional dysfunction, including anger and violence
- » Memory loss
- » Difficulty thinking

### **Mood Stabilizers**

Mood stabilizers are the most common medications for treating the manic episodes that occur in bipolar disorder. The oldest of them, Lithium, has been in use for over 50 years and has proven very effective, particularly for bipolar I disorder. However, regular blood tests are a requirement if you're taking Lithium, which has potential serious side effects to the kidneys and thyroid.

There are also newer mood stabilizers originally created as anticonvulsants that may work better than Lithium for some people. Mood stabilizers can prevent highs (manic or hypomanic episodes) and lows (depressive episodes). All have important side effects to know about and monitor.

### **Children and Medication**

Certain medications are safe and effective for children, while others haven't been formally researched yet. Doctors may treat children by prescribing these medications "off-label." Questions remain about how these medications affect a child's growing body and brain. Children may also experience different side effects than adults. Antidepressants, for instance, carry a warning that they may increase suicidal tendencies in young people. Because of these uncertainties, it's important to monitor children and teens closely when they're taking a medication.

### **Seniors**

As we age, our bodies process medicines more slowly, so older adults may need lower dosages. We're also more likely to take multiple medications, increasing the risk of unexpected and dangerous drug interactions. Memory problems may cause older adults to miss doses or overdose. And certain side effects may be more common in older adults, such as tardive dyskinesia, a side effect of antipsychotics. For all these reasons, older people should pay careful attention when monitoring treatment and symptoms.

# MEDICATION FAQs

## **DOES EVERYONE WHO LIVES WITH MENTAL ILLNESS HAVE TO BE ON MEDICATION?**

- » No. In some cases, the right combination of therapy and/or other supports can allow someone to feel strong in their recovery. However, many people who experience mental illnesses are very likely to need medication during their recovery.
- » If you have strong hesitations about medication or other mental health services, it may help to talk with a peer: another person who lives with mental illness. Check out pages 40.
- » If you have a loved one who does not feel they need treatment, learn about peer support (pg. 40), seek support from other family members and check out pages 67-68.

## **ARE MEDICATIONS ADDICTIVE?**

All psychiatric drugs have the potential to cause “withdrawal” reactions. You should never stop taking your medicine or change the dosage without talking to your doctor. Side effects of sudden changes can range from unpleasant to very dangerous. However, following your doctor’s instructions about dose reduction or discontinuation will reduce or eliminate the risk of withdrawal reactions.

For information about medication

and people with dual diagnoses (someone diagnosed with both a mental illness and a substance use disorder), please see pages 51-52.

## **WHO CAN PRESCRIBE MEDICATION?**

- » Psychiatrists (MD)
- » Physicians (medical doctors and osteopathic physicians, MD and DO)
- » Advanced Practice Nurse Practitioner (APNP)
- » Physician’s assistant (PA)

## **DO I HAVE TO BE ON MEDICATION FOREVER?**

Many people who live with serious mental illnesses find medication essential throughout their lives. Others do not. In many cases, the type and/or dosage may change (increase or decrease) over time. There is no “one-size-fits all” approach to medication.

## **CAN MEDICATION “CURE” MENTAL ILLNESS?**

No. Psychiatric medications do not make illnesses disappear. However, they can help to make symptoms extremely manageable. Medication should be accompanied by other supports that address non-medical elements in the recovery process: self-esteem, social support, a sense of belonging and opportunities for meaningful involvement in the community.

## **WHERE CAN I LEARN MORE ABOUT SPECIFIC MEDICATIONS?**

Visit NAMI's website at [nami.org/About-Mental-Illness/Treatments](http://nami.org/About-Mental-Illness/Treatments) for an overview of mental health medications. You can also visit [medlineplus.gov](http://medlineplus.gov), a website of the National Institute of Health.

## **WHERE CAN I KEEP UPDATED ON THE LATEST (NON-PHARMA FUNDED) PHARMACOLOGICAL RESEARCH?**

You can visit the National Institute on Mental Health (NIMH) website for extensive reports on current research: [nimh.nih.gov](http://nimh.nih.gov)

You can also visit the U.S. Food and Drug Administration website: [www.fda.gov/drugs](http://www.fda.gov/drugs)

## **TIPS FOR MEDICATION MANAGEMENT**

### **ASK QUESTIONS BEFORE YOU START TAKING A MEDICATION!**

- » What does this medication do and how will it help me?
- » What should I do if I miss a dose?
- » How will it interact with other medications and supplements? Make sure the doctor knows all medications and supplements you take (prescribed and otherwise).
- » What are the side effects and how can I manage them?
- » When should I expect a positive change?
- » Are there other ways to take this medication, such as a long-acting injection?
- » What is a possible next step if this medication is not effective?

### **ASK QUESTIONS ALL THE TIME!**

- » Do you feel like your doctor is listening and understanding your concerns about your medication? If not, see the “Developing a Relationship with your Provider” section.
- » Does medication help you get or keep things in your life that are most important to you?
- » Does your medication ever get in the way of your life or prevent positive change from happening?
- » Are you having trouble keeping track of your medications?

### **Pregnancy**

If you have a mental health condition and are currently pregnant, or become pregnant, you may face additional risks with medication. However, for some medicines there is not enough research to make the decision clear.

Those who stop taking medication because of pregnancy may experience symptoms, which

poses its own dangers for the parent and child. Some medications can be transmitted to the infant through the placenta or breastfeeding. You should discuss the pros and cons with your doctor. After giving birth, you should also consult your doctor about how to prevent postpartum depression and whether it's safe resume taking your normal medications.

Traditional medical and therapeutic methods have improved over the years, but often they do not completely lessen or eliminate symptoms of mental illness. As a result, many people use complementary and alternative methods to help with recovery. These non-traditional treatments can be helpful but it is important to remember that, unlike prescription medications, the U.S. Food and Drug Administration (FDA) does not review or approve most of them.

The National Center for Complementary and Integrative Health (NCCIH) is the main government agency for investigating non-traditional treatments for mental illness and other conditions. “Complementary health approaches,” the term favored by NCCAM, encompasses three areas of unconventional treatment:

- » Complementary methods where non-traditional treatments are given in addition to standard medical procedures
- » Alternative methods of treatment used instead of established treatment
- » Integrative methods that combine traditional and non-traditional as part of a treatment plan

## NATURAL PRODUCTS

Some people find that taking supplemental vitamins and minerals lessens the symptoms of their mental illness. There are several ways these substances may help.

Data is still lacking on the effectiveness and safety of many

complementary practices, but there are studies supporting that some of these strategies seem to have minimal, if any, adverse effects.

## OMEGA-3 FATTY ACIDS

Omega-3 fatty acids are a group of chemicals found in a number of different foods, including fish. Studies have found that certain types of omega-3 fatty acids are useful in the management of both medical and mental illnesses. Research shows that for young people experiencing an episode of psychosis for the first time, treatment with omega-3 fatty acids may help decrease their risk of developing a more chronic and serious form of schizophrenia.

## FOLATE

Folate is a vitamin required for the human body to perform many essential processes on a day-to-day basis. Also called folic acid or vitamin B9, folate is a compound that the human body is unable to make on its own. Some people with mental illness have been



shown to have low folate levels and may benefit from treatment with additional folate supplementation. At the current time, the FDA has approved only one form of folate—l-methylfolate (Deplin)—for use in the treatment of depression and schizophrenia. L-methylfolate has not been approved as a primary treatment, but rather as an additional form of treatment.

### MEDICAL FOODS

Medical foods are another type of product containing natural ingredients. These are foods made with or without specific nutrients to help treat a health condition. For example, gluten-free foods are designed to give people with celiac disease the nutrients they need but without the gluten which makes them sick. Like supplements, medical foods are not as closely monitored by the FDA as prescription medicines.

### MIND AND BODY TREATMENTS

Some types of mind and body treatments are:

- » Exercise
- » Mindfulness activities
- » Meditative movement

Mind and body treatments can improve mood, anxiety and other symptoms of mental illness. In addition, physical activity can help reduce weight gain, fatigue, and other side effects of many

conventional medicines used to treat mental health conditions.

### EQUINE THERAPY

Equine therapy, or equine-assisted psychotherapy (EAP), is a form of animal-assisted therapy that teaches individuals how to groom, care for and ride horses. The goal of equine therapy is to use experience with horses to improve emotional and behavioral outcomes.

Small studies and anecdotal evidence have shown equine therapy can help reduce symptoms of anxiety, depression and impulsiveness common to many mental health conditions. However, more data is needed to test its effectiveness.

A licensed equine therapy program is led by a mental health professional, who guides participants in reflecting on their relationship with the horse. Because horses live in herds and are prey to larger animals in the wild, they're highly sensitive to the emotions and behavior of others, including humans.

### MAKE SURE TO CHECK WITH YOUR DOCTOR

Even simple vitamins can interact with medication. While something may be safe to use with one prescription medicine, it can

make others less effective or toxic. Also, any new exercise or outdoor activity should be discussed with a doctor. People taking certain medicines for depression, schizophrenia or other illnesses

should make sure to stay cool and drink enough water to avoid heat stroke. Other medicines may cause a drop in body temperature, so special preparation may be needed for cold weather.

## ALLISON'S STORY

“My name is Allison and I have intrusive sexual thoughts. I have had this lesser known form of OCD since I was 13 and I am now 24. I have dealt with social anxiety and experienced chronic depression dating back to as far as I can remember. The intrusive thoughts have caused me the most suffering of my mental illnesses because this particular strain of OCD thrives off its inherently taboo nature. The themes of the thoughts have waxed and waned from fears of sexual arousal by children and family members and the general persistent fear that I am too sexual. My disorder has worsened in time as the very stigma that it thrives on prevented me from seeking help, or even breathing a word of these thoughts to a single soul until college.

With the aid of my fully supportive therapist and the life changing Google search that led me to discover Rose Bret cher, an intrusive thought activist and profound writer on the subject, I was able to claw my way to a relatively stable plateau of self-acceptance. In anxious times, the thoughts still can overtake me and I will sometimes begin slipping into believing I am a bad person again. Guilt and shame have stolen a lot of beautiful moments. It became a natural mental pattern of mine to directly identify with each negative thought, no matter how irrational and fear based. Today I practice regular reflections on gratitude and love. I am incredibly proud of the whole person I am and for persisting despite the uphill climb. My personal evolution excites me these days even if I experience a temporary ‘relapse’ of old thinking. I actively choose to embrace my OCD shadow with showers of endless compassion. I deserve an all-encompassing love and acceptance. We all do.”

# WHAT TO DO IN A CRISIS



# WHAT IS A CRISIS?

Mental health crises can be some of the scariest and most stressful situations one can experience. However, there are ways to make them safe, more manageable, or help prevent them altogether. This section gives an overview of information that can help you navigate a crisis when it occurs, and tools that can help prevent the next crisis.

## PRECURSORS TO A CRISIS

There are usually indicators when someone's mental health is starting to deteriorate. You may see more symptoms appear in yourself, or in the person you are supporting. The first thing to do if you feel your health is worsening is to call your mental health professionals and inform them of what's going on. Don't be afraid to speak openly and honestly. Your treatment provider can help make adjustments to your treatment—whether that be with

medication, additional therapy appointments, or something else—to help you re-stabilize before a crisis occurs. It is especially important to reach out for help and support if you are feeling suicidal. If you or someone else is at risk for suicide, call the National Suicide Prevention Hotline at 1-800-273-8255 as soon as possible. They have trained counselors available to speak with you 24/7 and assist in a crisis situation.

## IMPORTANT REMINDERS

- » Crisis does NOT happen because someone is weak, has “cracked” or should have worked harder to get well.
- » Crisis is NOT an inevitable or unavoidable part of living with mental illness.
- » Crisis often signals problems with services and/or support, not with the person's ability to get well.
- » Crisis looks and feels differently for each person.
- » Someone in a self-defined crisis should never be turned away from services.

# BASIC STEPS TO TAKE WHEN YOUR LOVED ONE IS IN A CRISIS

## 1. REDUCE THE INTENSITY AS MUCH AS POSSIBLE

**Speak calmly, softly and slowly.** Relax your body and voice.

**Be genuine.** Do not talk to the person like a child.

**Be non-judgmental.** Try to truly understand the person's experience, rather than assess, judge or push solutions.

**Ask simple, respectful questions** about what happened and your loved one's thoughts/feelings. Do not try to talk the person out of delusions or hallucinations. This will only create mistrust.

**Ask how you can help your loved one feel safe.** Try to find out what would help them feel more secure and in control.

## 2. IF THE PERSON IS WILLING TO SEEK CARE, ESTABLISH A GAME PLAN

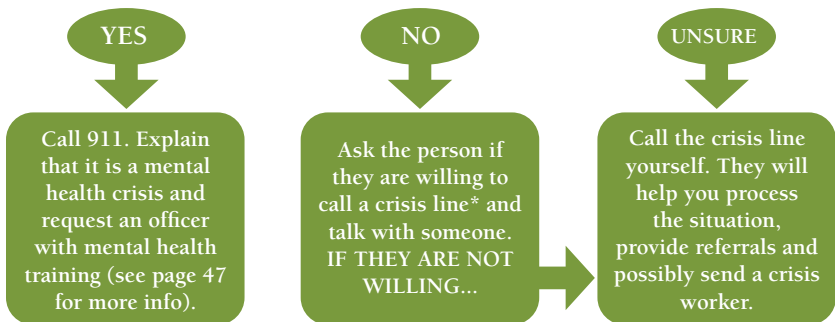
**Is there a therapist, doctor or other care provider we could call?** If the person already works with health care providers, contact them for advice.

**What has helped when you've had similar feelings in the past?**

The person may have a written plan of action for mental health crises or other ideas that work for them.

**What are your preferences?** Is there a certain hospital or clinic you prefer? Would you prefer non-medical support? Do you want to bring anything with you? Is there anyone else you would like to call? When we get there, do you want me to stay with you or drop you off?

## 3. INVOLVE PROFESSIONALS: IS THE PERSON IN IMMEDIATE PHYSICAL DANGER AND UNWILLING TO SEEK CARE?



# NAVIGATING POLICE INTERACTIONS

Many families are scared to call 9-1-1 during a crisis for fear of how police officers may respond to the call. Here are some suggestions about how to communicate with emergency responders during a crisis:

## WHAT TO SAY IF YOU NEED TO CALL THE POLICE DURING A MENTAL HEALTH CRISIS

1) Tell both the 911 dispatcher and the responding officer that the situation is a mental health crisis. *“I am calling because my family member is having a mental health crisis. My goal is for them to get help, not to be arrested or harmed.”*

4) Tell the officer if your loved one has made direct threats. *“My loved one has made direct threats of suicide (or violence).”*

2) Request that a CIT (Crisis Intervention Team) trained officer respond to the situation. This is an officer with special mental health training. *“I would like a CIT trained officer to respond, and help me get them to the hospital.”*

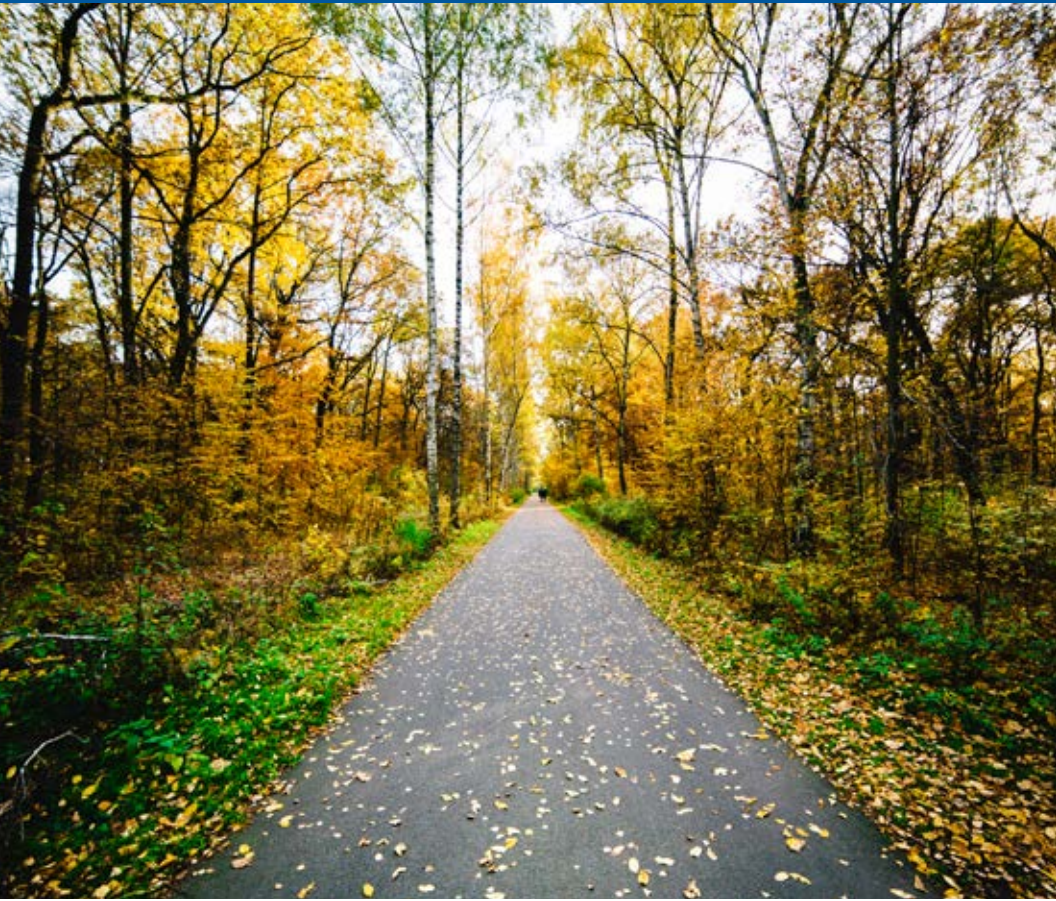
5) Briefly point out triggers that you believe could escalate the situation (e.g., speaking loudly, getting too close too quickly, etc.) *“In the past, \_\_\_\_\_ has been a trigger that escalates my family member further.”*

3) Tell the officer if you know whether or not your loved one has access to weapons, especially firearms. *“My loved one has access to \_\_\_\_\_ weapons.”* or *“My loved one does not have any weapons.”*

6) Point out things that may prevent escalation (e.g., speaking softly, having a trusted person nearby, being allowed to smoke a cigarette while they talk, etc.) *“Speaking softly and slowly usually helps calm them down.”*



# THE CRIMINAL JUSTICE SYSTEM



# THE CRIMINAL JUSTICE SYSTEM

Approximately two million people are incarcerated in our country. The number of incarcerated people with mental illness has grown to an alarming number, largely as a result of deinstitutionalization and closure of state hospitals accompanied by failure to invest in community-based services as a replacement. Most of the mental illnesses prisoners face are severe and persistent. Between 15 and 30 percent of inmates have a serious mental illness, compared to 8 percent in the US population overall.

Repeated prison terms are common among offenders with mental illness which results in both a huge expense to communities incarcerating these individuals, as well as a failure to address and treat the root cause of the illness which contributes to these repeated incarcerations. Crime rates increase which in turn leads to even more funding required for both additional incarceration and more intensive mental health treatment. With each additional incarceration and release back into the community, the costs of imprisoning and treating people with mental illness in our criminal justice system rises exponentially. The costs associated with releasing individuals with severe mental illness back into the community following repeated incarcerations has become unsustainable with this model, with no evidence that communities are becoming safer as a result. There is also no evidence that these individuals are being treated effectively given the constant “revolving door” they experience

in the criminal justice system. This results in higher crime and increased numbers of homeless individuals who are not receiving the treatment they need.

Individuals suffering from mental illness who are arrested by the police, booked, fingerprinted, and jailed encounter a much more destabilizing experience than those who are not afflicted by a brain disorder. Parents and professionals frequently note marked deterioration following an arrest. According to the Holmes-Rahe Life Stress Inventory, detention in jail is documented as the second most traumatic stress that an unmarried person can experience, second to the death of a loved one.

Many young people with mental health conditions may face this trauma, and a large percentage will sooner or later be detained in jail. Being “on the streets” and exhibiting bizarre behavior in public is the most likely reason cited. If a serious crime is committed, incarceration



## MJ'S STORY

My son David\* started having anxiety in 2009 during his junior year in college. He was eventually diagnosed with bi-polar/schizoaffective disorder and has never been stabilized on medication for more than 7 months. The first episode that alerted us that David was having mental health issues was a shoplifting incident he had at college when he had \$100 in his wallet. This was completely out of character for him and after two additional legal incidents we realized that petitioning for his entry into Mental Health Court would be the only way that he would agree to treatment. Through the years he has gained increased insight into his mental health issues, and he has received residential treatment in Santa Barbara since this type of treatment is not available in Washington. David has had more than 40 hospitalizations including Montana State Hospital and Western State Hospital. Many of these crises start with seizures that induce mania and include severe suicidal ideations, voices commanding him to call the police to “end it all” and even begging his family to take him to the police station so they can help him end his life.

Our family has worked closely with many facets of the criminal justice system, including law enforcement, King County Prosecutor's Office, Mental Health Court, ITA (Involuntary Treatment Act) Court, King County Correctional Facility, Jail Health Services and the psychiatric unit of the jail. In 2013, just days after a six month hospitalization, David had a “Suicide by Cop” attempt in front of our home in the hopes that police would shoot him. They did. He was critically wounded and underwent four operations to repair his liver, rebuild his arm and address serious infections. Following a long legal battle David received treatment in California for a year. Our family is committed to criminal justice reform and treatment for people with mental illness and incapacitated individuals rather than incarceration and isolation which only serve to exacerbate the symptoms of their mental illness. Jail is not the place where someone in acute mental distress should be sent to recover—we know that jail makes most people sicker.

My husband and I have given “Suicide by Cop: A Parent's Perspective” trainings at the Northwest Regional CIT Conferences and I am a NAMI Family-to-Family course instructor. While this journey has been wild, we have met many amazing and compassionate individuals who are committed to change!

\*Name has been changed

may be the only option available. If a person is deemed incompetent to stand trial, or is acquitted by reason of insanity, they will be admitted to a forensic unit at a state psychiatric hospital. Patients in the forensic unit of Western State Hospital receive no therapeutic treatment. The only goal for competency treatment is

to restore a patient to a level where they are competent enough to stand trial and participate in their defense. Services such as individual or group therapy, exercise, meditation, music or yoga classes are not offered to forensic patients, and are only offered to non-forensic units.

# WHAT TO DO AFTER AN ARREST

## WHAT TO DO AFTER AN ARREST IN KING COUNTY, WASHINGTON

This guide outlines how to advocate for a friend or family member with a mental health condition following an arrest. This guide does not constitute legal advice. The purpose of this guide is to increase the likelihood that inmates who need behavioral health treatment will have access to that treatment while incarcerated. Be advised that in many local jails, inmates may have to wait anywhere from 4 to 12 weeks to be seen by a psychiatrist.

### STEP ONE: GATHER INFORMATION

King County has an online database that allows anyone to search for inmates in county jails using a name and other basic identifying information.

- » King County Jail Inmate Lookup Service: <http://blue.kingcounty.gov/Courts/Detention/JILS/>

You'll find information including current custody status and location, charges filed, book date, release date and booking number (BA#). The BA# is the main identifier jail staff use, so make note of it.

Other people are taken to the SCORE jail (located in Des Moines) when arrested, and this jail uses a separate lookup service.

- » SCORE Jail Inmate Lookup Service: <https://jils.scorejail.org/>

If you think your family member is in jail, but don't know where they are, check <https://vinelink.com/>. This

lookup covers all of Washington State, including city jails in Kent and Issaquah. It is helpful to have a booking number, but not required.

In smaller city jails, you usually have to call in order to find out if someone is being held there. After a mental health screening, some inmates are transferred to mental health care facilities for further care or evaluation. The jail should put you in touch with the appropriate facility.

For ongoing cases within the Seattle Municipal Court, information about the case can be found at <https://web6.seattle.gov/courts/ECFPortal/Default.aspx>. Go to the Defendant Search section using the menu on the left-hand side of the webpage, and use the defendant's last name, first name, date of birth, and/or defendant number to find out information about the location and basic details of their court case.

Once you know what jail they are in, be sure to look at the visitation rules of that jail online. Contact for

inmates is very restricted, and it is helpful to know the rules in advance of attempting a visit.

### **Juveniles**

If your friend or family member is under 18, contact the juvenile division at 206-477-9890.

### **Interpreter Services**

King County Superior Court's Office of Interpreter Services has more than 140 languages available for interpretation. For more information on interpretation services, contact (206) 477-1415 or [scinterp@kingcounty.gov](mailto:scinterp@kingcounty.gov).

### **STEP TWO: SUPPORT**

- » Remind your friend or family member of the right to have an attorney present during questioning by law enforcement.
- » When someone is taken to jail, they should receive a mental health screening, so let your friend or relative in this situation know that it's safe to share information about a diagnosis and/or medications with the jail's medical staff.
- » Contact the case manager, psychiatrist or any other health care providers your friend or relative sees to inform them of the situation.
- » Remember, any communication you have with a family member

while they are in jail, via phone or in person, is monitored and recorded.

It is critical that in supporting your family member, you do not add to their legal issues. For example, if you have a restraining order against your family member and they call you while in jail, they can be prosecuted for violating the restraining order and a prosecuting attorney will have access to recorded phone calls from the jail.

Knowing the “lingo” is helpful. You can encourage your family member to communicate specific information like what their symptoms are, describe what medications or side effects were. The term “medical kite” describes past treatment/a request to be on wait list; write a formal medical grievance if not getting treatment. Grievances require a written response.

### **STEP THREE: INMATE HEALTH AND MEDICATIONS**

Call King County Jail health services at 206-296-1091 to relay any important medical or mental health information about an inmate. Use discretion when communicating this information; while it's important for people to receive treatment while in jail, you do not want to inadvertently give information that may affect the classification of their

case. We recommended giving basic information that is necessary to keeping them safe and their receiving medication/other treatment they need while incarcerated:

- » Any concerns about self-harm or suicide.
- » Current prescription medications and pharmacy. If you are able to bring an existing prescription bottle to the jail, this helps expedite the process of verifying their medication history and may help them receive their prescription more quickly.
- » Name and contact information of current caseworker or care provider.
- » Intellectual disability (developmental disability, traumatic brain injury).
- » Any addiction issues that may affect safety.

This conversation is to share medical information only, not to address any pending charges or change the legal outcome of their case. Be aware, information sharing is one-way. Medical and mental health care providers can take information from you, but in most cases cannot provide information or feedback, unless you have a Release of Information (ROI) signed by signed by your loved one. The best way to get an ROI signed is during visitation with the inmate, or by asking their

attorney to have them sign one. If you are able to bring an existing prescription bottle, this can expedite verification of their medication needs.

Some medication and doses are considered “not therapeutic” at certain doses. If this occurs, the inmate’s doctor should call public health and state that the prescription is the necessary dosage for this loved one.

Try not to get frustrated and remain patient.

### **STEP FOUR: LEGAL REPRESENTATION**

Whether using court-appointed or hired counsel, it’s important to provide the attorney with your friend or family member’s health history and mental health diagnoses to the best of your ability. It is often most effective to provide the attorney with a written document with as much information as possible about the medical and psychiatric history of your loved one.

#### **Court-appointed Attorneys:**

Arrested individuals receive appointed counsel at arraignment to assist them in their criminal case. For cases in King County Superior and District Court, the King County Office of Public Defense assigns counsel. For the City of Seattle, the

Seattle Municipal Court assigns counsel. If you are dissatisfied with your lawyer, you can ask the judge to reappoint one under the Sixth Amendment. This is a last resort, so only do so if you believe your court-appointed counsel is biased or not doing the best job.

**Private Attorneys:**

If retaining a private attorney, try to select one who has worked on mental health cases before and understands how to access available treatment and services.

Like medical providers, attorneys and their staff are limited in what information they can share with you. They are bound by the Rules of Professional Conduct which prohibit attorneys from sharing confidential information, unless there is a Release of Information (ROI) form signed by the inmate. Remember, an attorney represents their client and their primary responsibility is to that person, even if a family member is paying for their services.

# MENTAL HEALTH COURTS

Mental Health Courts are in place to help with the defendant's mental health needs, supporting continuity of care and access to treatment. Mental Health Courts use a wraparound approach to engage and sustain the stability of people with mental health disorders in the criminal justice system, and to reduce the likelihood of future criminal behavior. They are made up of a team of professionals who have specialized training and experience with mental health issues and therapeutic courts who collaborate to find a successful alternative to incarceration. This approach is designed to help the individual address their mental health concerns that are leading to arrest, warrants, and other difficulties. Mental Health Court is a voluntary program, and typically requires that the criminal activity in question is related to or caused by the defendant's mental health condition.

The City of Seattle has its own Mental Health Court with a presiding judge, mental health professional, and probation staff with mental health expertise, prosecutor and public defender. Referrals can come from anyone including judges, defense attorneys, jail staff, and others.

The general eligibility criteria for Seattle Municipal Court Mental Health Court are:

- » Significant mental health diagnoses, such as Schizophrenia, Bipolar Disorder, Major Depression with Psychotic Features. Depression without psychotic features, anxiety disorders or PTSD alone may not be enough to qualify.

- » Amenability to mental health treatment.
- » Amenability to substance abuse treatment if needed. All clients are required to be abstinent from alcohol and other drugs, and do urinalysis.
- » Ability to attend a lot of appointments, such as hearings and meetings with probation.
- » Willingness to be on intensive probation for up to 2 years.
- » Willingness to resolve cases. Mental Health Court does not do trials.

For additional information on Mental Health Court in Seattle visit <https://www.seattle.gov/courts/programs-and-services/specialized-courts/mental-health-court> or call (206) 684-5600.

Outside of Seattle, the King County District Court has a Regional Mental Health Court. Their team includes the judge, defense attorneys, social workers, prosecutors, victim advocates, peer specialists, probation mental health specialists, court clinicians, and the program manager.

The general eligibility criteria for Regional Mental Health Court are:

- » The charge(s) are being prosecuted by King County or a municipality within King County;
- » The defendant has been diagnosed with an Axis I disorder that is ongoing and that significantly impacts their ability to function at baseline;
- » Appropriate services are available in the community and the defendant is amenable to treatment and supervision.
- » There is a connection between the defendant's mental health symptoms and the

circumstances or behavior leading to their current involvement in the criminal justice system.

A defendant charged with a misdemeanor being prosecuted by the King County Prosecutor's Office can be referred to the Regional Mental Health Court by anyone, including defense counsel, at any stage of the proceedings. If the defendant is charged with a felony or their case is pending in a municipal court, the Prosecutor on their case must make the referral, and do so before final disposition.

For additional information, contact the Regional Mental Health Court Program Manager at 206-477-1692 or at [mentalhealthcourt@kingcounty.gov](mailto:mentalhealthcourt@kingcounty.gov), or contact the Regional Mental Health Court Prosecutor at [paomhc@kingcounty.gov](mailto:paomhc@kingcounty.gov).



# MISSING PERSONS

The thought of someone you care about going missing is scary. It can be even more serious when the person has a mental health condition and you don't know if they are hurt or need help. Taking action quickly can make a difference.

Contact the police immediately and provide them with as much information as possible. **In Seattle, you do not need to wait 24 hours before reporting a missing person. If it is a vulnerable person such as a child, developmentally disabled or elderly adult, call 9-1-1.** For other cases, call the Seattle Police Department non-emergency number at (206) 625-5011.

If the person is still missing after three days, ask the police to put them on the FBI National Crime Information Center (NCIC) as an “endangered adult”. This list is available nationwide.

Reach out to friends and acquaintances of the missing person. Call people who are close to them and find out more about the last time they were seen. Include anyone who had regular contact with them like coworkers, neighbors, or case managers.

Go to <https://namus.nij.ojp.gov> and upload information about your loved one. This resource will help you enter data about the person who is missing, including details about their physical appearance and where they were last seen.



# EMPLOYMENT



# SUPPORTED EMPLOYMENT

Despite large amounts of federal funding for supported employment programs, the employment rates for people with mental illness have continued to decline over the last decade. Unemployment among people served by the public mental health system is three times that of the general population.

Negative stereotypes about mental illness are rampant in the workplace, and disclosing an illness at work often has negative effects on being hired or promoted.

## **SUPPORTED EMPLOYMENT PROGRAMS**

Supported employment has been described as “paid, competitive employment in an integrated setting with ongoing supports.” Quality supported employment services should include rapid job search assistance, inclusion for anyone who wants to participate, integration of employment with other mental health services, focus on consumer preferences in employment, and

individualized long term supports. Studies show that the Individual Placement and Support (IPS) model of supported employment improves work outcomes for individuals with mental illness.

The King County Council first created a Supported Employment Program in 1990 for individuals with intellectual and developmental disabilities in response to the issue of employment inequality. Today, supported employment services in King County are offered through most of our large mental health service agencies. See the resource section in Appendix (5) for more information on this program.

# SELF-ADVOCACY IN THE WORKPLACE

Self-advocacy in the workplace is important for people who live with mental illness. Strong awareness of rights and resources can help you find and/or maintain fulfilling employment.

## **ARE THERE LEGAL PROTECTIONS FOR PEOPLE WITH MENTAL ILLNESS IN THE WORKPLACE?**

Yes. Any person with a disability is protected under the Americans with Disabilities Act (ADA). This law defines a disability as a “physical or mental impairment that substantially limits a major life activity” (e.g. sleeping, learning, concentrating, thinking, communicating).

This includes illnesses that are episodic or in “remission” but may return (such is the case with many mental illnesses). The following illnesses are always considered covered by the ADA: major depression, bipolar disorder, post-traumatic stress disorder (PTSD), obsessive compulsive disorder (OCD) and schizophrenia.

## **IF I CURRENTLY RECEIVE TREATMENT AND USUALLY FEEL WELL, AM I STILL PROTECTED BY THE LAW?**

Yes. When determining whether someone has a disability, the positive effects of treatment cannot be taken into consideration. The law looks at what things were like before treatment or how they would be if treatment stopped.

## **WHAT IS AN ACCOMMODATION?**

An accommodation is any adjustment to a job or work environment that will enable a qualified applicant or employee with a disability to participate in the application process or perform essential job functions.

## **WHAT PROTECTIONS DOES THE LAW PROVIDE?**

Your employer cannot:

- › Deny a request for accommodation of a known disability (unless it imposes undue hardship on the employer/company)
- › Deny job opportunities because you have a disability and/or need an accommodation
- › Retaliate following requests for accommodation

## **DO I HAVE TO TELL MY EMPLOYER ABOUT MY MENTAL ILLNESS BY A CERTAIN TIME IN ORDER TO BE PROTECTED UNDER THE LAW?**

No. You are not required to disclose your mental illness before being hired or upon starting the job in order to be protected under the law. You may request an accommodation at any time.

### **DO I HAVE TO REQUEST AN ACCOMMODATION IN WRITING?**

No. You also do not have to use the words “reasonable accommodation.” However, it is highly recommended that you do put the request into writing, including the date and your signature.

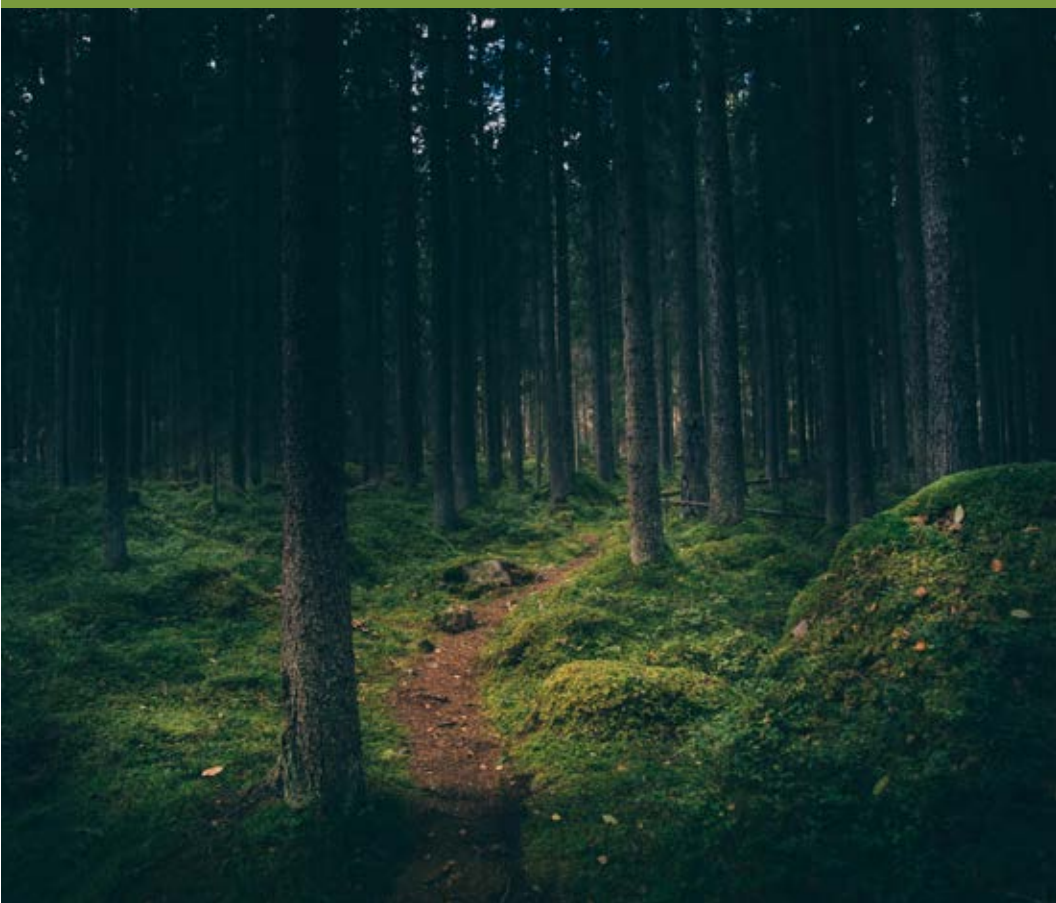
### **HOW CAN I PREPARE FOR TALKING TO MY EMPLOYER ABOUT AN ACCOMMODATION?**

It is best to bring clear ideas about what would help you be more successful at work, rather than expect the employer to have the answers. You can prepare these ideas by connecting with the Job Accommodation Network (JAN).

JAN provides free, expert, and confidential guidance on workplace accommodations and disability employment issues. JAN is a service of the U.S. Department of Labor that provides ideas for reasonable accommodations:

- » Templates for accommodation request letters
- » Free consultation regarding individual cases
- » Free consultation regarding disclosing your illness to an employer
- » Help is available online at [askjan.org](http://askjan.org) or over the phone (800) 526-7234

# HOUSING



# HOUSING

A basic need and ongoing challenge for people with chronic mental illness is finding a safe, affordable, permanent place to live. The struggle to find adequate housing is clearly reflected in our homeless population, with about 40% of adults experiencing homelessness living with a mental illness. People with mental illnesses who are involved in the criminal justice system and have a criminal record face additional challenges in securing housing.

Institutions, such as state hospitals, are not needed for most individuals with long-term mental illness. Once stabilized, many live with community support services designed to maximize their independence. Many people with chronic mental illness live with their families, often because there are not enough community resources to support independent living. Not all families are willing or able to do this for an adult with mental illness, particularly if their symptoms are severe or there are financial barriers to providing housing for the family member.

Across Washington, there are many housing projects subsidized by the U.S. Department of Housing and Urban Development and Washington cities. The Section 8 program provides rental subsidies to low-income people in regular housing, as long as rents are reasonable, the condition of the housing meets HUD standards, and landlords are willing to

participate. Rental subsidies make it possible to rent housing in the private market. Rent is based at 30 percent of income; subsidies pay the balance of the rental payment. Most Section 8 lists in King County have been closed due to the length of the current wait list (up to 3 years). Please check with your local housing authority regarding the status of Section 8 applications and wait lists.

In King County, the King County Mental Health Plan (KCMHP) contracts with mental health providers to support 2,300 units of affordable, subsidized housing for adults enrolled in the KCMHP system. Again, tenants pay approximately 30 percent of their income for rent and utilities in these units, and the level of support available varies depending on who manages the unit.

This section will provide a brief overview and definitions of different types of housing.



## TYPES OF HOUSING AND DEFINITIONS

### **Independent Housing**

For adults who are able to live independently, there is a wide variety of housing options, but individuals with mental illness who choose to live on their own are often limited by their income. Since many people experiencing mental illness are unemployed or underemployed, paying market rate rent in cities like Seattle may be out of financial reach.

There are also some housing developments owned and operated by local nonprofits and religious organizations. They provide safe, comfortable housing at below market-rate rents. Many projects are designed to serve those who do not qualify for Section 8 housing or for households with income who have difficulty affording available units. In general, the need for affordable housing for people living with mental health conditions exceeds what is available in our region.

### **Transitional Housing**

Transitional housing provides housing for people who otherwise would not qualify or are on waiting lists for subsidized housing. Transitional housing programs assist people who are ready to move

beyond emergency shelter into a more independent living situation. These programs work with individuals and families to further develop the stability, confidence, and coping skills needed to sustain permanent housing, and are typically limited to a specific period of time.

*Crisis/Respite Beds:* Provision of short term intensive residential care. The service could be as little as a few hours or as long as several weeks.

*Long-Term Rehabilitation (LTR):* This type of care is more intensive than Supervised Living and includes on-site psychiatric evaluation, medication management, and case management for both mental health and housing related needs. Formerly called transitional care, adult residential treatment, or adult residential care.

*Supervised Living/Adult Residential Care Facility:* Basic residential services. Individuals receive room and board, residential stabilization and daily support services. They have the opportunity to join in-house or community activities, and there are on-site staff to help residents with housing issues. Formerly called congregate care facility or congregate care facility/mental health.

*Supported Living/Supportive Housing:* When someone is stable and able to live alone or with several others, with assistance. Mental health agencies who operate supported living programs are required to provide a full range of services, from scheduled contacts each week up to 24 hours a day of care if necessary. Many of the agencies have obtained Section 8 housing certificates that enable them to offer these units as well. If the client moves voluntarily or is placed in another level of housing, the agency, not the resident, has the Section 8 certificate.

### **Adult Family Home**

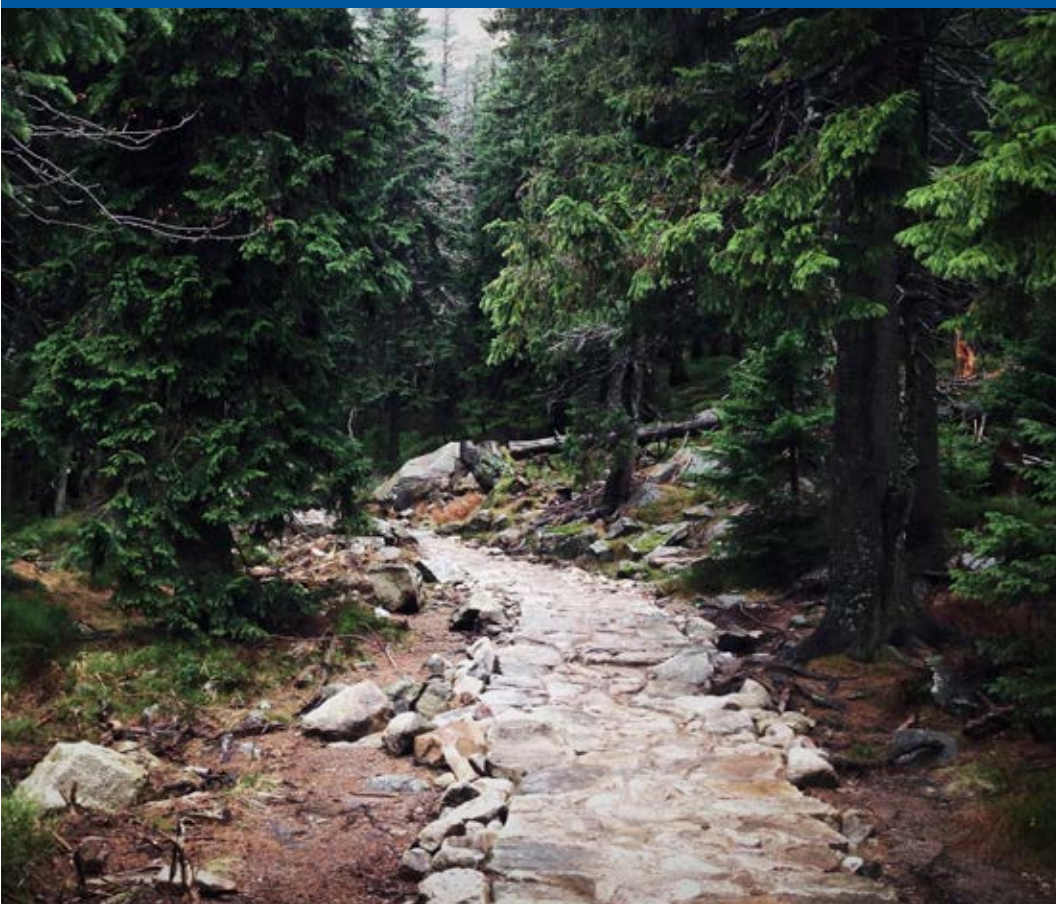
Adult family homes are regular neighborhood homes where staff

are present and responsible for the safety of the adults in the home. Room, meals, laundry, and varying levels of assistance with care are provided. Sometimes, nursing care may be provided in this setting. Some offer specialized care for people with mental health issues, developmental disabilities, or dementia. Adult Family Homes are licensed by the state and can have two to six residents. They are also referred to as “group homes”.

### **Alternative Living Services**

These are instructional services provided by individual contractors. They focus on individualized training to help enable a client to live as independently as they can with minimal residential services.

# GUARDIANSHIP AND ALTERNATIVES



# GUARDIANSHIP (AKA CONSERVATORSHIP) AND ALTERNATIVES

Individuals with mental health conditions sometimes require assistance in performing daily routines and managing both personal and financial affairs. There are many options available to assist the person in need. The different levels of care include representative payeeship, powers of attorney, and advanced directives or living wills. **Guardianships should be considered as a last resort**, because the process can be costly and may take away more autonomy than is necessary to assist the person with a mental health condition.

## WHAT IS A REPRESENTATIVE PAYEESHIP?

While most individuals receive their benefit payments directly, sometimes it is necessary to have assistance in money management, as well as guidance in handling daily activities. Benefits like social security are paid through representative payees who receive and manage the benefits on their behalf. Although family or friends can perform this function, this can sometimes create conflict. In such instances, SSA relies on state, local, or community resources to act as representative payees.

The main responsibility of the payee is to use the funds to pay for current and foreseeable needs of the beneficiary and save any remaining funds if they exist. The SSA sets limits on a beneficiary's resources which means that if a beneficiary's savings exceeds a specific amount their benefits might be affected. SSA is kept informed of a client's

benefits through the use of two forms: the Representative Payee Report (Form SSA-6234-F6) and the Representative Payee Report of Benefits and Dedicated Account (Form SSA-6233-BK). These forms must be submitted regularly and detail all expenditures, household changes, and other pertinent information. The schedule for submitting these forms varies according to the SSA office in your area.

## WHAT IS A POWER OF ATTORNEY?

When you give someone else the power to act for you, you give what is called a "power of attorney." If you give someone power of attorney, you are called the "principal" and the person you give it to is called the "agent" or "the attorney-in-fact." A document granting power of attorney should be clear and specific. The powers granted can be very limited or very broad, depending on the needs of the

principal. The agent can be allowed to consent to medical treatment, manage a principal's finances, or sue on behalf of the principal. A power of attorney can either take effect immediately or at some point in the future. It can last a limited amount of time or indefinitely. The power of attorney ends when the principal dies and, as such, is not a replacement for a will. A power of attorney cannot be given after a person has become incapacitated. In this case, a guardianship should be considered by the court.

### **WHAT IS A LIVING WILL?**

Living wills are given to your physicians and outline when you want life-sustaining medical care stopped. They can only become effective if you are either diagnosed with a terminal condition in which life-sustaining procedures would only prolong the process of dying, or if you are in an incurable comatose condition. If it is combined with a healthcare power of attorney, you can also appoint someone to make medical decisions for you.

To be valid, a living will must be dated and signed by two witnesses. To terminate a living will, you can physically destroy the document, cancel the document by a written and signed notice, or tell your physician that you would like to cancel the will.

### **WHAT IS A GUARDIAN AND HOW ARE THEY APPOINTED?**

A guardian is appointed by a court to manage the affairs of a person who has been incapacitated. Guardians can also handle health care decisions and non-financial related matters for the person.

Guardians are appointed by superior court judges or commissioners. A petition can be filed to start the process but the petitioner need not want to be appointed themselves.

Incapacity is defined by Washington State law as “disabilities caused by mental illness or mental deterioration; Alzheimer’s and related dementia; developmental disabilities; traumatic brain injury; chronic use of drugs or alcohol; or other physical diseases and debilitating conditions that may cause a person to be unable to provide necessary personal or financial self-care.”

### **WHAT IS A GUARDIAN AD LITEM AND WHAT DO THEY DO?**

A guardian ad litem (GAL) is an adult appointed by the court to represent an individual. The GAL performs an investigation and prepares a report for the court of their findings and recommendations. To become a GAL, an individual must complete a training program, give their

background information to the court, and meet all eligibility requirements.

GALs are often appointed to represent minors in family law cases, dependent children, or those who are incapacitated. They can be paid for their services, or serve voluntarily. Paid GALs often do GAL work as part or full-time employment. Most volunteer GALs serve as court-appointed special advocates (CASA).

A GAL must be independent, behave professionally, avoid conflicts of interest, become informed about the case, provide relevant information, only serve the court, explain their role, maintain privacy, maintain documentation, and keep records of time and expenses.

Each court maintains a list of individuals who are qualified to serve as GALs. Each court has a procedure for filing a grievance against a GAL.

### **WHAT ARE THE RESPONSIBILITIES OF THE GUARDIAN?**

A guardian must meet the needs of a person's incapacity. Limited guardianships only cover where a person requires assistance. The two types of broader guardianships are guardianships of the estate and guardianships of the person.

A guardian of the estate manages a person's property and finances. They must give an inventory to the court within three months and provide documents for accounting once per year.

A guardian of the person assesses the person's physical, mental, and emotional needs, and any need for assistance with daily living. Guardians must design a care plan to meet these needs for the court. They must provide the court with a report once per year. A guardian of the person may also be responsible for decisions on medical procedures.

A guardian cannot place someone in an institution, nursing home, or mental hospital against their will. A separate court hearing makes this decision. A person has all of the rights they had during the initial guardianship hearing.

Both a payee and a guardian can be modified or removed if circumstances change. For more information on modifying, removing, or complaining about a payee or a guardian, visit <https://www.disabilityrightswa.org/resources/guardianship>

# UNDERSTANDING HIPAA





The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that helps protect the privacy of individual health information. For individuals living with mental illness, this law is important, because it helps protect confidential mental health treatment records.

Over the years, however, there have been many misunderstandings about the type and range of information that mental health treatment providers are allowed to share with others. This sometimes has resulted in situations where family and friends of a person living with mental illness were unable to communicate with healthcare providers, often to the detriment of a loved one.

The federal Office of Civil Rights (OCR) at the Department of Health and Human Services (HHS) has enforcement authority over HIPAA. On Feb. 21, 2014, OCR released guidance clarifying how and when healthcare providers may share an individual's mental health treatment information with others. Open communication between a mental health provider and family members or friends of a person living with mental illness can help make sure that the individual receives the best treatment and care possible. Below is a set of questions and answers to make sure you know what HIPAA means for you.

**Can healthcare providers share mental health treatment information with family members and friends of a person living with mental illness?**

Yes, healthcare providers may share information about treatment with

a person's family or friends if the person with mental illness does not object.

**Are health care providers required to obtain a signed informed consent release before sharing information with family and friends?**

No, citing the "integral role that family and friend's play in a patient's health care," OCR's guidance states that providers may ask for permission to share relevant information, may tell the person that they intend to discuss information and give them the chance to object, or may infer from the circumstances, using professional judgment, that the person does not object. For example, if a person receiving treatment invites a family member and friend to be present in a treatment situation, the provider may assume that the person



does not object to disclosure of information.

### **What happens if the person living with mental illness objects to information sharing?**

If the person receiving treatment is an adult, objects to the release of information, and is deemed capable of making healthcare decisions by the healthcare provider, then the healthcare provider cannot share information with family or friends. If the healthcare provider determines that a person does not have the capacity to make healthcare decisions, then the provider may choose to share information with family, friends, or other individuals involved in the person's care if the provider believes it is in the person's best interest. A court order is not required for a determination that a person lacks capacity. Discretion lies with the treatment provider, based on professional judgment.

### **How much information can the healthcare provider share with a person's family members or friends?**

Healthcare providers should exercise professional judgment and disclose only the information that is necessary or directly related to the family member or friend's involvement in care. Psychotherapy notes, that are written by a provider during counseling sessions

detailing specific conversations, are treated differently than other healthcare information because they may contain especially private or sensitive information. In most instances, a provider must have a patient's permission before sharing information contained in psychotherapy notes.

### **May family members or friends communicate with a healthcare provider if they are worried about a person's health or wellbeing?**

Yes, family members or friends may share information that they believe might be relevant or helpful to a treatment provider. Healthcare providers are not required to disclose this communication to the individual receiving treatment.

### **Can healthcare providers share information with parents or guardians of children?**

Generally speaking, yes, a healthcare provider may share treatment information with a parent, guardian, or an individual acting as a personal representative for a child.

### **At what age is a child considered an adult for the purposes of healthcare decisions?**

Generally, age 18, but HIPAA defers to state law if a state has a different standard. The age of medical consent in Washington State is 13, which means that a child 13

years or older may make their own decisions about mental health care and who is authorized to receive information about their care.

**Are there any other restrictions on how and when a healthcare provider may share information with parents or guardians?**

HIPAA establishes a floor for the privacy of health information. State laws that are more protective of privacy supersede HIPAA. State laws vary and it is important to become familiar with the laws in your state.

In addition, there are some federal laws that may have additional restrictions on sharing treatment

information with parents or guardians. For example, the federal confidentiality statute that applies to federally-funded drug and alcohol treatment programs has standards that are stricter than HIPAA.

**Can healthcare providers share protected mental health information with law enforcement officials?**

Yes, in certain circumstances, particularly if the person living with mental illness poses a danger to self or others, then healthcare providers may disclose necessary information.

*From [www.nami.org](http://www.nami.org)*

# **TOOLKIT**

## **Mental Health Advanced Directives (MHADs) & Critical Advocacy Resources for Emergencies (CARE) Kits**



# MENTAL HEALTH ADVANCED DIRECTIVES

A mental health advance directive (MHAD) is a written legal document describing what you want to have happen if you become so incapacitated by mental illness that your judgement is impaired and/or you are unable to communicate effectively. It can inform others about what treatment you want or don't want, and can identify a person to whom you have given the authority to make decisions on your behalf. An MHAD is entirely voluntary and is intended to honor the treatment choices of the individual with a mental illness if a crisis strikes.

MHADs are part of the Revised Code of Washington, 71.32, and can be made by adults with "capacity." An adult who has not been found to be incapacitated by a mental health professional or a superior court has "capacity."

There are advantages to preparing an MHAD. Principals (AKA the person with mental illness creating the MHAD) and families can have more control over what happens if a crisis occurs. Providers and others will know what is wanted even if the principal can't express themselves well. MHADs can assist case managers and others involved in mental health treatment, and may even shorten hospital stays.

Anything related to treatment can be written in an MHAD, including:

- » The principal's preferences and instructions for mental health treatment
- » Consent to specific types of

mental health treatment

- » Refusal to consent to specific types of mental health treatment
- » Consent to admission to and retention in a facility for mental health treatment for up to 14 days
- » Descriptions of situations that may cause the principal to experience a mental health crisis
- » Suggested alternative responses that may supplement or be in lieu of direct mental health treatment, such as treatment approaches from other providers
- » Appointment of an agent to make mental health decisions on the principal's behalf, including authorizing the agent to provide consent on the principal's behalf to voluntary admission for inpatient mental health treatment
- » The principal's nomination of

a guardian or limited guardian for consideration by the court if guardianship proceedings are recommended. It is also suggested that the principal carefully specify when, how, and by whom they are declared incapacitated and when this declaration can be revoked.

Additionally, principals are advised to include situations under which they may cancel or revoke the MHAD. This is extremely important. Principals are advised to make it very clear what should be done if they tell treatment providers to ignore what is in their MHAD when in treatment. If a principal wants the MHAD or part of it to be cancelled after treatment has begun, the only way that this can be accomplished is if the principal has directed this in their MHAD.

An MHAD must be in writing and be signed by the principal and two witnesses and then notarized. The witness may not be:

- » A person designated to make health care decisions on the principal's behalf
- » A health care provider or professional person directly involved with the provisions of care to the principal at the time the directive is executed
- » An owner, operator, employee,

or relative of an owner or operator of a health care facility or long-term care facility in which the principal is a patient or resident

- » A person who is related by blood, marriage, or adoption to the person or with whom the principal has a dating relationship
- » A person who is declared to be an incapacitated person
- » A person who would benefit financially if the principal making the directive undergoes mental health treatment.

The law requires that providers respect what is written in a mental health advance directive to the fullest extent possible. However, there are instances when the MHAD will not be followed. These are:

- » When compliance with the provision would violate applicable law
- » When the requested treatment is not available
- » When it is an emergency situation and compliance would endanger any person's life or health
- » When committed under the Involuntary Treatment Act or when jailed
- » When compliance with the MHAD would violate the accepted standard of care

Providers of mental health services are immune from liability when they have acted in good faith and without negligence. These provisions apply when:

- » The provider provides treatment to the client without actual knowledge of the existence of a directive, or
- » The provider provides treatment following an MHAD, without knowledge of a revocation of the MHAD
- » The health care provider or mental health professional determines that the principal (client) is or is not incapacitated for the purpose of deciding whether to proceed, and acts upon their determination
- » The provider administers or does not administer mental health treatment according to the principal's (client's) directive in good faith, trusting that the directive is valid, and the directive is subsequently found to be invalid
- » The provider provides treatment according to the principal's MHAD

A client must be declared incapacitated for the MHAD to go into effect. Only certain entities can declare this. To do so, at least

one mental health professional or health care provider must personally examine the principal prior to determining capacity. A superior court may do so if the principal or their agent so request. Incapacity can also be declared by a mental health professional and one health provider, or two health care providers. One of the two making this determination must be a psychiatrist, psychologist, or a psychiatric advanced registered nurse practitioner. A mental health professional is defined as a psychiatrist, psychologist, psychiatric nurse, or social worker. A health care provider is an osteopathic physician or physician's assistant, a physician or a physician's assistant, or an advanced registered nurse practitioner.

The MHAD must be the principal's plan, not a service provider's or anyone else's. Staff at mental health facilities, when helping someone to complete an MHAD, may suggest writing, or even write themselves, their own preferences rather than the principal's. The National Empowerment Center suggests that a principal should never sign an MHAD prepared by someone else unless it truly reflects the principal's wishes. MHADs do not have to be signed if the principal does not agree that it reflects their wishes.

Although it is not required in Washington State, it is recommended that an agent be named in the MHAD. Naming an agent can prevent potential misunderstandings between clients, families, and treatment providers. The agent should be at least 18 years of age and must be reachable day and night. The agent must know the principal's wishes regarding mental health care through discussions and through access to the MHAD. They should be someone who the principal trusts deeply, who cares about the principal's welfare, and who knows the principal very well. An agent should be a strong, articulate advocate who is well informed about the types of proposed treatments and who care providers will take seriously. A spouse, adult child, brother, sister, friend, or parent may be an agent, as well as anyone else who meets the requirements. The agent may not be the principal's doctor or an employee of that doctor, the principal's case manager or an employee of that case manager, nor the owner or an employee of the health-care facility where the principal receives care or where the principal lives.

Copies of the MHAD should be given to the agent, the client's

mental health provider, the client's lawyer, and trusted family members. All treatment providers who get a copy are required to make it a part of the principal's medical records. Principals should bring a copy of the MHAD when admitted to a mental health facility. According to the Washington State Hospital Association, hospitals do not require that a principal has an MHAD, but they must ask if one has been prepared.

Changes to the MHAD can be made when the client is not incapacitated. All of the people who originally received copies of the MHAD must be provided new copies if it changes. To cancel or revoke an MHAD, the principal must make a statement in writing, stating that they want to cancel or revoke the directive. This statement must be signed. Copies of any of these actions should again be given to all who originally received the MHAD.

For information regarding MHADs or for referral to local attorneys who can help create an MHAD, contact: Disability Rights, Washington  
315 5th Ave S, Ste. 850  
Seattle, WA 98104  
(206) 324-1521, or  
(800) 562-2702, TTY: 711  
info@dr-wa.org  
disabilityrightswa.org

## BUILDING A CARE KIT

The law and a template MHAD form can be accessed online at the DSHS website: <https://www.dshs.wa.gov/altsa/home-and-community-services/legal-planning>

### BUILDING A CARE KIT

It's a great idea to create a CARE (Critical Advocacy Resources for Emergencies) kit for when a crisis strikes. A CARE kit is a ready file of materials that you can quickly share with treatment professionals in a crisis, whether in a three-ring binder, on an easily-accessed computer drive or online storage system or written down in a notebook or in your phone. Be sure to include:

Psychiatric history summary: It is unlikely that treating professionals will have immediate access to, or time to review, the full medical records of someone brought in for an emergency evaluation. A one-page summary of psychiatric history can be very useful (and may also be useful as evidence in commitment hearings.) Keep at least five copies of this important document in your CARE kit, so it can be easily and quickly shared with more than one person in a short span of time. Keep it current and short, but be sure it contains the most critical information, including the following:

- » Full name and Date of birth
- » Social security number
- » Town or city of residence
- » Psychiatric diagnosis
- » Age at diagnosis
- » Current symptoms
- » Current concerns (suicidal, homeless, missing, vulnerable, violent, abusing substances, other)
- » Providers names, emails and phone numbers
- » Dates of previous hospitalizations and locations
- » Dates of previous arrests or jailing and charge(s)
- » Current medication name(s)
- » Past medication(s) that have helped
- » Past medication(s) that have not helped
- » Past history of symptomatic behaviors (e.g., running up huge debt, getting into car accidents, threatening family members, inability to care for basic needs)
- » Full name, contact numbers, and address for emergency contact person
- » A recent picture
- » A list of vital statistics (such as height, age, weight, hair color)
- » Any additional medical conditions to be aware of (such as allergies or diabetes).
- » A copy of your state's criteria for emergency evaluations



and for civil commitments.

If anyone contradicts or misunderstands the law, you have a copy of it in hand.

- » Blank copies of involuntary commitment forms. Complete any non-incident-related information ahead of time.
- » A signed release that allows you access to the person in crisis's medical information.
- » An advanced directive. As discussed earlier in this section, Mental Health Advance Directives are legal documents

that allow individuals with mental illness to dictate aspects of their care in case they become incapacitated by illness. They include the designation of a person to make treatment decisions should the subject become incapacitated.

For more support and tips on preventing a crisis, if you are local to the Seattle area, visit [www.namiseattle.org](http://www.namiseattle.org) or call NAMI Seattle at (206) 783-9264. See appendix (4) for other useful forms.



# ADVOCACY



## LEGISLATIVE ADVOCACY

Advocacy can be a healing experience and give a sense of meaning and purpose to the mental health challenges that you have experienced personally, or as a support person for someone else. By definition, advocacy is “the act of speaking, writing, or acting in support of something or someone.” There are many ways to get involved in advocacy efforts and use your experience to change hearts and minds and policies.

Policy change is one major way we can make a difference in the lives of people living with mental health conditions and their families. NAMI’s national legislative and public policy priority is to support Americans affected by mental illness’ opportunities to build better lives. NAMI advocates for an array of issues including:

- » Maintaining mental health parity laws and improving parity in practice
- » Protecting people’s access to treatment and services
- » Securing better funding for research

NAMI maintains an active presence in the U.S. Capitol on priority issues, driven by our board-directed NAMI Public Policy Platform and emerging issues. Our state organization, NAMI Washington, joined by 22 affiliates including NAMI Seattle, has a strong presence during legislative session advocating for statewide laws that improve the lives of people impacted by mental illness. Locally, NAMI

Seattle focuses on county and city level policy advocacy.

To learn about State-level issues and information on policy makers, visit the Washington State Legislative website at [leg.wa.gov](http://leg.wa.gov). For issues at the Federal level, use the website [www.congress.gov](http://www.congress.gov). To learn more about NAMI’s stance on public policy issues, from Medicaid to Parity to Mental Health reform, visit <https://www.nami.org/Advocacy/Policy-Priorities>.

Involvement in the political process—legislative action, policy-setting, and decision-making activities—is one of the most critical aspects of the advocacy movement. Although a relatively small amount of actual time is spent in the political arena, the impact of this effort is probably the most influential in effecting change.

Remember politicians represent you; your opinion counts. Policy makers need to see the reality of the impact of their actions or inaction that only

## SAM'S STORY

NAMI Day was my very first experience lobbying legislators directly. Nearly 200 NAMI members descended on the capitol in Olympia to make our voices heard. One of our banners read, "Everyone Knows Someone." For me, this message really strikes at the heart of our struggle: mental illness is common, it affects communities and families immensely, and we need to treat people who have mental illness with dignity, care, and humanity.

I had the opportunity to meet my state Representative, which though short, I felt made a deep impression. We had little time to communicate our concerns, and luckily the Representative was already well versed in the mental health issues we wanted to discuss. We advocated for better mental health funding and demanded repairs to the broken healthcare system in our state. She listened.

I approached the day with both awe and anxiety, but by the end I felt I had participated in something deeply meaningful and of incredible importance. I sincerely hope that more and more people will advocate for better mental healthcare and have the opportunity to be part of lobby day. Mental health affects all of us. Everyone knows someone.

a person experiencing it can bring. Your stories, your passion, and your insight are valuable to them, but they will never hear it unless you take action.

To get started, focus on one or two bills. Get to know the prime legislative sponsors, their aides, and others involved. Provide information in writing to these key people. Get copies of all related statutes on the same subject. Follow the bills through the various committees and be prepared to move into action at a moment's notice.

Positive and effective impact on the political decision-making process occurs when:

- » It's well-organized.
- » It's done by a group or coalition.
- » It's targeted and specific.
- » The timing is right.

Next to face-to-face contact with policy makers, a brief, personal letter or voicemail is probably the most effective tool. A few letters and calls to each legislator on a specific bill can help assure its passage or defeat. Social media (especially Twitter and Facebook) is also an

easily accessible tool for reaching politicians and affecting change.

When writing, identify the bill or issue. Since hundreds of bills are introduced each session, it is important to give the exact bill number or describe it by its popular title. (For example: Involuntary Treatment Act, House Bill 1290, “Becca” bill, or Initiative 601.)

Effective letters or emails should be short and to-the-point. Include reasons for taking a stand. Call for specific action, stating exactly what you want your legislator to support or oppose. Be timely and persistent. Keep up the momentum. Personal stories that directly relate to the issue are very powerful and can be the most effective tool citizen advocates have.

NAMI Seattle, NAMI Washington, and other advocacy organizations organize “lobby days” at the state and national level. If you are a NAMI member, you will receive action alerts for national and local legislation efforts that need your support. Stay involved with these organizations and participate in those events where like-minded advocates meet with policy makers on a select set of issues and work together as teams to influence policy makers and provide mutual support. When it’s all over, give the legislator

a pat on the back: write a thank-you note.

## **CONTACTING YOUR LEGISLATORS**

### **The President of the United States**

The White House  
1600 Pennsylvania Ave NW  
Washington, D.C. 20500  
(202) 456-1111  
whitehouse.gov

### **Governor of Washington**

Office of the Governor  
PO Box 40002  
Olympia, WA 98504  
(360) 902-4111  
governor.wa.gov

### **City of Seattle**

(206) 684-4000  
600 4th Ave, Seattle, WA  
7th Floor  
Seattle, WA 98104  
Seattle City Council: (206) 684-8888

### **King County Council**

<https://kingcounty.gov/council.aspx>

### **U.S. House Of Representatives Switchboard**

(202) 224-3121  
house.gov

### **WA State Legislative Hot Line**

(800) 562-6000 This toll-free number may be called during legislative sessions to get information and to leave messages.

Know your legislative district and the names of your senator and representatives. If you are a registered voter, your voter registration card contains your legislative district number and precinct numbers. Otherwise, this information can be obtained by calling your county auditor and asking for Voter Information or on the websites previously mentioned. Give your name, address, and zip code, and someone at the agency will provide you with the names of your elected officials and your legislative district number.

In King County the Voter Registration number is:

Voice: 206.296.8683

TTY: 206.296.0109

Online: [app.leg.wa.gov/districtfinder](http://app.leg.wa.gov/districtfinder)

### EVERYDAY ADVOCACY

Legislative advocacy isn't the only way to create change. Every day we are presented with opportunities to educate others about mental health conditions and change the way society views mental illness.

We can reduce stigma by sharing stories—research shows that the best way to reduce stigma is to get to know someone who lives with mental illness. Facts and figures do help, but without the personal story, we cannot really understand the experience of mental illness and what recovery looks like. Contact NAMI Seattle or your local NAMI affiliate to arrange a presentation at your workplace, classroom, church, or other community group!

### ALEX'S STORY

I describe my experience through depression as my “personal hell.” I believe everyone has one and I went through mine. I wouldn't wish what I went through on anyone. I now dedicate as much of my free time as possible to volunteer for a number of causes and non-profit organizations gaining experience, sharing my story and giving hope. NAMI has been a large part of that. Being able to go to schools and universities sharing my story has helped me tremendously in my recovery, along with the practice of mindfulness. I plan to one day become a School Psychologist and do the best that I can to make sure no child has to go through what I did and knows how to use mindfulness in their everyday lives.

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People with mental illness are less likely to receive standard levels of diabetes care and routine cancer screenings (Nasrallah et al, 2006; Xiong et al, 2008).

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**STIGMA IS A CLUSTER OF NEGATIVE ATTITUDES AND BELIEFS**

that motivate the general public to fear, reject, avoid, and discriminate against people, in this case, with mental illnesses. Due to internal or “self-stigma,” many people feel too ashamed or afraid to seek services.

**DISCRIMINATION IS THE REAL-LIFE CONSEQUENCE OF STIGMA**

because of stigma, many people face discrimination in housing, jobs, health care and social relationships.

**WE CAN REDUCE STIGMA BY SHARING STORIES**

Research shows that the best way to reduce stigma is to get to know someone who lives with mental illness. Facts and figures do help, but without the personal story, we cannot truly understand what recovery looks like. Contact your local NAMI to arrange a presentation for your workplace, faith community, classroom or other community group!

**TIPS TO FIGHT STIGMA IN YOUR DAILY LIFE**

**1. USE PERSON-FIRST LANGUAGE**

Rather than saying “John is schizophrenic,” say “John has schizophrenia.” This puts the PERSON before the illness.

**2. KEEP MENTAL HEALTH IN THE CONVERSATION!**

Saw an article about mental health? Share it on social media!  
Went to a NAMI event? Tell your friends and family!  
Hear a stigmatizing comment? Don’t let it slide!



## AISLIN'S STORY

I started out with only the desire to be more active as a NAMI volunteer. The Ending the Silence program was a chance to do that, in addition to serving a cause I am very passionate about: educating young people about mental illness. I knew my story, particularly developing mental illness at a very young age, could be valuable, but I truly never imagined I would be any good at sharing it!

I was so nervous the first time I presented. I was sure I would botch my story and ruin the whole presentation. I wrote out, practiced, and memorized my part(s). Any time I missed a single word, I would have to start over. I believed, at first, that the hardest part would be sharing something so personal with a crowd. Ironically, sharing my emotions and experiences gave me a sense of relief. These people now KNEW me, and they weren't disgusted or afraid. They didn't run away, but wrote feedback about how courageous and engaging I was! Ending the Silence, and speaking my story aloud, unleashed a passion in me for public speaking.

I really recommend being trained in NAMI speaking programs to anyone who wants to get involved in mental health advocacy and fighting stigma. I didn't know if I had it in me. I honestly have a great deal of unresolved negative emotional baggage surrounding parts of my story, resentment, fear, disappointment...but the sense of release that comes each time I tell my story has slowly relieved some of the burden. I am valuable; I have something to offer. It's such a validating experience.



# APPENDICES



# APPENDIX 1: GOVERNMENT BENEFITS

## **Government Benefits**

A formidable challenge affecting many people with mental illness is lack of health care and/or poverty. Due to the disabilities caused by mental illness, many people depend on government agencies, such as the State of Washington's Department of Social and Health Services (DSHS) or the Federal Government's Social Security Administration (SSA) to meet their basic needs. Mental health professionals, clients, advocates, and families all have important roles in accessing and keeping benefits, which can improve health outcomes and increase stability. The information below is a summary and guide only. Be sure to access additional information and current financial figures for anyone seeking to establish or retain their eligibility for government assistance.

In Washington State, once a decision is made that government assistance is needed, the process often begins with DSHS. This department is able to respond with assistance more quickly than the SSA. Application may be made in person at one of their many community services offices throughout the state (listing follows, or online at the DSHS website, [dshs.wa.gov](http://dshs.wa.gov)). The main financial assistance programs available through DSHS are:

### **The Aged, Blind or Disabled Program**

The Aged, Blind or Disabled program provides a monthly cash grant. Learn more: <https://www.dshs.wa.gov/esa/community-services-offices/aged-blind-or-disabled-abd-program>

### **Medicaid**

Medicaid is a comprehensive health insurance program for those with limited income. Applications to Medicaid can be made online, over the phone or through the mail through Washington Health Plan Finder. Learn more: [wahealthplanfinder.org/HBEWeb/Annon\\_DisplayHomePage.action](http://wahealthplanfinder.org/HBEWeb/Annon_DisplayHomePage.action)

### **Temporary Assistance for Needy Families (TANF)**

TANF provides limited assistance and requires active job searching or training. To be eligible, an adult must have one or more dependent children and have limited income and resources.

Those eligible for TANF may also qualify for the Diversion Cash Assistance program. Families who choose this program can get help with living

expenses when a family needs short term assistance and meets program requirements. Learn more: <https://www.dshs.wa.gov/esa/automated-client-eligibility-system-aces/temporary-assistance-needy-families-tanf>

### **Food Stamps**

Food stamps are funded by the Federal Government and administered by DSHS to assist those with limited income and resources for purchasing food. Learn more: <https://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program>

### **Social Security: SSI and SSDI**

The Social Security Administration (SSA) offers two very different financial assistance programs to those with disabilities: Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) programs. Both examine disability the same way. Applications may be made in person at one of their district offices throughout the state. Learn more: 800-772-1213, [ssa.gov](http://ssa.gov)

### **Disability as Defined by the SSA**

Disability is legally defined as an inability to engage in any substantial, gainful activity due to a medically determined physical or mental impairment that has lasted or is expected to last a minimum of 12 months.

The disability must be severe enough to rule out the performance of any significant and productive physical or mental work for pay or profit. The performance of any other kind of work must be ruled out based on the disability of the claimant.

To apply for Disability Benefits, visit [ssa.gov/disabilityssi/](http://ssa.gov/disabilityssi/) or call (800) 772-1213 or TTY (800) 325-0778 for the deaf or hard of hearing

The impairment must result from physical or psychological health difficulties that are identified by clinical and laboratory diagnostics. The impairment must be documented by signs, symptoms, and laboratory findings from a licensed physician, osteopath, certified psychologist, optometrist, or other individuals authorized to provide copies or summaries of medical records. Parents, guardians and other caregivers, schools, social service agencies, audiologists, and speech pathologists/therapists may provide supporting information.

## Disability for Children

Disability for children that must be met in all cases is as follows:

A physical or mental impairment that has lasted (or is expected to last) for at least one year or to result in death. The impairment results in marked and severe functional limitations.

The child's behavior and functional capacities—physical, mental, emotional, and social—are taken into account, and information about the following areas of functioning is needed:

- » Cognition/communication (all ages)
- » Motor (all ages)
- » Social (all ages)
- » Personal (all ages)
- » Concentration, persistence or pace (age 3 to age 18)
- » Responsiveness to stimuli (birth to age 1)

The SSA assesses the child's ability to perform daily activities. This is done by comparing the child's functioning to others of the same age who are not living with the same disability. Questions may include: "What activities is the child able or not able to perform?" "Which activities are performed, but are limited due to the disability?" "How can we help the child complete age-appropriate activities?"

To learn more about Disability Benefits for Children: <https://www.ssa.gov/pubs/EN-05-10026.pdf>

The disability definitions used by Social Security are more rigid than the definitions used by many private plans. Eligibility for private disability plans does not automatically make one eligible for disability benefits from Social Security. A diagnosis does not mean that someone necessarily is disabled. The definitions that Social Security uses include signs and symptoms of impairment and the resulting functional limitations.

Evaluating an adult includes signs and symptoms of limitations in activities of daily living; social functioning; concentration, persistence and pace; and deterioration in work or work-like settings. For more information on the Definition of Disability: <https://www.ssa.gov/benefits/disability/qualify.html>

Documentation is necessary to establish the presence of a mental disorder. Reports from individual providers, such as psychiatrists or psychologists

and facilities such as hospitals and clinics are necessary. Providers that work in psychiatric rehabilitation, supported housing, supported employment, day treatment, case management, or similar front-line service providers to adult consumers where there is frequent and prolonged contact are in a good position to comment on these functional limitations. Family members and consumers themselves are similarly well positioned to comment here.

Reports from providers are essential to the evaluation. The best letters provide a thorough clinical write-up and accurate descriptions of the functional limitations, and are signed by the treating physician and the non-physician most familiar with the consumer (e.g. primary therapist, case manager etc.).

Evaluation of functional limitations must take into account variations in it over time. Providers of community-based services that have frequent, prolonged, and tenured contact with applicants are vital sources of information. Work evaluation or psychiatric rehabilitation program progress notes are to be included wherever possible. Information about any attempts to work, either independently or through a provider, is particularly useful.

Symptoms may be controlled or lessened by placement in a hospital, a board and care facility, or another structured environment. These environments may greatly reduce the mental demands placed on the individual. However, the individual's ability to function outside of a supportive setting may not have changed. Social Security considers the effect that highly structured settings have on the ability to function. Medications can control many of the symptoms of a mental disorder, but attention must also be paid to functional restrictions. Side effects that contribute to functional limitations, such as hand tremors, psychomotor agitation, learning impairments, or blurred vision must be considered in evaluating overall impairment.

### **The Essential Features of SSI**

Supplemental Security Income (SSI) is a program that makes payments to aged, blind, and disabled people (including children under age 18). As a need-based program, the claimant must meet the means test in addition to being medically disabled, aged, or blind. The means test examines three areas: income, resources, and living arrangements. In this process, the law recognizes that part of the parents' income and resources normally are used to support children. Not all resources count toward the SSI resource limit.

Payment amounts are set by the state. The federal government funds SSI from general tax revenues. Individual states choose how much, if any, additional dollars to add to the standard federal benefit level. The standard payment amount for an eligible couple in Washington with no other income is the federal benefit level. SSI benefits are paid retroactive to the date of application.

An SSI recipient in Washington is co-entitled to Medicaid retroactive to the date of application.

To learn more about SSI: [ssa.gov/onlineservices/](http://ssa.gov/onlineservices/)

### **Application Sequence**

Applying for disability benefits can be a daunting process, and many people are denied the first time and have to file an appeal. If you are planning to apply for disability, consider hiring a disability attorney to assist you.

Applications may be started in person, online, or by phone. A variety of forms and releases are then sent to the applicant to complete and sign. This is often where providers and other advocates can help. Providers, family members, and other advocates may have personal knowledge or access to medical or service records that may prove to be helpful. Advocates recommend developing a “resume” of sorts that details work history, lists providers of treatment or rehabilitation both inpatient and outpatient. Other items include past and present living situations, past and present social activities, activities of daily living and others. It is important to list how the person worked, their health, their living situation, their daily functioning, and their activities in the past, prior to disability.

Contrasting the functioning then and now is an effective way to meet the disability definition. The advantage of the “resume” is that it is done well beforehand, lessening reliance on memory. When the application call is placed or when the forms come, both the advocate and the consumer are ready to respond in a meaningful and comprehensive way. The greater the detail that can be provided the better the chances of an affirmative decision earlier in the process.

After the application is taken and all forms signed, the file is shipped to the appropriate state agency. In Washington, this is the Disability Determination Services (DDS). DDS is part of the Medical Assistance Administration in



DSHS. DDS then develops the file. Medical records are requested from the providers listed and the state agency applies the disability definitions from the listing of impairments. In some cases, a consultative examination with a doctor will be scheduled in order to provide more medical information.

For details on Disability Determination Services (DDS):  
[dshs.wa.gov/esa/disability-determination-services](https://dshs.wa.gov/esa/disability-determination-services)

A letter written by a provider and cosigned by the treating physician can help in get the claim approved more quickly. This should be requested of the primary provider of mental health services.

When the claim is denied, which most often is the case even for someone who has a disability, a form letter is sent detailing the denial and appeal procedures.

The first level of appeal is known as Reconsideration. This is appropriate as this is exactly what is being asked of SSA: to reconsider its decision to deny benefits. Certain papers must be sent; the SSA then notifies the state agency to review the case again. A different team does so.

There will be an attachment to the denial notice. This details what medical and other records were considered and why state agency denied the disability claim. This provides advocates with an inventory to compare to the “resume” and the original application materials. Check whether most of the medical sources listed were contacted and their records obtained and used in the initial decision. If key pieces of medical records are missing, this is probably why the claim was denied. Help may very likely be needed to ensure that these records are present during the appeal. If the primary provider's own medical records were missing, ask: Was a request received? Was it responded to, or is it sitting in an in box? This makes sure that more records get considered during the appeal.

In spite of best efforts here, the claim often gets denied again. A similar form letter is sent and, with it, another rationale sheet detailing the records considered and the rationale for denying the claim. Read the rationale sheet carefully; it contains valuable information.

Once this process reaches a hearing, a favorable decision is more likely because this is the first time that the decision-makers will actually see the

person applying. The hearing is informal with questions asked by the judge and by the person's representative. These questions focus on the areas of the disability listing that you are trying to prove. Most have an attorney to represent them in a hearing. Non-attorneys can be very effective and capable advocates for their clients, and the SSA permits this. After the hearing, a detailed, written decision is issued by the ALJ, that covers all of the testimony given, all of the medical records—essentially everything.

If the claim is denied again, the next level of appeal is to request review by the Appeals Council. This is the final administrative appeal. The Appeals Council reviews and acts on ALJ decisions, or creates its own motion. Appeals Council members also recommend action concerning decisions appealed to the courts. The Appeals Council will almost always accept a case for review if it can be established that the ALJ abused his/her/their authority or neglected to consider an important piece of testimony or a medical record.

Should the Appeals Council decline to review the case, the next level of appeal is to file an action in Federal District Court (FDC).

If the FDC denies the claim, the next level of appeal is to the U.S. Court of Appeals.

The final level of appeal is the U.S. Supreme Court, which will only hear cases that involve constitutional law issues.

### **Work Incentives Applicable to Both SSDI and SSI** *Impairment-Related Work Expenses*

If someone getting ready to work purchases certain items and services; they are not counted in SSDI earnings. These are also deducted before earnings are evaluated. Adjusting the SSI check may now include out-of-pocket expenses for medications, therapy, doctor visits, lab work; expenses for a “job coach” if in a supported employment program; fees or co-pays to attend an outpatient clinic or other program; mileage expenses for an approved vehicle; and limited to travel related to employment etc. In both cases, the amount of earnings considered by SSA are decreased. This always works to the advantage of the client.

## **Work Incentives for SSDI**

### *Trial Work Period*

The client has nine months to work and receive full benefits, no matter how much is earned. The nine months do not need to be in a row. When there are nine such months within a 60-month rolling period, Social Security will review the work. If this is the case, benefits continue for a “grace period” of three more months. If the work and its earnings are below the SGA level, SSDI benefits continue.

### *Extended Period of Eligibility*

This reinstatement period lasts for 36 consecutive months following the end of the trial work period. The beneficiary must continue to have a disabling impairment in addition to having earnings below the SGA level for that month.

### *Continuation of Medicare Coverage*

Most people with disabilities who work will continue to receive hospital and medical insurance under Medicare. The beneficiary pays no premium for hospital insurance. Although cash benefits may cease due to work, the beneficiary has the assurance of continued health insurance. Hospital insurance (Part A) may be purchased at the same monthly cost that uninsured eligible retired beneficiaries pay, and medical insurance (Part B) may be purchased at the same monthly cost that uninsured eligible retired beneficiaries pay. It is permissible to buy hospital insurance (Part A) separately without medical insurance (part B). However, you can buy medical insurance (Part B) only if you also buy hospital insurance (Part A).

For more information on Medicare & Social Security, including steps for application: <https://www.ssa.gov/benefits/medicare/>

Some people with low incomes and limited resources may be eligible for state assistance with the costs of buying health insurance. In Washington, this assistance is known as Healthcare for Workers with Disabilities (HWD). This program recognizes the employment potential of people with disabilities, and represents Washington State’s response to the Ticket to Work legislation passed by Congress in 1999. Under HWD, people with disabilities can earn more money and purchase healthcare coverage for an amount based on a sliding income scale. HWD benefits include a Medicaid

benefit package and greater personal and financial independence, and enrollees earn and save more without the risk of losing healthcare coverage.

For more information on Healthcare for Workers with Disabilities (HWD): <https://www.dshs.wa.gov/esa/medical/healthcare-workers-disabilities-hwd-s08>

### **Work Incentives for SSI**

#### *Earned Income Exclusion*

Most of a client's income, including pay received in a sheltered workshop or work activities center, can be excluded when figuring the SSI payment amount.

#### *Student Earned Income Exclusion*

A beneficiary under the age of 22 and regularly attending school may exclude some earned income per month, with a maximum exclusion.

#### *Blind Work Expenses*

This provision provides that any earned income that a blind beneficiary uses to meet expenses needed to earn that income, is not counted in determining SSI eligibility and the payment amount if the beneficiary is under age 65, or age 65 or older, and received SSI due to blindness for the month before they attained having turned 65.

#### *Plan for Achieving Self-Support (PASS):*

A beneficiary is allowed to set aside income and/or resources for a specified period of time for a work goal. For example, a person may set aside money for an education, vocational training or starting a business. Any income or resources set aside is excluded under the SSI income and resources test. An individualized plan is required and must be approved by Social Security.

For more information on PASS: [ssa.gov/disabilityresearch/wi/pass.htm](https://ssa.gov/disabilityresearch/wi/pass.htm)

#### *Property Essential to Self-Support*

This provision allows a beneficiary to exclude certain resources (e.g., property used in a business or trade), that are essential to the person's means of self-support.

### *Section 1619 Work Incentives*

Section 1619a allows beneficiaries to receive cash payments even when earned income exceeds the substantial gainful activity level. All other eligibility conditions must be met. Section 1619b allows continued Medicaid coverage for most working beneficiaries when their earnings become too high to allow an SSI cash payment.

For more information on Section 1619b:  
[ssa.gov/disabilityresearch/wi/1619b.htm](http://ssa.gov/disabilityresearch/wi/1619b.htm)

### *Ticket to Work*

The Ticket to Work and Work Incentives Improvement Act of 1999 increases the beneficiary's choices in obtaining rehabilitation and vocational services to help them work and attain their employment goals; removes barriers that require people with disabilities to choose between healthcare coverage and work; and ensures that more Americans with disabilities have the opportunity to participate in the workforce and lessen their dependence on public benefits. The law is intended to give people who receive Social Security benefits the services and support they need to go to work.

Most Social Security and Supplemental Security Income (SSI) disability beneficiaries will receive a “ticket” they may use to obtain vocational rehabilitation, employment, or other support services from an approved provider of their choice to help them go to work and achieve their employment goals. A ticket is a voucher that can be turned in to an “employment network” to receive services. An employment network can be a public program, like the Division of Vocational Rehabilitation (DVR), or a nonprofit corporation or private business that has been approved to help provide the services and support needed to go to work. 18 to 64 year olds who are receiving SSI or SSDI cash benefits are eligible to receive a ticket.

The program is voluntary. Tickets can be used upon receipt, saved for future use or not used at all. Benefits will not be lost if the ticket is not used. The goal is for people to turn their tickets in to DVR or another employment network in exchange for services and supports that will help them go to work. The Ticket to Work program is voluntary.

For more information on Ticket to Work: [ssa.gov/work/](http://ssa.gov/work/)

### *Overpayments*

These are created when SSA alleges that a beneficiary was paid benefits and was not eligible for them. This happens more often with those on SSI because of its status as a “welfare” program. All recipients must sign a statement at application for benefits that they will report changes in their income, living arrangement, resources, or if they start or stop a job. So, one can never claim that they did not know that one had to report such information. The most frequent overpayments are caused by beneficiaries who find employment and fail to notify SSA. The short-term gain of full benefits and wages is not worth the eventual discovery of this, subsequent non-eligibility for benefits, recovery of the overpayment through withholding of funds from monthly checks, and hardship. By being proactive and vigilant in this area consumers can sustain their full eligibility even after they start working.

Sometimes, SSA is the cause of the overpayment by continuing to pay beneficiaries after notification of an event that should have resulted in a reduction in the monthly cash benefit. An overpayment may be waived if the beneficiary shows that they were not at fault in causing the overpayment. Beneficiaries must be able to show that they would experience hardship if SSA were to recover the overpayment.

Most supported employment programs send two copies of notification to SSA when someone starts working—one is retained by SSA, with the other returned bearing a stamp by SSA acknowledging receipt. This is all the documentation a beneficiary needs if at some subsequent date SSA alleges that the beneficiary never notified them of starting work. “At fault” is only established with clear and compelling evidence.

If the alleged overpayment did not occur, request reconsideration. If the beneficiary agrees that the overpayment took place but believes that they were not at fault and that the proposed repayment would constitute hardship, then a waiver of the overpayment should be requested, using the Request for Waiver of Overpayment Recovery or Change in Repayment Rate form. The form helps establish the case regarding the two criteria of “at fault” and “hardship” for SSA to consider. SSA then renders a written Notice of Decision to the beneficiary, who can appeal it if denied. If a Waiver Request is submitted within 10 days of receipt of a notice of overpayment, SSA must continue benefits at the current level while the matter is under

review. The same sequence of appeal applies as discussed above and applies to appealing any unfavorable Notice of Decision. This same form is utilized to renegotiate the recovery of the overpayment with SSA. Sometimes SSA wants to recover an overpayment by withholding a monthly amount from the beneficiary's check when the beneficiary's overall budget is considered. The form can be used to suggest an alternative and reduced figure.

### *Continuing Disability Reviews*

These are scheduled for all SSDI and SSI beneficiaries who have disabilities that are viewed as “subject to improvement.” Such reviews center on whether or not a beneficiary continues to be disabled as defined by SSA. A disability is an inability to engage in substantial gainful activity due to a mental health condition that has lasted, or is expected to last, at least 12 months.

List all places where treatment has been sought or received since the date of the last review. What is going on vocationally? Jobs started? Reasons for leaving? What's happening in the activities of the daily living area? Are things overall better, the same, or worse? Medical records will be obtained, letters written by doctors, and information provided by the consumer on a form.

The state agency will obtain the records and compare the condition to the disability definition. SSA then generates a Notice of Decision to the beneficiary with the same appeal sequence. Should a beneficiary disagree with the Notice of Decision, it should be appealed so that benefits will continue at the current level until the dispute is resolved.

Social Security makes a number of publications available that can be very helpful. The Social Security Red Book is a reference for SSDI, SSI, and work incentives updated annually and available online at <https://www.ssa.gov/redbook/index.html> or through the Social Security district office in your community. Staff can provide help in getting and keeping things straight regarding a consumer's benefits. They can also provide the Red Book and other helpful publications, verify earnings reports, and acknowledge start and stop letters on a consumer's work.

Consumers and their advocates should try to do business over the toll-free number first, wherever possible. If staff at the toll-free number cannot help,

they will refer to the local district office. The toll-free number can handle most routine matters. Use it and document the contact, especially the name of the person you talked to and the date and time. Keeping a file of all contacts, written or otherwise, with SSA.

### **Supplemental Security Income Facts**

For more information on Supplemental Security Income (SSI):  
[ssa.gov/ssi/](http://ssa.gov/ssi/)

Not everyone gets the same amount. You may get more if you live in a state that adds money to the federal SSI payment. Or you may get less if you or your family has other income. Where and with whom you live can determine if you qualify for SSI and make a difference in the amount of your SSI payment.

### **How do you qualify?**

#### *Income*

Your income includes the money you earn, your Social Security benefits, your pensions, and the value of items you get from someone else, such as food, clothing, and shelter. Where you live affects the amount of income you can have each month and still get SSI. Different states have different rules.

#### *Ownership*

SSA does not count everything you own when it decides if you can get SSI. It does not count your home, and it usually does not count your car. It does count cash, bank accounts, and stocks and bonds.

#### *U.S. Residency*

You must live in the United States or Northern Mariana Islands to get SSI. If you are not a U.S. citizen, but are a resident, you still may be able to get SSI. If you are a fugitive, felon, or probation or parole violator, you cannot get SSI for any months in which there is an outstanding warrant for you.

For more information on qualifying for SSI, visit:  
[ssabest.benefits.gov/](http://ssabest.benefits.gov/)

#### *Other Benefits*

To get SSI, you also must apply for any other cash benefits you may be able to get. If you get SSI, you usually can get food stamps and Medicaid too.



Medicaid helps pay doctor and hospital bills, and food stamps help pay for food.

### **How do you apply for SSI?**

#### *Contacting Social Security*

For more information and to find copies of its publications, visit [socialsecurity.gov](http://socialsecurity.gov) or call (800) 772-1213. SSA can answer specific questions and provide information by automated phone service 24 hours a day. All calls are confidential. SSA wants to make sure you receive accurate and courteous service. A second Social Security representative may monitor some telephone calls.

#### *Self-Help Advocacy Tools for Benefits Recipients*

*Information:* For more specific information, contact your Social Security or Community Services Office.

*Appeal:* If you are dissatisfied with the decision on your benefits application, request a fair hearing as soon as possible. The time limit should be stated on the written notice of your eligibility. If you need additional help contact a Welfare Rights Family or Consumer Advocacy Group, or a local Ombudsman Office. Getting an attorney frequently assures success. State Welfare agencies are listed in local phone books.

### **Hints for Applying for Assistance**

- » Go to the benefits office in pairs! You are permitted to bring anyone you wish to an interview.
- » Ask to see your file. You have the right to see it upon request.
- » Keep a record of all conversations with your caseworker or any other staff or key people. Include names and dates. Always remember to ask the name of the person with whom you are speaking.
- » Always keep every document you receive regarding your application or benefits.
- » Request a copy of the regulation that justifies a department decision. You have the right to read Manual “A” (state regulations) and Manual “F” (local procedures). These can prove especially helpful if your grant is being reduced or terminated.
- » Ask to speak to the supervisor or office administrator if you feel you have been treated rudely or unfairly.
- » If you are in an emergency situation (in danger of eviction, utility turn-off, or if you are without food or money), tell the receptionist that you want Expedited Service.

- » File for a fair hearing if you think that your grant has been wrongly denied, reduced, or terminated.
- » Request everything in writing. No department decision is valid until it is in writing.

### **THE AMERICANS WITH DISABILITIES ACT (ADA)**

The U.S. Equal Employment Opportunity Commission (EEOC) defines “Americans with Disabilities Act” (ADA) as “an act to establish a clear and comprehensive prohibition of discrimination on the basis of disability.” With its passage, services and employment opportunities were opened up to the more than 43 million Americans with disabilities.

Title I of the ADA prohibits employers from discriminating against those applicants and employees who are or who may become disabled.

## APPENDIX 2: THE ADA

Title II prevents state and local governments from discriminating against those with disabilities in their provision of programs and activities and provides requirements for structural accessibility for public entities.

Title III prohibits private enterprises, such as restaurants, hotels, stores, health care facilities, public transportation, etc. from denying services or goods to people due to their disability and provides requirements for structural accessibility for private entities.

Title IV mandates that telecommunications devices and services are available for the hearing and speech impaired.

Title V describes the ADA's relationship to other laws, explains insurance issues, prohibits state immunity, provides congressional inclusion, sets regulations by the Architecture and Transportation Barriers Compliance Board (TBCB), explains implementation of each title, and notes amendments to the Rehabilitation Act of 1973.

A person has a disability if they:

1. Have a physical or mental impairment that substantially limits one or more major life activities
2. Have a record of such an impairment (for example, is in recovery from a mental illness)
3. Are regarded as having such an impairment.

Major life activities include learning, thinking, concentrating, interacting with others, caring for oneself, speaking, performing manual tasks, working, or sleeping. Mental impairments under the ADA include major depressive disorder, bipolar disorder, anxiety disorders, schizophrenia, and personality disorders. An individual who is taking medication for a mental impairment has an ADA disability if there is evidence that the mental impairment, when left untreated by medication, substantially limits a major life activity. Chronic, episodic conditions may constitute substantially limiting impairments if they are substantially limiting when active or have a high likelihood of recurrence in substantially limiting forms.

The EEOC published EEOC Enforcement Guidance on the Americans with Disabilities Act and Psychiatric Disabilities in March 1997. Among the highlights are:

1. Employers are prohibited from asking disability-related questions before making an offer of employment. An exception is if an applicant asks for reasonable accommodation during the hiring process. If the need for accommodation is not obvious, an employer may ask an applicant for reasonable documentation about their disability.
2. Employers may condition a job offer on the satisfactory result of a post-offer medical examination or medical inquiry if this is required of all entering employees in the same job category.
3. Employers may not ask questions that are likely to elicit information about a disability before making an offer of employment.
4. Employers are required to keep all medical information confidential, including psychiatric information.
5. Employers must provide reasonable accommodations to those applicants or employees who have a mental disability. These accommodations can be considered after the disabled employee or their representative makes the request to the employer. Requests for reasonable accommodations can be oral, in writing, or any other mode of communication and can be made at any time during the hiring process or at any time during the period of employment. Employers must provide these accommodations only if they do not cause “undue hardship” to the employer. The Department of Justice defines undue hardship as “action requiring significant difficulty or expense when considered in light of a number of factors, including the nature and cost of the accommodation in relation to the size, resources, nature, and structure of the employer’s operation.” Reasonable accommodations for those with psychiatric disabilities are made on a case-by-case basis and include but are not limited to:
  - a. Modification of work schedule. Use of accrued paid leave or providing additional unpaid leave for treatment or recovery related to a psychiatric

disability unless employee's absence would impose an undue hardship in the operation of the business. This includes leaves of absence, occasional leave (a few hours at a time), or part-time scheduling.

b. Change in regularly scheduled working hours. For example, allowing the disabled person to work from 10am to 6pm rather than 9am to 5pm due to medications that might cause grogginess and lack of concentration earlier in the day.

c. Physical accommodations. For those who have difficulty with concentration, providing room dividers, partitions, or other soundproofing; providing visual barriers between workspaces; moving employee away from noisy machinery; or permitting an individual to wear headphones to block out noisy distractions.

d. Modification of workplace policies. Examples: (1) A retail employer does not allow employees working as cashiers to drink beverages at checkout stations. The employer also limits cashiers to two 15-minute breaks during an eight-hour shift. Change the policy so that an individual with a psychiatric disability may drink a beverage approximately once an hour in order to combat dry mouth, a side effect of a psychiatric medication. (2) Granting an employee time off work or an adjusted work schedule may require modifying leave or attendance policies.

e. Adjusting supervisory methods. Example: adjusting a supervisor's method of communicating assignments, instructions, or training to one that is most effective for a disabled individual.

f. Provision of a job coach to assist in training or guiding the performance of an individual with a disability.

g. Reassignment when the employer and employee voluntarily agree to this change.

To file a charge of employment discrimination based on disability in the State of Washington, you may contact the Seattle Field Office of the Equal Employment Opportunity Commission:

Federal Office Building

909 First Ave, Ste. 400

Seattle, WA 98104

800.669.4000

ASL Video Phone: 844.234.5122

TTY: .800.669.6820

The Seattle Field Office of the EEOC also allows online requests and inquiries at <https://www.eeoc.gov/field-office/seattle/location>.

### FILING A PETITION FOR INITIAL INVOLUNTARY DETENTION IN WASHINGTON STATE: JOEL'S LAW

#### **What Is Joel's Law?**

On July 24, 2015, a new section of Washington State's involuntary mental health treatment law, Chapter 71.05 Revised Code of Washington (RCW), called Joel's Law, went into effect. It allows for an immediate family member, legal guardian or conservator to petition the superior court for initial detention of someone with mental illness who poses a threat to herself or others.

#### **When Should I file a Joel's Law Petition?**

*A Joel's Law Petition can be filed when:*

- » You are an immediate family member, legal guardian or conservator of the person that you seek to have detained. The law defines "immediate family member" as a spouse, domestic partner, child, stepchild, parent, stepparent, grandparent or sibling.
- » A Designated Mental Health Professional (DMHP) has conducted an investigation and decided not to detain that person for evaluation and treatment.
- » It has been 48 hours since the DMHP received a request for investigation, and the DMHP has not taken action to have the person detained.

#### *Petitioning the Court under Joel's Law*

1. Go to your county's Superior Court and ask the clerk for a Joel's Law Petition for Initial Detention. The petition requires the following:

- » A description of the relationship between you and the person you are seeking to have detained.
- » The date the investigation was requested from the DMHP. In the petition, the person you are seeking to have detained will be called the "Respondent."

2. Complete a written and sworn declaration in support of your petition that describes why the person should be detained. You may describe past behavior, including a history of one or more violent acts, such as behavior that resulted in death, attempted suicide, nonfatal injuries or substantial damage to property. You may also list prior commitments or determinations of incompetency or insanity.

### **Your declaration must include:**

- » Your certification that the statement is true, under penalty of perjury and under the laws of the state of Washington.
- » Your signature.
- » The date, city and state.

You may also provide written and sworn declarations prepared and signed by family members, landlords, neighbors or anyone else with significant contact and a history of involvement with the Respondent. Their declarations must include the same content listed above for your declaration.

3. File your petition and any written and sworn declarations with the clerk of the superior court in the county where the DMHP is located who decided not to detain the person, or did not take action to have the person detained within 48 hours. [Click here](#) for a list of county Superior Court offices.

*Note: If a DMHP files a petition for the initial detention of the person you are seeking to have detained, the court will dismiss your petition. The petition filed by the DMHP will move forward.*

### **What Happens After I File?**

1. A judge or court commissioner will review your petition within one judicial day (a day the court is open) from the date you filed it. The judge or court commissioner will decide whether your petition has sufficient evidence to support your request. If the judge or court commissioner does not find sufficient evidence exists, your petition will be dismissed.
2. If the judge or court commissioner finds that sufficient evidence exists, a copy of your petition will be sent to the DMHP agency. That agency must file with the court – within one judicial day – a written and sworn statement describing their decision not to seek the initial detention. The agency must also provide a copy of all information that supports their decision.
3. After you have filed your petition, and before the judge or court commissioner makes a decision, anyone may file with the court a written and sworn declaration that either supports or opposes your petition.
4. After reviewing all of the information provided to the court, the judge or court commissioner will issue a final decision on your petition, no later than



five judicial days from the day you filed it. That judge or court commissioner may enter an order for initial detention if:

- » There is probable cause to support the person's detention and
- » the person has refused to voluntarily accept the appropriate evaluation and treatment. You will receive a copy of the court's final decision on your Joel's Law Petition.

**What Happens After the Court Orders a Detention?**

- » The court must provide the order to the DMHP agency.
- » That agency must execute the order without delay, and the order remains valid for 180 days from the date the judge or court commissioner enters it.
- » The order will provide for the initial detention of the person to a designated evaluation and treatment facility, which will not last longer than 120 hours.
- » During the 120-hour period, the evaluation and treatment facility may decide to discharge the person, or the person may voluntarily agree to remain in the facility (or a less-restrictive alternative, such as outpatient treatment), under a court order.
- » If a facility wishes to hold the person beyond the 120-hour period, the person will be entitled to a hearing before a judge or court commissioner.
- » At that hearing, the judge or court commissioner will decide whether to dismiss the petition, order a less-restrictive alternative, or commit the person for up to 14 days of additional inpatient treatment.

## CRISIS PLAN APPOINTMENT PREP SHEET

# CRISIS PLAN

**COUNTY CRISIS LINE** phone number: \_\_\_\_\_

**FAMILY** members you want involved:

**NAME**

**PHONE**

\_\_\_\_\_  
\_\_\_\_\_

**FRIENDS** or other supporters you want involved:

**NAME**

**PHONE**

\_\_\_\_\_  
\_\_\_\_\_

**PROVIDERS** you want involved — doctor, therapist, case manager, etc.

**NAME**

**PHONE**

\_\_\_\_\_  
\_\_\_\_\_

**WARNING SIGNS:** how can family and friends tell when a crisis is developing/could develop?

\_\_\_\_\_  
\_\_\_\_\_

**HELPFUL THINGS PEOPLE CAN SAY**

\_\_\_\_\_  
\_\_\_\_\_

**THINGS PEOPLE SHOULD NOT BRING UP**

\_\_\_\_\_  
\_\_\_\_\_

**HOW PROVIDERS CAN HELP** (Explain things clearly, talk slowly, observe personal space, etc.)

\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL INFORMATION:** other health problems, current medications, allergies

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



# APPOINTMENT PREP SHEET



## #1 ISSUE OR QUESTION

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## NOTES ON DOCTOR'S RESPONSE

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## #2 ISSUE OR QUESTION

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## NOTES ON DOCTOR'S RESPONSE

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## #3 ISSUE OR QUESTION

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## NOTES ON DOCTOR'S RESPONSE

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## QUESTIONS FOR NEXT TIME:

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## APPENDIX 5: RESOURCES IN PUGET SOUND & BEYOND

### WASHINGTON STATE COMPREHENSIVE INFORMATION AND REFERRAL

**Phone: 211    [www.211.org](http://www.211.org)**

Specialized help lines, like the Mental Health Help Line operated by NAMI Seattle (800.782.9264), work with other phone lines, providing specific information and consultation through a line's area of expertise. This is another help line staffed by the Department of Information Services for state-wide services that are funded by the Department of Social and Health Services (DSHS).

### CRISIS RESOURCES

**King County Crisis Line**  
**206.461.3222**

Crisis Clinic offers telephone-based emotional support to those in crisis or considering suicide through their 24-Hour Crisis Line.

**King County Crisis and Commitment Services**  
**206.263.9200**

<https://kingcounty.gov/depts/community-human-services/mental-health-substance-abuse/services/crisis-services.aspx> (more direct King County Crisis and commitment Services provide evaluations for possible involuntary treatment of people with mental health conditions).

**Seattle Police Crisis Intervention Team: 206.625.5011 or 911**  
<https://www.seattle.gov/police/about-us/crisis-response-team>

### BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATIONS (BH-ASOS) CRISIS LINES BY COUNTY

Adams County–Spokane County BHO-ASO: 1.877.266.1818  
Asotin Count–Greater Columbia BHO-ASO: 1.888.544.9986  
Benton Count–Greater Columbia BHO-ASO: 1.888.544.9986  
Chelan Count–Beacon Health Options BHO-ASO: 1.800.852.2923  
Clallam Count–Salish BHO-ASO: 1.888.910.0416  
Columbia Count–Greater Columbia BHO-ASO: 1.888.544.9986

Cowlitz Count– Great Rivers BHO-ASO: 1.800.803.8833  
Douglas Count–Beacon Health Options: 1.800.852.2923  
Ferry Count–Spokane County BHO-ASO: 1.877.266.1818  
Franklin Count–Greater Columbia BHO-ASO: 1.888.544.9986  
Garfield Count–Greater Columbia BHO-ASO: 1.888.544.9986  
Grant Count–Beacon Health Options: 1.800.852.2923  
Grays Harbor Count–Great Rivers BHO-ASO: 1.800.803.8833  
Island Count–North Sound BHO-ASO: 1.800.584.3578  
Jefferson Count–Salish BHO-ASO: 1.888.910.0416  
King Count–King County BHO-ASO: 1.866.427.4747  
Kitsap Count–Salish BHO-ASO: 1.888.910.0416  
Kittitas Count–Greater Columbia BHO-ASO: 1.888.544.9986  
Klickitat Count–Greater Columbia Beacon Health Options: 1.800.626.8137  
Lewis Count–Great Rivers BHO-ASO: 1.800.803.8833  
Lincoln Count–Spokane County BHO-ASO: 1.877.266.1818  
Mason Count–Thurston.Mason BHO-ASO: 1.800.270.0041 or 1.360.754.1338  
Okanogan Count–Beacon Health Options: 1.800.852.2923  
Pacific Count–Great Rivers BHO-ASO: 1.800.803.8833  
Pend Oreille Count–Spokane County BHO-ASO: 1.877.266.1818  
Pierce Count–Beacon Health Options: 1.800.576.7764  
San Juan Count–North Sound BHO-ASO: 1.800.584.3578  
Skagit Count–North Sound BHO-ASO: 1.800.584.3578  
Snohomish Count–North Sound BHO-ASO: 1.800.584.3578  
Spokane Count–Spokane County BHO-ASO: 1.877.266.1818  
Stevens Count–Spokane County BHO-ASO: 1.877.266.1818  
Thurston Count–Thurston.Mason BHO-ASO: 1.800.270.0041 or 1.360.754.1338  
Wahkiakum Count–Great Rivers BHO-ASO: 1.800.803.8833  
Walla Walla Count–Greater Columbia BHO-ASO: 1.888.544.9986  
Whatcom Count–North Sound BHO-ASO: 1.800.584.3578  
Whitman Count–Greater Columbia BHO-ASO: 1.888.544.9986  
Yakima Count–Greater Columbia BHO-ASO: 1.888.544.9986

## LEGAL RESOURCES

### **King County Bar Association**

1200 5th Ave, Suite 700,  
Seattle, WA 98101  
206.267.7100

King County Bar Association provides legal assistance (including pro bono), lawyer referral services, and information about legal matters in King County.

## **CLEAR (Coordinated Legal Education, Advice and Referral)**

Outside of King County: 1.888.201.1014

In King County: Call 211

CLEAR is a legal referral hotline offered by Northwest Justice Project for low income individuals.

## **Neighborhood Legal Clinics**

206.267.7070

<https://www.kcba.org/For-the-Public/Free-Legal-Assistance/Neighborhood-Legal-Clinics>

Neighborhood legal clinics provide free 30 minute consultations with lawyers at multiple locations across King County. Call the number above to make an appointment.

## **Benefits Law Center**

1404 E Yesler Way

Suite 203

Seattle, WA98122

206.686.7252

Email: [info@benefitslawcenter.org](mailto:info@benefitslawcenter.org)

Seattle Community Law Center provides legal counsel for applying for SSI and SSDI as well as appeals and denials of benefits.

## **HOUSING RESOURCES**

### **Low Income Housing Institute**

1253 S Jackson St. Suite A

Seattle, WA 98144

<https://lihi.org/>

Low Income Housing Institute (LIHI) owns and/or manages low income housing units in six counties throughout the Puget Sound region.

### **Seattle Housing Authority**

190 Queen Anne Ave N

Seattle, Washington 98109-1028

206.615.3300

<https://seattlehousing.org/>

Seattle Housing Authority provides long-term rental housing and rental assistance to more than 26,000 people in the city of Seattle. The agency owns and operates buildings of all shapes and sizes on more than 400 sites throughout the city.

### **King County Housing Authority (KCHA)**

600 Andover Park W  
Tukwila, WA 98188  
206.574.1100

The King County (WA) Housing Authority provides affordable housing to people in King County. KCHA owns and manages almost 3,500 units of subsidized housing for families, the elderly, and people with disabilities.

### **Compass Housing Alliance**

77 S. Washington St., 5th Floor  
Seattle, WA 98104  
206.474.1000

Compass Housing Alliance provides housing programs at 23 locations throughout the Puget Sound region. Services include emergency shelter, housing, and support services for men, women, veterans, and families.

### **Sound Health (CPC and Sound Health Combined)**

11000 Lake City Way NE,  
Seattle, WA 98125  
206.901.2000

CPC is a community mental health organization in King County that provides housing and case management services to individuals with mental illness. CPC's housing programs include Shelter Plus Care, Standard Supportive Housing, and the Cluster Housing Program.

### **Transitional Resources**

2970 SW Avalon Way  
Seattle, WA 98126  
Phone: 206.883.2051, TDD: 206.461.3651  
info@transitionalresources.org  
<http://www.transitionalresources.org/>

Transitional Resources' mission is building better health, stable housing, and a community of support for people living with mental illness.



## **Valley Cities Behavioral Health Care**

253.833.7444

Valley Cities is a community mental health organization in King County that provides housing and case management services to individuals with mental illness.

The Downtown Emergency Service Center (DESC) works to end the homelessness of vulnerable people, particularly those living with serious mental or addictive illnesses. Through partnerships and an integrated array of comprehensive services, treatment and housing, DESC gives people the opportunity to reach their highest potential.

## **Community House Mental Health Agency**

2212 S. Jackson St.

Seattle, WA 98144

206.322.2387

<https://chmha.org/>

Community House provides housing to several hundred individuals in the King County area. Housing opportunities include cluster housing, independent apartments, supervised living, and licensed group boarding homes.

## **The Inn Shelter**

1911 Aurora Avenue North

Seattle, WA 98109

206.283.6070

<https://ccsww.org/get-help/shelter-homeless-services/the-inn/>

The Inn Shelter not only houses homeless people temporarily, but allows qualified applicants to save money for permanent housing while learning skills to acquire better jobs. The Inn Shelter helps people by letting them help themselves and others.

## **EMPLOYMENT**

### **King County Behavioral Health Supported Employment Network**

401 5th Ave, Suite 500

Seattle, WA 98104

SE Manager: Lisa Floyd

[lisa.floyd@kingcounty.gov](mailto:lisa.floyd@kingcounty.gov), 206.263.8959

Supported employment is the placement of individuals with mental illness in competitive employment with ongoing support. This practice integrates individuals with disabilities with nondisabled people as much as possible.

### **WorkSource Downtown Seattle**

YWCA

2024 3rd Ave. 2nd Floor

Seattle, WA 98121

206.436.8600

WorkSource Centers provide all the information, technology, and services that both businesses and job seekers need to thrive and be successful. A statewide partnership of state, local, and nonprofit agencies represent a unique concept in the labor market—everything in one place.

### **Job Accommodation Network (JAN)**

800.526.7234 (Voice)

877.781.9403 (TTY)

askjan.org

Job Accommodation Network (JAN) contact is an international toll-free consulting service. Anyone may call JAN for information about job accommodations and the employability of people with functional limitations:

## **DISCRIMINATION/RIGHTS RESOURCES**

### **Disability Rights Washington**

Voice: 800.562.2702 or 206.324.1521

Language interpreters are available via the AT&T Language Line.

Use 711 for Washington Relay Service (TTY).

<http://www.disabilityrightswa.org/>

Disability Rights Washington's (DRW) mission is to advance the dignity, equality, and self-determination of people with disabilities. DRW works to pursue justice on matters related to human and legal rights.

### **King County Mental Health Ombuds Service**

Confidential Message Service: 206.477.0630

ombuds.mhd@kingcounty.gov

The Mental Health Ombuds Service for King County offers information and referral and also helps with complaints and grievances. When a complaint is received, an Ombudsman will research and investigate the situation, advocate for the expressed interest of the client, and facilitate a resolution\*

### **Office of Consumer Partnerships**

Responds to complaints and issues about mental health in local areas by making referrals to local ombuds offices and quality review teams who also advocate to improve the quality of care for people with mental illness.

## **ADVOCACY**

### **County Mental Health Advisory Boards**

Active participation on mental health advisory boards is a major avenue through which family advocates, recovering clients, social service professionals, and concerned citizens can influence policy and create change. If every county had several knowledgeable and dedicated advocates on boards, the system would change rapidly. Each local nonprofit mental health agency has an administrative board that is legally responsible for the agency. Each county and region has an advisory mental health board that oversees contracts and helps develop long-range plans for local areas. Board composition must be representative of the mental health community, 51 percent must be consumers, family, or advocates. Typically, boards meet once a month and members receive no reimbursement other than travel and day costs. Participation on local advisory boards is probably the single most effective way of influencing policy, monitoring care, and ensuring accountability.

Interested individuals should contact local community mental health agencies, county coordinators of mental health services, or the Division of Mental Health.

It is absolutely essential that family and client advocates become active participants in the mental health system. You can apply for membership on your County Mental Health Board, or on the Board of Directors of any of these agencies. The County Mental Health Board can be contacted through the County Administration or County Courthouse. The boards of publicly funded community mental health centers or other non-profit mental health agencies must recruit and include concerned citizens. As a board member of a Community Mental Health Center, you set governing policy and are responsible for overseeing actions by the agency. This is the

single most effective way to learn what is happening in your community and ensuring accountability and quality of care for those experiencing serious mental illness. In contrast, county boards are only advisory. Final decisions for county programs and BHNs are made by local elected officials, such as county councils or boards of commissioners. In some counties, the Community Mental Health Center Board also serves as the County Board.

## **OUTPATIENT MENTAL HEALTH TREATMENT**

### **Program for Assertive Community Treatment (PACT)**

Chris Mitchell

(206) 263-8951

[pact@kingcounty.gov](mailto:pact@kingcounty.gov)

<https://kingcounty.gov/depts/community-human-services/mental-health-substance-abuse/diversion-reentry-services/PACT.aspx>

The Program for Assertive Community Treatment (PACT) is an individualized treatment approach that offers intensive services in the community, 24 hours a day. PACT assists participants in their recovery from mental illness.

**The following agencies provide outpatient mental health services including counseling and case management in the Puget Sound area:**

### **Sound Mental Health**

1600 East Olive Street

Seattle, WA 98122

206.901.2000

<https://www.sound.health/>

### **Community Psychiatric Clinic**

11000 Lake City Way NE

Seattle, WA 98125

206.901.2000

<https://www.sound.health/>

### **Valley Cities Behavioral Health Care**

10521 Meridian Ave. N.

Seattle, WA 98133

Comprehensive Services/Administration Offices  
325 West Gowe Street  
Kent, WA 98032  
253.833.7444  
<http://www.valleycities.org/>

**Navos**

2600 SW Holden Street  
Seattle, WA 98126  
206.248.8226  
<https://www.navos.org/>

**Downtown Emergency Service Center (DESC)**

Main Office: 515 Third Avenue  
Seattle, WA 98104  
206.464.1570  
[info@desc.org](mailto:info@desc.org)

**Loveland Therapy**

<https://thelovelandfoundation.org/loveland-therapy-fund/>

With the barriers affecting access to treatment by members of diverse ethnic and racial groups, the Loveland Therapy Fund provides financial assistance to Black women and girls seeking therapy nationally.

**MEND Therapy**

4501 Rainier Ave S Seattle, WA 98118  
206.660. 4396  
<https://mendseattle.com/>

MEND Seattle provides quality, reasonable-cost mental health counseling to individuals, couples and groups. We are a collective of healers with diverse educational backgrounds and identities committed to an anti-oppressive and liberatory approach to therapy. We emphasize serving the QTBIPOC.

**Antioch Counseling and Psych Clinic**

2505 3rd Avenue Suite 200 Seattle, WA 98121  
206.268.4840  
[clinic.aus@antioch.edu](mailto:clinic.aus@antioch.edu)  
<https://www.antioch.edu/centers-institutes/aus-counseling-center/>

**Liberating Jasper**

535 Dock Street, Suite 104 Tacoma, WA 98402

253.444.2311

info@liberatingjasper.com

<https://www.liberatingjasper.com/offerings>

**Open Path**

<https://openpathcollective.org/city/seattle/>

**Multicultural Counselors**

<https://www.multiculturalcounselors.org/>

425.310.2356

admin@multiculturalcounselors.org

## CHILD AND ADOLESCENT RESOURCES

**Children's Crisis Outreach Response System**

206.461.3222

[kingcounty.gov/depts/community-human-services/mental-health-substance-abuse/mental-health/services/Youth/CrisisOutreach.aspx](http://kingcounty.gov/depts/community-human-services/mental-health-substance-abuse/mental-health/services/Youth/CrisisOutreach.aspx)

**Family Reconciliation Services (FRS)**

<https://www.dcyf.wa.gov/services/at-risk-youth/frs>

The state of Washington offers FRS through the Division of Child and Family Services. This program helps families address concerning behaviors, such as a child running away or not following reasonable family rules. It also addresses serious problems between parents and their child. DCFS provides services to youth between the ages of 13 and 17. Services can include assessments, crisis counseling and, when appropriate, short placement of the youth out of the home.

**Children's Long Term Inpatient Program (CLIP)**

CLIP Administration

2940 Westlake Ave N #301

Seattle, WA 98109

Phone: 206.588.2985

E-mail: [contactclip@clipadministration.org](mailto:contactclip@clipadministration.org)

[clipadministration.org](http://clipadministration.org)

Each child's length of stay varies according to their individual needs and progress toward treatment goals. The average length of stay is 6 to 12

months, and children are returned to their home community as soon as possible.

***CLIP Residential Treatment Facilities***

1201 South Proctor St.  
Tacoma, WA 98405  
253-396-5937

Operated by Tacoma Comprehensive Mental Health, Pearl Street Center has 12 publicly funded CLIP beds.

***Tamarack Center***

2901 W. Elliott Dr.  
Spokane, WA 99224

Overseen by Spokane County. Tamarack has 16 publicly funded CLIP beds and capacity to serve three additional children on a private pay basis.

***Family Behavioral Health through Catholic Community Services (CCS)***

Family Behavioral Health Services–King County  
631 Strander Blvd., Bldg A  
Tukwila, WA 98188  
253.850.2500

<https://ccsww.org/get-help/child-youth-family-services/family-behavioral-health/>

An integrated, intensive service area within CCS provides care using a Wraparound approach. Services are designed for children, youth and families with complex needs, who are often involved in multiple child-serving programs. Below is CCS contact information for different counties:

***Division of Child and Family Services Field Offices***

***Tumwater Field Office***

6860 Capitol Blvd., Bldg. 2, Tumwater, WA 98501  
360.725.6701

The Division of Child and Family Services (DCFS) is responsible for children and youth. It focuses on family reconciliation services for families in crisis, investigation of child abuse complaints, and provision of alternative living arrangements for children who can no longer live

at home. DCFS also supports day-care programs. Contact local county coordinators for this service.

## SENIOR CITIZENS RESOURCES

### **OASIS**

Navos West Seattle Campus  
22525 SE 64th Place #2266  
Issaquah, WA 98027  
425.276.7613  
<https://www.navos.org/about/>

OASIS is a range of services for adults age 60 and over with serious mental illnesses. Clients are served in their independent or family homes through an intensive case management program or in a model program, called “Midway.” Midway offers supported housing and staff on-site 10 hours a day, seven days a week, for up to 22 individuals. Highline West is a residential treatment program staffed 24 hours a day.

### **Evergreen Healthcare Behavioral Health Services**

11800 NE 128th Street, Suite 200  
Kirkland, WA 98034  
425.899.6300

Geriatric Crisis Service is a specialized crisis intervention and stabilization service available to older adults in King County. It consists of geriatric mental health specialists, social workers, an on-call occupational therapist and a psychiatrist. The team works collaboratively to provide in-home medical, psychosocial and functional assessments for people age 60 and older who meet the criteria for eligibility.

### **Northwest Hospital's Geropsychiatric Center**

1550 N 115th St  
Seattle WA 98133-9733  
206.668.1747

Northwest Hospital & Medical Center's Geropsychiatric Center is the most comprehensive psychiatric program for senior adults offered in Washington State, providing both inpatient and outpatient care.



## **Deaf Services**

### **Sound Mental Health Deaf Services**

Voice: 206.302.2811

Video Phone: 206.455.7929

Email: [anneb@smh.org](mailto:anneb@smh.org)

<https://www.smh.org/deaf-hard-of-hearing/>

Sound Mental Health offers therapy for those who are deaf and hard of hearing. Deaf Services therapists are professional counselors as well as Deaf Specialists. If one does not have a VTTY phone and wishes to obtain more information, contact: Washington Relay Services: 800.833.6384 (for Voice). For those with a hearing impairment and want a Voice call, dial 800.833.6388. Relay services may be contacted by dialing 711 to connect with a communication assistant.

## **ADDICTION AND DUAL DIAGNOSIS RESOURCES**

### **King County's Harborview Medical Center Addictions Program**

Patricia Steel Building, 401 Broadway, 1st floor  
Seattle, WA 98104

This integrated chemical dependency, mental health, and medical primary care treatment program is operated out of Harborview Mental Health Center in Seattle in an outpatient setting.

### **MultiCare Behavioral Health**

Pierce County Crisis: 800.576.7764

King County Crisis: 866.427.4747

<https://www.multicare.org/services-and-departments/behavioral-health/>

MultiCare Behavioral Health provides chemical dependency treatment in Pierce County.

### **Washington Recovery Helpline**

866.789.1511

<https://www.warecoveryhelpline.org/>

Washington Recovery Helpline is a 24-hour hotline that provides support and referrals for those struggling with issues related to mental health, substance abuse, and problem gambling.

## VETERANS

**Statewide Assistance:** (800) 562-2308

### **Veterans Homes WDVA**

(877) VETS-R-US

1.877.838.7787

<https://www.dva.wa.gov/veterans-their-families/veterans-homes>

The Washington State Department of Veterans Affairs manages facilities throughout the state where veterans are treated with dignity and respect in distinctive settings that provide a sense of belonging unique to veterans: Washington Soldiers Home in Orting, Washington Veterans Home in Retsil, Spokane Veterans Home, Walla Walla Veterans Home. All homes share a common goal of providing responsive medical and supportive care to veterans who can no longer provide for themselves. All are Medicaid and Medicare certified facilities.

### **Seattle Vet Center**

305 S. Lucile St.

Seattle, WA 98108

206.764.5130

The Seattle Vet Center offers mental health assessment, readjustment counseling for Vietnam-era veterans and other veterans of periods of armed conflict, and counseling for vets and their family members.

### **Federal Way Vet Center**

32020 32nd Ave S, Suite 110

Federal Way, WA 98001

253.838.3090

24/7 phone number: 877.927.8387

<https://www.va.gov/federal-way-vet-center/>

The Federal Way Vet Center is a safe and confidential place to talk. Veterans who served more than 24 hours on active duty in a theater of combat operations, or have experienced sexual assault or harassment during their time in service qualify for services. Family members are also welcome. 65% of the Vet Center Staff are Combat Veterans. All services are free for those who qualify.

# ROADMAP TO MENTAL HEALTH

## Navigating the System in Puget Sound

This “roadmap” will give families and individuals with mental health conditions help and hope for living in a world affected by mental illness, from an overview of symptoms to navigating the health system in Puget Sound. People in recovery who live with mental illness and their families can be an influential force that can inspire their communities, fight stigma and transform the state of mental health care. Together, we can develop an array of readily available services designed to meet the diverse needs of persons with mental illness and their families.

[namiseattle.org](http://namiseattle.org)



**NAMI** | Seattle  
National Alliance on Mental Illness