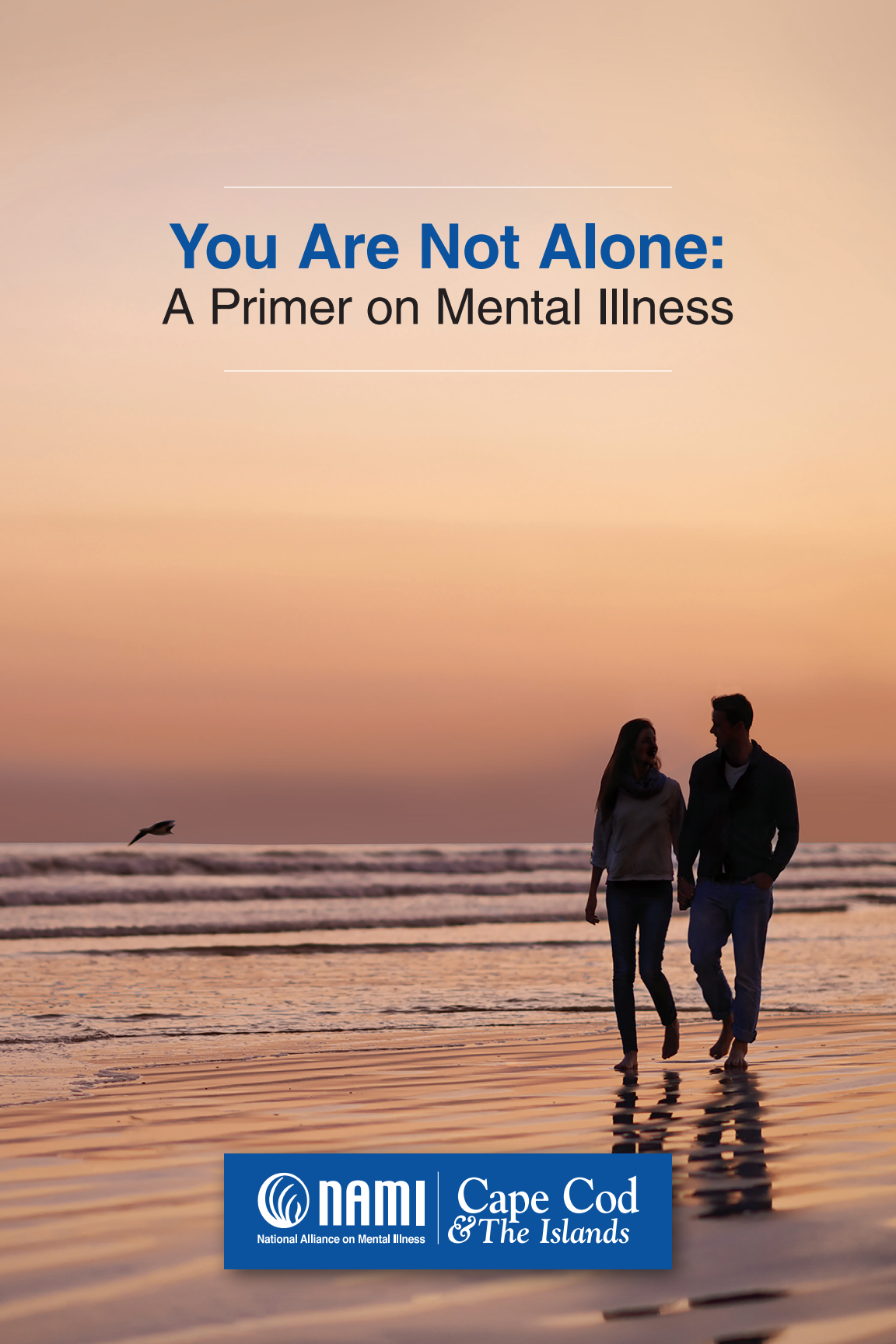
You Are Not Alone:
A Primer on Mental Illness



NAMI
National Alliance on Mental Illness
Cape Cod & The Islands

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OUR MISSION

NAMI Cape Cod & The Islands serves individuals and their families who are affected by the broad spectrum of mental illness and neurological disorders through support, education and advocacy, and promotes mental wellness for all.

OUR VISION

NAMI Cape Cod & The Islands strives to provide an understanding of the broad spectrum of neurological disorders and differences. We provide a network of systems, support groups, and educational programming for individuals and their families. We advocate for and support services for the mental wellness of our total constituency. Enlightenment and education of the general public on matters of mental health are part of the ultimate goal.

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You Are Not Alone:
A Primer on Mental Illness

Presented by the
National Alliance on Mental Illness
Cape Cod & The Islands

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Disclaimer

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PREFACE

NAMI Cape Cod & The Islands is pleased to offer this booklet, *The Primer*, as a tool for families and friends of those suffering from mental/behavioral health issues. The topics were chosen based on the questions that were most often posed and the issues presented in our support calls at the office. It became evident that there was a need to supply some basic information and to make it available to the community.

Judson Phelps, MS, LADC I, our NAMI CC&I Director of Client Services, proposed the idea of a "primer" addressing the most common mental health issues facing our clients and took on the management of the project as a part of his mission of client support. This primer has been a year in the making, has been reworked several times, and has been revised to reflect some major changes in services during the past twelve months. The information contained in it is current as of December 2017. If there are questions, please feel free to call us (508-778-4277). An important part of our mission at NAMI CC&I is to connect people with services. In an area as demographically diverse and geographically challenging as the Cape and Islands, access to services can be confusing and difficult, and we are here to try to help people navigate a fragmented system which unfortunately describes the state of mental health services in our country as a whole.

In using this primer, it is important to keep an open mind. The primer is not meant to be a diagnostic tool, but rather a guideline. The purpose of the booklet is to acquaint "newcomers" to mental illness and to give them information they may need to feel empowered to advocate for friends and/or family members who are experiencing mental health issues. It is important to remember that every individual is different, thinking and moods fluctuate, and often diagnoses overlap. Again, this booklet is a guide and there is still much to be learned about the brain, our most complex organ.

In addition to Jud Phelps and Mary Zdanowicz of our staff, we wish to thank Sarah Stanley of DMH for her significant time and effort. We also want to thank members of the Behavioral Health Centers team at CCHC for their suggestions, input, and guidance. And finally, this project could not have been completed without the editing skills of Arlene Hoxie, our Office Administrator at NAMI CC&I.

I hope that you will find this effort a useful and educational tool as you find yourself working to help those with mental health issues. We at NAMI CC&I believe "It Takes a Community" to address the mental health issues facing our society.

Jacqueline Lane, Executive Director, NAMI CC&I

TABLE OF CONTENTS

Section 1: Overview 2
- The Basics: Answers to Common Questions 2
- Dispelling the Myths of Mental Illness 3
- You Are Not Alone! 7
- Famous and Influential Individuals with Mental Illness 8

Section 2: Getting Help!!!! 10
- Calling the Police – 911 11
- The Hospital Emergency Department and Behavioral Health Center 11
- Bay Cove/Boston Medical Center Help Line and Urgent Care Center 11
- Insurance Issues 12
- Privacy Issues 12

Section 3: Introduction to Mental Illness 14
- The Stages of Mental Illness 14
- Anosognosia: The Denial of Mental Illness 15

Section 4: Disorders 18
- Schizophrenia 18
- Schizo-Affective Disorder 21
- Bipolar Disorder 22
- Dissociative Disorder 25
- Borderline Personality Disorder 28
- Depression 30
- Anxiety Disorder 34
- Post-Traumatic Stress Disorder (PTSD) 37
- Obsessive-Compulsive Disorder (OCD) 39
- Psychiatric Medications 41

Section 5: Substance-Related and Addictive Disorders 46

Section 6: Considerations for Family Members: The Importance of Self Care 56

Section 7: Department of Mental Health (DMH) Community Services 60

Section 8: Legal Issues in Mental Health 66
- Guardianship 66
- Section 12A, Involuntary Psychiatric Hospitalizations 67
- HIPAA 68

Section 9: Additional Resources for Families 72

Section 10: Personal Stories 80

You Are Not Alone:
A Primer on Mental Illness

Section 1

OVERVIEW

OVERVIEW

THE BASICS: ANSWERS TO COMMON QUESTIONS

1. WHAT IS MENTAL ILLNESS?

A mental illness is a condition that affects a person's thinking, feeling or mood. Such conditions may affect someone's ability to relate to others and to function each day. Each person will have different experiences, even people with the same diagnosis.

Recovery, including meaningful roles in social life, school and work, is possible, especially when you start treatment early and play a strong role in your own recovery process.

A mental health condition isn't the result of one event. Research suggests multiple, linking causes. Genetics, environment and lifestyle influence whether someone develops a mental health condition. A stressful job or home life makes some people more susceptible, as do traumatic life events like being the victim of a crime. It is important to know that mental illness is a disease of the brain and should be viewed like any other health condition. Mental *illness* is foremost an *illness*.

2. HOW IS A PSYCHIATRIC DISORDER, A PSYCHOLOGICAL DISORDER OR MENTAL ILLNESS IDENTIFIED?

Any pattern of psychological or behavioral symptoms that causes an individual considerable distress, impairs their ability to function in life, and/or significantly increases their risk of death, pain, disability or loss of freedom. In addition, the symptoms must be more than an exaggerated or expected response to a particular event (e.g. normal grief after loss of a loved one).

The individual with mental illness is often unable to recognize the severity of their illness or symptoms, especially during the early or most acute phases of their illness. Even once the individual recognizes their mental illness, it is often difficult for them to accept that they have a diagnosis that may impact their life, relationships and future. They may experience denial and/or blame others for the consequences of their illness/behaviors. They may not recognize the impact of their own negative choices, and they may feel as though they are a victim of their negative circumstances.

Some mental illnesses are primarily of mood/feelings (depression, anxiety, panic). Other forms of mental illness cause one's mood to fluctuate, cause changes to one's personality (such as an elevated and exaggerated sense of self-importance or grandiosity) or cause distortions of thinking that cause one to lose touch with reality (psychosis, delusions, paranoia.)

Mental illness is not a condition that can be caught; there is no contagion or germs. It can, however, be passed along through parental genes. It can also be triggered and/or exacerbated by difficult or frightening experiences.

3. WHAT IS RECOVERY FROM MENTAL ILLNESS? IS IT POSSIBLE? WHAT DOES "RECOVERY" REALLY MEAN?

The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) provides the following definition:

> *A journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential. (For more information, please go to: http://www.samhsa.gov/recovery)*

Recovery can also be described as "returning" to everyday living, seeing the world as most others see it, contributing to the greater community, coming to accept one's mental illness and recognizing what one needs to stay mentally healthy and well.

One in five adults experiences a mental health condition every year. One in 17 lives with a serious mental illness such as schizophrenia or bipolar disorder. In addition to a person's directly experiencing a mental illness, family, friends and communities are also affected. Half of mental health conditions begin by age 14, and 75% of mental health conditions develop by age 24. The normal personality and behavior changes of adolescence may mimic or mask symptoms of a mental health condition. Early engagement and support are crucial to improving outcomes and increasing the promise of recovery.

DISPELLING THE MYTHS OF MENTAL ILLNESS

Family support is central to the recovery and well-being of an individual with mental illness, but it is often difficult to know how to help. Having information about your loved one's diagnosis, treatment options, and the best way to offer support (while maintaining your own well-being) is invaluable. We hope this primer will provide you with the information you need, as well as hope for your family and your loved one.

The following article by Sarah Powell of NAMI (http://www.nami.org/Blogs?NAMI/July-2015/Dispelling-Myths-on-Mental-Illness) helps to dispel the most common myths related to mental illness:

> **MYTH: MENTAL HEALTH CONDITIONS ARE UNCOMMON.**
>
> **Fact:** Mental illness is more prevalent than many people think: One in five Americans experiences it in their lifetime. One in twenty-five Americans experience a serious mental illness in a given year that substantially interferes with or limits one or more major life activities. It can affect anyone, including all ages, races, income levels and religions. These common conditions are medical, and can cause changes in how people think and feel.

MYTH: MENTAL ILLNESS IS THE RESULT OF BAD PARENTING.

Fact: Children can, and do, have mental health conditions. Research shows that one in five children between the ages of 13 and 18 have or will have a mental illness. In fact, 50% of all lifetime cases begin by age 14. While environmental factors can affect a person's mental health, biological factors can affect individuals just as actively. Mental health conditions are not simply a side effect of parenting, but a combination of influences.

MYTH: PEOPLE ARE "FAKING IT" OR DOING IT FOR ATTENTION.

Fact: No one would choose to have a mental illness, just as no one would choose to have a physical illness. The causes for mental health conditions are intensively studied and they are real. For anyone living with a mental health condition, their specific symptoms may not always be visible to an untrained observer. It can be challenging to relate to what people with mental health conditions are going through, but that doesn't mean that their condition isn't real.

MYTH: MENTAL ILLNESS IS CAUSED BY PERSONAL WEAKNESS.

Fact: Just like any major illness, mental illness is not the fault of the person who has a mental health condition. It is caused by environmental and biological factors, not a result of personal weakness. A stressful job or home life makes some people more susceptible, as do traumatic life events like being the victim of a crime. Biochemical processes and circuits as well as basic brain structure may play a role too.

MYTH: DIFFERENT RACES ARE MORE PRONE TO MENTAL ILLNESS.

Fact: All races and ethnicities are affected by the same rate of mental illness. There is no single group of people more likely than others to have a mental health condition. However, some people have cultural influences that may affect how they interpret symptoms of a mental health condition that could prevent them from getting help. And while the rates are the same, awareness of mental illness in varying minority groups is important to highlight, as these groups often times get overlooked in the potential differences of outcomes in mental illnesses.

MYTH: YOU'RE JUST SAD, NOT DEPRESSED.

Fact: Depression is not something a person can will away. People often have the misconception that a person can just "cheer up" or "shake it off." It is not just "the blues," but a serious medical condition that affects the biological functioning of our bodies. However, there are treatments like cognitive therapy or medication that can help address the symptoms of depression.

MYTH: YOU DON'T NEED THERAPY. JUST TAKE A PILL.

Fact: Everyone has different treatment needs. There is no one, right way to recovery. While medication can help, it may not be the only thing a person needs to feel their absolute best. Often a combination of therapy and medication provides the best outcomes. You should speak with a mental health professional to help determine what the best treatment plan is.

MYTH: PEOPLE WITH MENTAL ILLNESS CAN'T HANDLE WORK OR SCHOOL.

Fact: Stressful situations can be difficult for all people, not just those who live with mental illness. People with mental health conditions have jobs, go to school, and are active members of their communities.

MYTH: PEOPLE WITH MENTAL HEALTH CONDITIONS ARE VIOLENT AND DANGEROUS.

Fact: Having a mental health condition does not make a person more likely to be violent or dangerous. The truth is that living with a mental health condition makes you more likely to be a victim of violence, four times the rate of the general public. Studies have shown that 1 in 4 individuals living with a mental health condition will experience some form of violence in any given year. (Editor's Note: A person with an **untreated** mental illness may become dangerous or violent)

MYTH: PSYCHIATRIC DISORDERS ARE NOT REAL MEDICAL ISSUES.

Fact: Just as with heart disease and diabetes, mental illnesses are a legitimate medical illness. Research shows there are genetic and environmental causes and similar to other medical conditions, they can be treated effectively.

MYTH: YOU CAN NEVER GET BETTER FROM A MENTAL ILLNESS.

Fact: Mental health issues are not always lifelong disorders. For example, some depression and anxiety disorders only require a person to take medication for a short period of time. Innovations in medicine and therapy have made recovery a reality for people living with a mental health issue, even chronic conditions. While all symptoms may not be alleviated easily or at all, with the right recovery plan, people can live the productive and healthy lives they've always imagined.

MYTH: IF YOU FEEL BETTER, YOU ARE CURED.

Fact: Some people, after getting on the proper treatment plan, feel much better. Many of the symptoms may go away, but this does not

mean they are “cured.” The relief they feel is because of the treatment plan. In order to sustain their mental health, they may need to continue treatment even after they feel better. It doesn’t matter if they need to take medication short-term or long-term, they should never stop taking medication, or change their treatment plan without talking about it with their health provider first.

Symptoms of a mental health condition can come and go. There are often environmental factors that can influence the way person feels. Additionally, there are also just times when a person may exhibit symptoms more strongly.

MYTH: PEOPLE WITH MENTAL ILLNESS ARE “DAMAGED” AND DIFFERENT.

Fact: A mental illness does not make someone any less of a person. They are not broken or odd; they just have different experiences that not everyone has to face.

MYTH: A PERSON CAN TREAT THEMSELVES WITH POSITIVE THOUGHT AND PRAYER.

Fact: Positive thought, religion, and spirituality can be powerful tools in recovery, but they shouldn’t be the only form of treatment. The most effective treatment someone can receive is one that is planned by their licensed health provider and themselves. If someone would like to incorporate his or her religion and spirituality with their treatment plan, they can look at NAMI’s FaithNet for additional resources.

MYTH: YOU CAN’T HELP SOMEONE WITH MENTAL ILLNESS.

Fact: Everyone can help those living with mental illness by speaking and acting in a way that preserves personal dignity. If you are a part of removing mental illness stigma in our society you are helping everyone affected by a condition. Two easy ways to do this are:

- Using person-first language. This means that a person is not their illness; an example would be saying “she has depression” not “she is depressed.”
- Do not use offensive slang. A person with a mental health condition is not “crazy,” “psycho,” “insane,” or “loony.” When you use these words you are implying again that a person is solely their illness.

If you are directly in care of someone living with a mental illness you can:

- Learn as much as possible about mental health and your family member’s condition.
- Show interest in your family member’s treatment plan.
- Encourage your family member to follow the treatment plan.

- Strive for an atmosphere of cooperation within the family.
- Listen carefully.
- Resume “normal” activities and routines.
- Don’t push too hard.
- Find support.
- Express your support out loud.
- Keep yourself and your family member safe.
- Prepare a crisis plan.
- Don’t give up.

MYTH: PEOPLE WITH MENTAL ILLNESSES SHOULD BE KEPT IN INSTITUTIONS.

Fact: While not always the case in psychiatric history, today, the majority of people living with mental illness do not need long-term hospitalization. A more comprehensive and ever-expanding understanding of mental health conditions have progressed treatments with respect and medical advancements. Like other diseases, there are periods of time where a person is particularly unwell and needs a short hospital stay, but very few stay longer than a week or two. Many people with mental health conditions live productive, happy and healthy lives.

YOU ARE NOT ALONE!

YOU ARE NOT ALONE! MENTAL ILLNESS TOUCHES OVER 25% OF ALL FAMILIES.

> *“This is one of the basic challenges of all mental health care, that a person is less sick, less disabled – temporarily or permanently – by illness, because some of the external stressors involved are somehow not extreme enough, not overly ‘traumatic enough’. It is really difficult to make people who don’t have those illnesses, or don’t treat these illnesses, understand that it doesn’t matter if your particular combination of genetics and life experience seems destructive enough to an outsider to lead to a crippling depression or anxiety attack. The question is only whether your symptoms – however you got them – have reached the point where they are preventing you from living a normal life.”*
> *(Patrick J. Kennedy, **A Common Struggle**, Blue Rider Press, 2015)*

Mental illness is often caused by a combination of genetics and environmental factors. Treatment and recovery are possible, but everyone’s journey to the most successful treatment plan will be unique. It often takes a combination of treatment approaches and several trials through different treatment models and/or medications before an individual finds what works best. Social stigma, shame,

guilt, fear, isolation, past unsuccessful treatment experiences, co-morbid medical issues, side effects from prescribed medications, and addiction/ substance use issues can also be barriers to recovery, but it is important to maintain hope and persevere, as recovery and success are possible at any point in life, regardless of how many past failures, challenges, or relapses have occurred.

It is important to remember: You did NOT cause it, you CANNOT control it, and you CANNOT cure it.

FAMOUS AND INFLUENTIAL INDIVIDUALS WITH MENTAL ILLNESS

There are many famous, highly regarded, influential, successful people who have lived with various forms of mental illness. Patrick J. Kennedy is one who openly acknowledges that he has suffered throughout his life from anxiety disorder, bipolar disorder, alcoholism and drug addiction. Prince Harry has recently begun discussing his depression following his mother's death. The following successful and prominent individuals also carry mental health diagnoses:

Abraham Lincoln
Mary Todd Lincoln
Winston Churchill
FDR
Teddy Roosevelt
Art Buchwald
Mike Wallace
Jackson Pollock
Napoleon
Ernest Hemmingway & family
Demi Lovato
Martin Luther
Michelangelo
Catherine Zeta-Jones
Paula Dean

Lady Gaga
Patty Duke
Robin Williams
Beethoven
Charles Dickens
Sylvia Plath
Carrie Fisher
Tennessee Williams
Tipper Gore
Terry Bradshaw
Lionel Aldridge
Leo Tolstoy
John Nash
Mel Gibson
Bruce Springsteen
Richard Dreyfuss

Kristen Bell
Virginia Wolfe
Jane Pauley
Ted Turner
Buzz Aldren
Brooke Shields
Kurt Cobain
Brian Williams
Jimmy Piersall
John Keats
Maurice Benard
Isaac Newton
Van Gogh
Herschel Walker
Emma Thompson

Section 2

GETTING HELP!!!!

GETTING HELP!!!!*

EMERGENCY
(IMMINENT DANGER TO ONESELF OR OTHERS)

Call 911 – tell dispatcher it is a mental health emergency and ask for a CCIT trained officer

CRISIS SITUATION
(NON-LIFE-THREATENING)

OPTION 1	OPTION 2	OPTION 3
Call Crisis line (24 hour) 1-800-981-HELP (4357)	*Go to Urgent Care Center 270 Communication Way, Hyannis (Mon-Fri: 7 am-10 pm and weekends: 7 am-7 pm)	Go to the Emergency Room Cape Cod Hospital or Falmouth Hospital

*You need to call the Crisis line first.

MENTAL HEALTH ISSUE
(NEED ADVICE, SUPPORT, RESOURCES)

Call NAMI CC&I
(Mon-Fri: 9 am-5 pm)

We connect people with services.

We offer free educational classes.

We advocate for those with mental illness and their families.

*See the following pages for more in-depth instructions and advice when seeking help.

USEFUL INFORMATION WHEN SEEKING HELP:

CALLING 911 (THE POLICE)

Although it is sometimes frightening to call the police, often in an emergency, it is the best way to get help and prevent potential tragedy. Share all information with the dispatcher and make it very clear that this a mental health emergency. Request a CCIT or CIT-trained officer. (These officers have been trained to respond to mental health calls.) When the police arrive, try to stay calm, give them all useful information, and step back and let them do their job. They may have to restrain your loved one and put him in a cruiser or an ambulance. Again the police are ensuring the safety of the ill person as well as your safety and their own.

In Massachusetts the police can do the following:

1. Transport a willing person to the hospital – often a trained officer can calm a person down and convince him to go to the hospital voluntarily
2. Take a person to the hospital involuntarily for a mental health evaluation (section 12 – see mental health law section)
3. Call the 24-hour Boston Medical Center line for consultation
4. Do a wellness check on your loved one if they are alone and you are worried about him/her

AT THE HOSPITAL EMERGENCY DEPARTMENT

When a person is taken to the hospital either by the police or by relative or friend for an evaluation, he will first be examined to be medically cleared. Following that clearance, he will have a psychiatric evaluation to determine the next step for treatment. If hospitalization is recommended and a bed is available, he may be admitted to the Behavioral Health Center at Cape Cod Hospital. If there is no bed available, a bed search will begin and the patient can be “boarded” in the “purple zone”, an area of the emergency department set aside for psychiatric patients. If the patient has no insurance or certain types of insurance, a Bay Cove clinician will be called in to do the evaluation and do a bed search for a facility that will accept his type of insurance or no insurance. (See below section on insurance for more information.)

BAY COVE/BOSTON MEDICAL CENTER URGENT CARE CENTER

1-800-981 HELP (4357): Bay Cove Urgent Care Center, located at 270 Communication Way in Hyannis, can be used for an office-based evaluation, thus avoiding the Emergency Room at the hospital. You can take the individual there if he/she is willing to go during their scheduled hours. You must call the Crisis line first. They may suggest that you need to call 911 or they can also send a clinician to your location to do an evaluation. The police can also use this service.

INSURANCE ISSUES

Where you can get care and treatment is dependent upon the type of insurance that you have or your lack of insurance. Also, it is important to know that insurance companies evaluate cases and also often determine the length of a hospital stay. If you feel that your person is being discharged too soon, it may have been determined by the insurance company and is often as frustrating for the hospital staff as it is for you. The Bay Cove Urgent Care Center treats people with no insurance and all Mass Health plans (not all Connector plans) as well as those with Beacon Health Strategies managed plans, Fallon, Harvard Pilgrim, Neighborhood Health Plan, Senior Whole Health, Tufts Health Plan (Navigator, Spirit) Unicare State Indemnity Plan, Medicare, and DMH only. If you have other private health insurance such as Blue Cross/Blue Shield, go to the Emergency Room at the hospital.

PRIVACY ISSUES

If this is a first hospitalization, it can be upsetting and confusing, and there may not be a lot of information available. The HIPAA laws (see section on mental health laws), which are meant to safeguard a patient's privacy, make it very difficult to get information from health care providers, including whether a person has even been admitted to the facility. If possible, ask the person to sign a HIPAA release form so that you can obtain information; however, during a mental health episode the person may be uncooperative and refuse to sign the document.

If this is not the first hospitalization, it is very helpful if you have documented all previous episodes, symptoms, hospitalizations, diagnoses, medications and the responses to them, and any other information you have. Many people have found that using a binder with tabs is the best way to keep this information available. The more information that you have, the better the providers will be able to form a treatment plan. Even if the ill person does not sign a HIPAA form and you are not able to get information from the providers, you still have the right to speak to the providers and give them information and convey patient history to them. They should agree to listen to you even though they cannot respond with current information.

Section 3

Introduction to Mental Illness

STAGES OF MENTAL ILLNESS

Like most medical illnesses, there are identifiable stages of mental health conditions. The MHA (Mental Health America) divides these into four stages, as noted following:

STAGE 1:

Mild symptoms and warning signs. A person may begin to show symptoms; is still able to function, but probably not quite as well as before. There is a feeling that the individual is feeling just “not right.”

When there is an observable combination of at least two or more of these symptoms, there is indication of a potential mental health issue. These symptoms are:

- Problems with concentration, memory, clear thinking
- Changes in eating with either loss of appetite or excessive eating
- Inability to complete school or work tasks
- Feeling overly worried
- Feeling sad, empty, hopeless or worthless
- Overly sensitive and reactive to sounds, sights, smells or touches
- Irritable and restless
- Feeling like his brain is playing “tricks” on him
- Loss of interests in activities normally enjoyed
- Energy levels and sleep patterns change

STAGE 2:

The symptoms noted above increase in frequency and severity. Some symptoms may strengthen, while new ones may appear. School and work tasks become more difficult. Personal responsibilities may slacken.

STAGE 3:

Symptoms worsen. Relapses and repeating episodes heighten. Symptom severity increases. The individual may feel that she/he may be losing control of her/his life. Serious disruptions occur in the person’s activities and roles. These intense and chronic symptoms may result in development of other medical conditions. Other critical issues may arise such as unemployment, hospitalization and/or incarceration.

There are studies showing that it may take 10 years from the initial signs of mental health concerns until a correct diagnosis and treatment are defined. Often these initial signs may manifest themselves by age 14. If the condition is caught early and treated appropriately, the individual may well respond better.

STAGE 4:

Symptoms persist and grow in severity. Due to the continuing extended and intense symptoms, often other conditions develop, i.e., diabetes, high blood pressure, as well as crisis events, such as unemployment, hospitalization or even incarceration.

ANOSOGNOSIA*

When someone rejects a diagnosis of mental illness, it's tempting to say that he's "in denial."

But someone with acute mental illness may not be thinking clearly enough to consciously choose denial. They may instead be experiencing "lack of insight" or "lack of awareness." The formal medical term for this medical condition is anosognosia, from the Greek meaning "to not know a disease."

When we talk about anosognosia in mental illness, we mean that someone is unaware of their own mental health condition or they can't perceive their condition accurately. Anosognosia is a common symptom of certain mental illnesses, perhaps the most difficult to understand for those who have never experienced it.

Anosognosia is relative. Self-awareness can vary over time, allowing a person to acknowledge their illness at times and making such knowledge impossible at other times. When insight shifts back and forth over time, we might think people are denying their condition out of fear or stubbornness, but variations in awareness are typical in anosognosia.

WHAT CAUSES ANOSOGNOSIA?

We constantly update our mental image of ourselves. When we get a sunburn, we adjust our self -image and expect to look different in the mirror. When we learn a new skill, we add it to our self-image and feel more competent. But this updating process is complicated. It requires the brain's frontal lobe to organize new information, develop a revised narrative and remember the new self-image.

Brain imaging studies have shown that this crucial area of the brain can be damaged by schizophrenia and bipolar disorder as well as by diseases like dementia. When the frontal lobe isn't operating at 100%, a person may lose—or partially lose—the ability to update his self-image.

Without an update, we're stuck with our old self- image from before the illness started. Since our perceptions feel accurate and familiar, we conclude that our loved ones are lying or making a mistake. If family and friends insist they're right, the person with an illness may get frustrated or angry or begin to avoid them.

Anosognosia affects 50% of people with schizophrenia and 40% of people with bipolar disorder. It can also accompany illnesses such as major depression with psychotic features. Treating these mental health conditions is much more complicated if lack of insight is one of the symptoms. People with anosognosia

are placed at increased risk of homelessness or arrest. Learning to understand anosognosia and its risks can improve the odds of helping people with this difficult symptom.

WHY IS INSIGHT IMPORTANT?

For a person with anosognosia, this inaccurate insight feels as real and convincing as other people's ability to perceive themselves accurately. But these misperceptions cause conflicts with others and increased anxiety. Lack of insight also typically causes a person to avoid treatment. This makes it the most common reason for people to stop taking their medications. And, as it is often combined with psychosis or mania, lack of insight can cause reckless or undesirable behavior.

*Taken from Nami.org: https://www.nami.org/Learn-More/Mental-Health-Conditions/Related-Conditions/Anosognosia

Section

4

Disorders & Psychiatric Medications

DISORDERS & PSYCHIATRIC MEDICATIONS

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, affecting about 1% of Americans. 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.

SCHIZOPHRENIA: SYMPTOMS

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. In young people who develop schizophrenia, this stage of the disorder is called the "prodromal" period.

With any condition, it's essential to get a comprehensive medical evaluation in order to obtain the best diagnosis. For a diagnosis of schizophrenia, some of the following symptoms are present in the context of reduced functioning for at least 6 months:

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 who 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: Negative symptoms diminish a person's abilities. They can often include being emotionally flat or speaking in a dull, disconnected way. People with negative symptoms may be unable to start or follow through with activities, show interest in life, or sustain relationships. Negative symptoms are sometimes confused with clinical depression.

COGNITIVE ISSUES/DISORGANIZED THINKING: People with the cognitive symptoms of schizophrenia often struggle to remember things, organize their thoughts or complete tasks. Commonly, people with schizophrenia have *anosognosia* or "lack of insight." This means the person is unaware that he has the illness, which can make treating or working with him/her much more challenging.

SCHIZOPHRENIA: CAUSES

Research suggests that schizophrenia may have several possible causes:

- **Genetics:** Schizophrenia is caused not by just one genetic variation, but a complex interplay of genetics and environmental influences. While schizophrenia occurs in 1% of the general population, having a history of family psychosis greatly increases the risk. Schizophrenia occurs for roughly 10% of people who have a first-degree relative with the disorder, such as a parent or sibling. The highest risk occurs when an identical twin is diagnosed with schizophrenia. The unaffected twin has a roughly 50% chance of developing the disorder.
- **Environment:** Exposure to viruses or malnutrition before birth, particularly in the first and second trimesters has been shown to increase the risk of schizophrenia. Inflammation or autoimmune diseases can also lead to increased immune system problems.
- **Brain chemistry:** Problems with certain brain chemicals, including neurotransmitters called dopamine and glutamate, may contribute to schizophrenia. Neurotransmitters allow brain cells to communicate with each other. Networks of neurons are likely involved as well.
- **Substance use:** Some studies have suggested that taking mind-altering drugs during teen years and young adulthood can increase the risk of schizophrenia. A growing body of evidence indicates that smoking marijuana increases the risk of psychotic incidents and the risk of ongoing psychotic experiences. The younger the user and the more frequent the use, the greater the risk. Another study has found that smoking marijuana led to earlier onset of schizophrenia and often preceded the manifestation of the illness.

SCHIZOPHRENIA: DIAGNOSIS

Diagnosing schizophrenia is complex. Sometimes using drugs, such as methamphetamines or LSD, can cause a person to have schizophrenia-like symptoms. The difficulty of diagnosing this illness is compounded by the fact that many people who are diagnosed do not believe they have it. Lack of awareness is a common symptom of people diagnosed with schizophrenia and greatly complicates treatment.

While there is no single physical or lab test that can diagnosis schizophrenia, a health care provider who evaluates the symptoms and the course of a person's illness over six months can help ensure a correct diagnosis. The health care provider must rule out other factors such as brain tumors, possible medical conditions, and other psychiatric diagnoses, such as bipolar disorder or drugs.

To be diagnosed with schizophrenia, a person must have two or more of the following symptoms occurring persistently in the context of reduced functioning:

- Delusions
- Hallucinations
- Disorganized speech
- Disorganized or catatonic behavior
- Negative symptoms

Delusions or hallucinations alone can often be enough to lead to a diagnosis of schizophrenia. Identifying it as early as possible greatly improves a person's chances of managing the illness, reducing psychotic episodes, and recovering. People who receive good care during their first psychotic episode are admitted to the hospital less often, and may require less time to control symptoms than those who don't receive immediate help.

People can describe symptoms in a variety of ways. How a person describes symptoms often depends on the cultural lens through which they are looking. African Americans and Latinos are more likely to be misdiagnosed, probably due to differing cultural or religious beliefs or language barriers. A person who has been diagnosed with schizophrenia should try to work with a health care professional who understands their cultural background and shares the same expectations for treatment.

SCHIZOPHRENIA: TREATMENT

There is no cure for schizophrenia, but it can be treated and managed in several ways. There is much ongoing research that may lead to better ways to treat psychosis.

Treatments for schizophrenia focus on eliminating the symptoms of the disease. They include a combination of antipsychotic medication and behavioral therapy. Hallucinations and other symptoms of agitation usually subside within days after starting medications. It typically takes about six weeks on these medications for people to experience a marked improvement.

Individual response to treatment can vary widely among individuals, so people living with schizophrenia will need to work collaboratively with their psychiatrist and other treatment providers to determine the course of medication, behavioral therapy, and other recovery supports that will most effectively help them to achieve the highest possible level of function.

Those who are diagnosed with schizophrenia can benefit from medication and

behavioral therapies, including:

- Antipsychotic medications
- Cognitive-behavioral therapy—Therapy helps patients to understand and cope with symptoms that do not go away even when they take medication.
- Group therapy or mutual support groups—These groups provide support and help people feel less isolated.
- Rehabilitation—This involves social and vocational training to help people with schizophrenia function better in their communities.
- Family education—People with schizophrenia are often discharged from the hospital into the care of their families, so it is important that family members learn about the illness. With the help of a therapist, family members can learn coping strategies and problem-solving skills.
- Illness management—Once patients learn basic facts about schizophrenia and its treatment, they can make informed decisions about their care and watch for the early warning signs of relapse.

SCHIZOAFFECTIVE DISORDER

Schizoaffective disorder is a generally continuous psychotic illness concurrent with intermittent major mood episodes, either manic or depressive. It is difficult to diagnose because it has symptoms of schizophrenia and either depression or bipolar disorders.

SCHIZOAFFECTIVE DISORDER: SYMPTOMS

- Psychosis, i.e., delusions or hallucinations for 2 or more weeks
- A major mood episode that is present for the majority of the total duration of the illness–either mania or depression. They may be catatonic, which is a trance-like state that includes stupor, lack of response to external stimuli, muscular rigidity, or mutism, or they may be agitated.

SCHIZOAFFECTIVE DISORDER: TREATMENT

Treatment includes a combination of medications such as mood stabilizers, antipsychotics and antidepressants. Electroconvulsive therapy (ECT) has also been used in treatment-resistant situations.

Once the person is stabilized, Cognitive Behavior Therapy (CBT) has been used in conjunction with the medications.

BIPOLAR DISORDER

Bipolar disorder, once called manic-depression, is a chronic mental illness that causes dramatic shifts in a person's mood, energy and ability to think clearly. People with bipolar disorder have high and low moods, known as mania and depression, which differ from the typical ups and downs most people experience. If left untreated, the symptoms usually get worse. However, with a strong lifestyle that includes self-management and a good treatment plan, many people live well with the condition.

With mania, people may feel extremely irritable or euphoric. People living with bipolar disorder may experience several extremes in the shape of agitation, sleeplessness and talkativeness or sadness and hopelessness. They may also exhibit extreme pleasure-seeking or risk-taking behaviors.

People's symptoms and the severity of their mania or depression vary widely. Although bipolar disorder can occur at any point in life, the average age of onset is 25. Every year, 2.9% of the U.S. population is diagnosed with bipolar disorder, with nearly 83% of cases being classified as severe. Bipolar disorder affects men and women equally.

BIPOLAR DISORDER: SYMPTOMS

A person with bipolar disorder may have distinct manic or depressed states. A person with mixed episodes experiences both extremes simultaneously or in rapid sequence. Severe bipolar episodes of mania or depression may also include psychotic symptoms such as hallucinations or delusions. Usually, these psychotic symptoms mirror a person's extreme mood. Someone who is manic might believe he has special powers and may display risky behavior. Someone who is depressed might feel hopeless and helpless and be unable to perform normal tasks. People with bipolar disorder who have psychotic symptoms may be wrongly diagnosed as having schizophrenia.

Mania: To be diagnosed with bipolar disorder, a person must have experienced mania or hypomania. Hypomania is a milder form of mania that doesn't include psychotic episodes. People with hypomania can often function normally in social situations or at work. Some people with bipolar disorder will have episodes of mania or hypomania many times; others may experience them only rarely. To determine what type of bipolar disorder a person has, doctors test how impaired he/she is during their most severe episode of mania or hypomania.

Although someone with bipolar disorder may find an elevated mood appealing—especially if it occurs after depression—the "high" does not stop at a comfortable or controllable level. Moods can rapidly become more irritable, behavior more unpredictable and judgment more impaired. During periods of mania, people frequently behave impulsively, make reckless decisions and take unusual risks. Most of the time, people in manic states are unaware of the

negative consequences of their actions. It's key to learn from prior episodes the kinds of behavior that signal "red flags" to help manage the illness.

Depression: Depression produces a combination of physical and emotional symptoms that inhibit a person's ability to function nearly every day for a period of at least two weeks. The level of depression can range from severe to moderate to mild low mood, which is called dysthymia when it is chronic.

The lows of bipolar depression are often so debilitating that people may be unable to get out of bed. Typically, depressed people have difficulty falling and staying asleep, but some sleep far more than usual. When people are depressed, even minor decisions such as what to have for dinner can be overwhelming. They may become obsessed with feelings of loss, personal failure, guilt or helplessness. This negative thinking can lead to thoughts of suicide. In bipolar disorder, suicide is an ever-present danger, as some people become suicidal in manic or mixed states. Depression associated with bipolar disorder may be more difficult to treat.

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 violent. 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 Diagnostic and Statistical Manual of Mental Disorders (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.

BIPOLAR DISORDER: CAUSES

Scientists have not discovered a single cause of bipolar disorder. They believe several factors may contribute:

- Genetics: The chances of developing bipolar disorder are increased if a child's parents or siblings have the disorder. But the role of genetics is not absolute. A child from a family with a history of bipolar disorder may never develop the disorder. And studies of identical twins have found that even if one twin develops the disorder the other may not.
- Stress: A stressful event such as a death in the family, an illness, a difficult relationship or financial problems can trigger the first bipolar episode. Thus, an individual's style of handling stress may also play a role in the development of the illness. In some cases, drug abuse can trigger bipolar disorder.
- Brain structure: Brain scans cannot diagnose bipolar disorder in an individual. Yet, researchers have identified subtle differences in the average size or activation of some brain structures in people with

bipolar disorder. While brain structure alone may not cause it, there are some conditions in which damaged brain tissue can predispose a person. In some cases, concussions and traumatic head injuries can increase the risk of developing bipolar disorder.

BIPOLAR DISORDER: DIAGNOSIS

To diagnose bipolar disorder, a doctor may perform a physical examination, conduct an interview and order lab tests. While bipolar disorder cannot be identified through a blood test or body scan, these tests can help rule out other illnesses that can resemble the disorder, such as hyperthyroidism. If no other illnesses (or other medicines such as steroids) are causing the symptoms, the doctor may recommend the person see a psychiatrist. To be diagnosed with bipolar illness, a person must have had at least one episode of mania or hypomania.

The DSM-5 defines four types of bipolar illness:

- Bipolar I Disorder is an illness in which people have experienced one or more episodes of mania. Most people diagnosed with Bipolar I will have episodes of both mania and depression, though an episode of depression is not necessary for a diagnosis. To be diagnosed with Bipolar I, a person must have manic or mixed episodes lasting at least seven days or of such severity that hospitalization is necessary.
- Bipolar II Disorder is a subset of Bipolar Disorder in which people experience depressive episodes shifting back and forth with hypomanic episodes, but never a full manic episode.
- Cyclothymic Disorder or Cyclothymia is a chronically unstable mood state in which people experience hypomania and mild depression for at least two years. People with Cyclothymia may have brief periods of normal mood, but these periods last less than eight weeks.
- Bipolar Disorder “other specified” and “unspecified” is diagnosed when a person does not meet the criteria for Bipolar I or II or Cyclothymia but has had periods of clinically significant abnormal mood elevation. The symptoms may either not last long enough or not meet the full criteria for episodes required to diagnose Bipolar I or II.

People can describe symptoms in a variety of ways. How a person describes symptoms often depends on the cultural lens through which they are looking. In Western cultures, people generally talk about their moods or feelings, whereas in many Eastern cultures, people refer to physical pain. Research has shown that African Americans and Latinos are more likely to be misdiagnosed, so people who have been diagnosed with bipolar disorder should look for a health care professional who understands their background and shares their expectations for treatment.

BIPOLAR DISORDER: TREATMENT

Bipolar disorder can be treated with a range of medications depending on the specific symptoms experienced. These medications include mood stabilizers, antipsychotics, and antidepressants.

A number of psychotherapies can help with the treatment of bipolar disorder including Cognitive Behavioral Therapy to identify negative patterns and behaviors, interpersonal and family therapies that help people with bipolar disorder improve relationships and communications, and psycho-education, which can educate people with bipolar disorder and their family members about the illness and help them to identify the signs of mood swings when they first occur.

DISSOCIATIVE DISORDERS

Dissociative disorders are characterized 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.

It's estimated that 2% of people experience dissociative disorders, with women being more likely than men to be diagnosed. Almost half of adults in the United States experience at least one depersonalization/derealization episode in their lives, with only 2% meeting the full criteria for chronic episodes.

The symptoms of a dissociative disorder usually first develop as a response to a traumatic event, such as abuse or military combat, to keep those memories under control. 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.

DISSOCIATIVE DISORDERS: 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
- Mental health problems 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 a dissociative disorder depend on the type of disorder diagnosed. There are three types of dissociative disorders defined in the DSM-5.

- **Dissociative amnesia:** The main symptom is difficulty remembering important information about oneself. Dissociative amnesia may surround a particular event, such as combat or abuse, or more rarely, information about identity and life history. The onset of an amnesic episode is usually sudden, and an episode can last minutes to years. There is no average for age onset, and a person may experience multiple episodes throughout his/her life.
- **Depersonalization disorder:** This disorder involves ongoing feelings of detachment from actions, feelings, thoughts and sensations as if they are watching a movie (depersonalization). Sometimes other people and things in the world around them may feel 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 among 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. Onset for the full disorder can happen at any age, but it is more likely to occur in people who have experienced severe, ongoing trauma before the age of 5. 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.

DISSOCIATIVE DISORDERS: CAUSES

Dissociative disorders usually develop as a way of dealing with trauma. Dissociative disorders most often form in children exposed to long-term physical, sexual or emotional abuse. Natural disasters and combat can also cause dissociative disorders.

DISSOCIATIVE DISORDERS: DIAGNOSIS

Doctors diagnose dissociative disorders based on a review of symptoms and personal history. A doctor may perform tests to rule out physical conditions that can cause symptoms such as memory loss and a sense of unreality (for example, head injury, brain lesions or tumors, sleep deprivation or intoxication). If physical causes are ruled out, a mental health specialist is often consulted to make an evaluation.

Many features of dissociative disorders can be influenced by a person's cultural background. In the case of dissociative identity disorder and dissociative amnesia, patients may present with unexplained, non-epileptic seizures, paralyses or sensory loss. In settings where possession is part of cultural beliefs, the fragmented identities of a person who has DID may take the form of spirits, deities, demons or animals. Intercultural contact may also influence the characteristics of other identities. For example, a person in India exposed to Western culture may present with an "alter" who only speaks English. In cultures with highly restrictive social conditions, amnesia is frequently triggered by severe psychological stress such as conflict caused by oppression. Finally, voluntarily induced states of depersonalization can be a part of meditative practices prevalent in many religions and cultures, and should not be diagnosed as a disorder.

DISSOCIATIVE DISORDERS: TREATMENT

Dissociative disorders are managed through various therapies including:

- Psychotherapies
  - Cognitive Behavioral Therapy (CBT)
  - Dialectical Behavioral Therapy (DBT)
- Eye movement desensitization and reprocessing (EMDR)
- Medications such as antidepressants can treat symptoms of related conditions

BORDERLINE PERSONALITY DISORDER (BPD)*

Borderline personality disorder (BPD) is a condition characterized by the inability to manage emotions effectively. This disorder occurs in the context of relationships; sometimes all relationships are affected, sometimes only one. It usually begins during adolescence or early adulthood.

While some people with BPD are high functioning in certain settings, their private lives may be in turmoil. Most people who have BPD suffer from problems regulating their emotions and thoughts, impulsive and sometimes reckless behavior and unstable relationships.

Other disorders, such as depression, anxiety disorders, eating disorders, substance abuse and other personality disorders can often exist along with BPD. The diagnosis of BPD can be missed or misdiagnosed. Bipolar disorder is one example of a misdiagnosis as it includes mood instability. There are important differences between these conditions but both involve unstable moods. For the person with bipolar disorder, the mood changes exist for weeks or even months. The mood changes in BPD are much shorter and can even occur within the day. Anecdotally, people note that the person with BPD goes from 0 to 60 in a flash.

- BPD affects 5.9% of adults (about 14 million Americans) at some time in their life.
- BPD affects 20% of patients admitted to psychiatric hospitals and 10% of people in outpatient mental health treatment. 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.

BORDERLINE PERSONALITY DISORDER: SYMPTOMS

- 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 such as cutting and burning
- 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
- Difficulty returning to a stable baseline after an emotionally intense event
- 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: CAUSES

The causes of borderline personality disorder are not fully understood, but scientists agree that it is the result of a combination of factors:

- **Genetics:** While no specific gene has been shown to directly cause BPD, studies in twins suggest this illness has strong hereditary links. BPD is about five times more common among people who have a first-degree relative with the disorder.
- **Environmental factors:** Certain events during childhood may also play a role in the development of BPD, such as those involving emotional, physical or sexual abuse, neglect and separation from parents.
- **Brain function:** The way the brain works is often different in people with BPD, suggesting that there is a neurological basis for some of the symptoms. Specifically, the portions of the brain that control emotions and decision-making/judgment may not communicate well with one another.

The current theory is that some people are more likely to develop BPD due to their biology or genetics, and harmful childhood experiences can further increase the risk.

BORDERLINE PERSONALITY DISORDER: DIAGNOSIS

There is no single medical test to diagnose BPD, and a diagnosis is not based on one sign or symptom. BPD is diagnosed by a mental health professional following a comprehensive psychiatric interview that may include talking with previous clinicians, medical evaluations and, when appropriate, interviews with friends and family. To be diagnosed with BPD, a person must have at least 5 of the BPD symptoms listed above.

BORDERLINE PERSONALITY DISORDER: TREATMENT

Research shows that outcomes can be good for people with BPD, particularly if they are engaged in treatment. With specialized therapy, most people with BPD find their symptoms reduced and their lives improved. Although not all symptoms may ease, there is often a major decrease in problem behaviors and suffering. There are several treatments that are most often used to manage BPD.

Dialectical behavior therapy (DBT) is the most studied treatment for BPD and the one shown to be most effective. DBT teaches skills to control intense emotions, reduce self-destructive behavior, manage distress and improve relationships. It seeks a balance between accepting and changing behaviors.

- **Medications** cannot cure BPD but can help treat other conditions that often accompany BPD such as depression, impulsivity and anxiety. Sometimes, several medications can be used off-label to treat the remaining symptoms. For example, mood stabilizers and antidepressants help with mood swings and dysphoria. Antipsychotic medication may help control symptoms of rage and disorganized thinking.
- **Self-care** activities include regular exercise, good sleep habits, a nutritious diet, taking medications as prescribed and healthy stress management. Lack of sleep can lead to an increase in symptoms while good self-care can help to reduce common symptoms of BPD such as mood changes, impulsive behavior and irritability.
- **Short-term hospitalization** may be necessary during times of extreme stress and/or impulsive or suicidal behavior to ensure safety.

*Much of this information has been taken from the NEA-BPD website which is an excellent source for additional resources on BPD.

DEPRESSION

Depression may be the most prevalent of all mental illnesses; it impacts 10% of the U.S. adult population. Depression is more than just feeling sad or going through a rough patch. It's a serious mental health condition that requires understanding, treatment and a good recovery plan. With early detection, diagnosis and a treatment plan consisting of medication, psychotherapy and lifestyle choices, many people get better. Left untreated, depression can be devastating, both for the people who have it and for their families.

Some people have only one episode in a lifetime, but for most people depression recurs. Without treatment, episodes may last a few months to several years. People with severe depression can feel so hopeless that they become a risk for suicide.

An estimated 16 million American adults—almost 7% of the population—had at least 1 major depressive episode last year. People of all ages and all racial, ethnic and socioeconomic backgrounds can experience depression, but it does affect some groups of people more than others. Women are 70% more likely than men to experience depression, and young adults aged 18–25 are 60% more likely to have depression than people aged 50 or older.

Getting a comprehensive evaluation is important. Underlying medical issues that can mimic a major depressive episode, side effects of other medications (like beta blockers or anti-hypertensives) or any other medical causes need to be

ruled out. Understanding life stressors and prior responses to treatment efforts can help shape a good treatment plan. Understanding how any co-occurring conditions fit into the diagnostic picture also informs treatment options.

DEPRESSION: SYMPTOMS

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

- **Changes in sleep:** Many people have trouble falling asleep, staying asleep or sleeping much longer than they used to. Waking up early in the morning is common for people with major depression.
- **Changes in appetite:** Depression can lead to serious weight loss or gain when a person stops eating or uses food as a coping mechanism.
- **Lack of concentration:** A person may be unable to focus during severe depression. Even reading the newspaper or following the plot of a TV show can be difficult. It becomes harder to make decisions, big or small.
- **Loss of energy:** People with depression may feel profound fatigue, think slowly or be unable to perform normal daily routines.
- **Lack of interest:** People may lose interest in their usual activities or lose the capacity to experience pleasure. A person may have no desire to eat or have sex.
- **Low self-esteem:** During periods of depression, people dwell on losses or failures and feel excessive guilt and helplessness. Thoughts like “I am a loser” or “the world is a terrible place” or “I don’t want to be alive” can take over.
- **Hopelessness:** Depression can make a person feel that nothing good will ever happen. Suicidal thoughts often follow these kinds of negative thoughts—and need to be taken seriously.
- **Changes in movement:** People with depression may look physically depleted or they may be agitated. For example, a person may wake early in the morning and pace the floor for hours.
- **Physical aches and pains:** Instead of talking about their emotions or sadness, some people may complain about a headache or an upset stomach.

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

DEPRESSION: CAUSES

Depression does not have a single cause. It can be triggered, or it may occur spontaneously without being associated with a life crisis, physical illness or other risk. Scientists believe several factors contribute to cause depression:

- **Trauma:** When people experience trauma at an early age, it can cause long-term changes in how their brains respond to fear and stress. These brain changes may explain why people who have a history of childhood trauma are more likely to experience depression.
- **Genetics:** Mood disorders and risk of suicide tend to run in families, but genetic inheritance is only one factor. Identical twins share 100% of the same genes, but will both develop depression only about 30% of the time. People who have a genetic tendency to develop depression are more likely to show signs at a younger age. While a person may have a genetic tendency, life factors and events seem to influence whether he/she will ever actually experience an episode.
- **Life circumstances:** Marital status, financial standing and where a person lives have an effect on whether a person develops depression, but it can be a case of "the chicken or the egg." For example, depression is more common in people who are homeless, but the depression itself may be the reason a person becomes homeless.
- **Brain structure:** Imaging studies have shown that the frontal lobe of the brain becomes less active when a person is depressed. Brain patterns during sleep change in a characteristic way. Depression is also associated with changes in how the pituitary gland and hypothalamus respond to hormone stimulation.
- **Other medical conditions:** People who have a history of sleep disturbances, medical illness, chronic pain, anxiety, and attention-deficit hyperactivity disorder (ADHD) are more likely to develop depression.
- **Drug and alcohol abuse:** Approximately 30% of people with substance abuse problems also have depression.

DEPRESSION: DIAGNOSIS

To be diagnosed with depression, a person must have experienced a major depressive episode that has lasted longer than two weeks. The symptoms of a major depressive episode include:

- Loss of interest or loss of pleasure in all activities
- Change in appetite or weight
- Sleep disturbances
- Feeling agitated or feeling slowed down
- Fatigue

- Feelings of low self-worth or guilt
- Difficulty concentrating or making decisions
- Suicidal thoughts or intentions

Diagnosing depression can be complicated because a depressive episode can be part of bipolar disorder or another mental illness. How a person describes symptoms often depends on the cultural lens through which they are looking. Research has shown that African Americans and Latinos are more likely to be misdiagnosed, so people who have been diagnosed with depression should look for a health care professional who understands their background and shares their expectations for treatment.

DEPRESSION: TREATMENT

Depressive disorders are characterized by a pervading sense of sadness and/or loss of interest or pleasure in most activities, and include major depressive disorder and persistent depressive disorder (dysthymia). Like most mental illness, depressive disorders are best treated with a combination of medication and counseling.

Many medications exist for the treatment of depressive disorders. People sometimes need to try different medications to find a medication that relieves their depression and has tolerable side effects.

People with a depressive disorder often benefit from seeing a psychiatrist, psychologist, or other mental health professional. If medication is needed, the person must see a psychiatrist or other health care professional with prescribing privileges.

It is important that those with major depression who experience suicidal thinking, a common symptom of major depression, and who are treated with antidepressants, have ongoing close psychiatric follow-up because energy levels may improve before mood symptoms and suicidal thinking improve, thereby potentially increasing the risk of suicide early in the course of treatment.

Although depression can be a devastating illness, it very often responds to treatment. The key is to get a specific evaluation and a treatment plan. Today, there are a variety of treatment options available for people with depression.

- **Medications** including antidepressants, mood stabilizers and antipsychotic medications
- **Psychotherapy** including family-focused therapy and interpersonal therapy
- **Cognitive Behavior Therapy** to address the thoughts and behaviors that can accompany depressive disorders
- **Brain stimulation therapies** including electroconvulsive therapy (ECT) or repetitive transcranial magnetic stimulation (rTMS) (Note: ECT has come a long way in the past few years and is no longer

the scary treatment it once was. It has been quite successful in treatment-resistant depression.)

- **Light therapy** which uses a light box to expose a person to full spectrum light and regulate the hormone melatonin
- **Alternative therapies** including acupuncture, meditation and nutrition
- **Self-management strategies and education**
- **Mind/body/spirit approaches** such as meditation, exercise, faith and prayer

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 things, an anxiety disorder may be the cause.

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

ANXIETY DISORDERS: SYMPTOMS

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

Emotional symptoms:

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

Physical symptoms:

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

ANXIETY DISORDERS: THE DIFFERENT TYPES

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

Panic Disorder

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

Many people will go to desperate measures to avoid having an attack, including social isolation or avoiding going to specific places.

Phobias

Although most people try to avoid certain things or situations that make them fearful or uncomfortable, for someone with a phobia, certain places, events or objects create powerful reactions of strong, irrational fear along with physical symptoms of rapid heartbeat, light headedness or rapid breathing. Most people with specific phobias have several triggers. To avoid the sensations of panic, someone with a specific phobia will work hard to avoid their triggers. Depending on the type and number of triggers, this fear and the attempt to control it can seem to take over a person's life.

Generalized Anxiety Disorder (GAD)

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

Social Anxiety Disorder

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

Other anxiety disorders include agoraphobia where the sufferer may be unable to leave their home; separation anxiety disorder; and substance/ medication-induced anxiety disorder involving intoxication or withdrawal or medication treatment.

ANXIETY DISORDERS: CAUSES

Scientists believe that many factors combine to cause anxiety disorders:

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

ANXIETY DISORDERS: DIAGNOSIS

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

ANXIETY DISORDERS: TREATMENT

The use of medication to treat anxiety disorders may be recommended, and while medication alone does not address the underlying reasons that a person develops an anxiety disorder, the use of medication can help keep symptoms under control while other forms of treatment are implemented. Importantly, medications work differently in different people and need to be prescribed and monitored by appropriate medical personnel.

Effective treatments for anxiety disorders also include various forms of counseling, including:

- **Cognitive behavioral therapy** helps people address their fears by modifying the way they think and respond to stressful events
- **Mindfulness therapy** helps patients stay focused in the present and stop struggling to control distressing thoughts and feelings resulting in greater self-acceptance
- **Exposure therapy** uses a method of gradual exposure to fearful situations which leads to decreased anxiety

Exercise and relaxation techniques such as meditation can be useful for people with this disorder because they help to lower stress and to manage severe worry. Positive support from family, friends, and other peers also helps to reinforce anxiety disorder treatment. *It is crucial to acknowledge that the fear experienced is very real to the person suffering no matter how inconsequential it is to others.*

POST-TRAUMATIC STRESS DISORDER – PTSD

Post-traumatic stress disorder (PTSD) is a reaction to traumatic stress, and people with PTSD may feel stressed or frightened even when they are no longer in danger following a traumatic event. PTSD can affect different people, from survivors of sexual or physical assault or natural disasters to men and women in military service. Not everyone who experiences trauma develops PTSD. However, about 10% of women and 5% of men are diagnosed with PTSD in their lifetime. PTSD affects 3.5% of the U.S. adult population—about 7.7 million Americans—but women are more likely to develop the condition than men. About 37% of those cases are classified as severe. While PTSD can occur at any age, the average age of onset is the early 20s.

Traumatic events, such as military combat, assault, 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 and pumping blood to muscles for movement, 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 PTSD.

PTSD: 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 scary thoughts.
- **Avoidance,** which can include staying away from certain places or objects that are reminders of the traumatic event. A person may also feel numb, guilty, worried or depressed or have trouble remembering the traumatic event.
- **Dissociation,** which can 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.

Over the last five years, 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

PTSD: DIAGNOSIS

Symptoms of PTSD usually begin within 3 months after a traumatic event, but occasionally emerge years afterward. Symptoms must last more than a month to be considered PTSD. PTSD is often accompanied by depression, substance abuse or another anxiety disorder.

People can describe symptoms in a variety of ways. How a person describes symptoms often depends on the cultural lens through which they are looking. In Western cultures, people generally talk about their moods or feelings, whereas in many Eastern cultures, people more commonly refer to physical pain. African Americans and Latinos are more likely to be misdiagnosed, so they should look for a health care professional who understands their background and shares their expectations for treatment.

Because young children have emerging abstract cognitive and limited verbal expression, research indicates that diagnostic criteria should be more behaviorally anchored and developmentally sensitive to detect PTSD in preschool children. Read more on the preschool subtype at the **National Center for PTSD.**

PTSD: TREATMENT

Treatment strategies work best when they are customized to meet a person with PTSD's individual needs. The selection of treatment and services should also reflect an individual's stage of recovery. Some of the most common forms of treatment for PTSD include:

- **Exposure therapy** helps people face and control their fear by exposing them to the trauma they experienced in a safe way. It uses mental imagery, writing, or visits to the place where the event happened to encourage the development of coping strategies.
- **Cognitive restructuring** helps people make sense of bad memories and address negative thinking.
- **Psychological therapies** teach people helpful ways to react to frightening events that trigger their PTSD symptoms.
- **EMDR** (eye movement desensitization and reprocessing) has been shown to help people recover from their memories.

PTSD is treated and managed in several ways.

- **Medications,** including mood stabilizers, antipsychotic medications and antidepressants
- **Therapies,** such as cognitive behavioral therapy or group therapy
- **Self-management strategies,** such as "self-soothing." Many therapy techniques, including mindfulness, are helpful to ground a person and bring her back to reality after a dissociative episode or a flashback
- **Service animals,** especially dogs, can help soothe some of the symptoms of PTSD

OBSESSIVE COMPULSIVE DISORDER - OCD

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. More than 2% of the U.S. population (nearly 1 out of 40 people) will be diagnosed with OCD during their lives.

OCD: SYMPTOMS

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 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 neglected something, like turning off the stove or not 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

OCD: CAUSES

The exact cause of obsessive-compulsive disorders is unknown, but researchers believe that activity in several portions of the brain is responsible. More specifically, these areas of the brain may not respond normally to

serotonin, a chemical that some nerve cells use to communicate with each other. Genetics are thought to be very important. If you, your parent or a sibling has an obsessive-compulsive disorder, there's close to a 25% chance that another immediate family member will have it as well.

OCD: DIAGNOSIS

A doctor or mental health care professional will make a diagnosis of OCD. A general physical with blood tests is recommended to make sure the symptoms are not caused by illegal drugs, medications, another mental illness, or by a general medical condition. The sudden appearance of symptoms in children or older people merits a thorough medical evaluation to ensure that another illness is not causing these symptoms.

To be diagnosed with OCD, a person must have:

- Obsessions, compulsions or both
- Obsessions or compulsions that are upsetting and cause difficulty with work, relationships or other parts of life and typically last for at least an hour each day

OCD: TREATMENT

A typical treatment plan will often include a combination of psychotherapy and medication:

- **Medication,** especially a type of antidepressant called a selective serotonin reuptake inhibitor (SSRI), is helpful for many people to reduce the obsessions and compulsions.
- **Psychotherapy** is also helpful in relieving obsessions and compulsions. Cognitive behavior therapy (CBT) and exposure and response therapy (ERT) are effective for many people. Exposure response prevention therapy helps a person tolerate the anxiety associated with obsessive thoughts while not acting out a compulsion to reduce that anxiety. Over time, this leads to less anxiety and more self-mastery.

PSYCHIATRIC MEDICATIONS

Medications can play a major role in treating several mental disorders and conditions. Choosing the right treatment plan should be based on a person's individual needs and medical situation, and under a mental health professional's care.

ANTIDEPRESSANTS

Antidepressants are used to treat depression. The most common antidepressants are called selective serotonin reuptake inhibitors (SSRIs). Examples of SSRIs include:

- Fluoxetine (Prozac)
- Citalopram (Celexa)
- Sertraline (Zoloft)
- Paroxetine (Paxil)
- Escitalopram (Lexapro)

Other types of antidepressants are serotonin and norepinephrine reuptake inhibitors (SNRIs). SNRIs include:

- Venlafaxine (Effexor)
- Duloxetine (Cymbalta)

Another antidepressant that is commonly used is bupropion (Wellbutrin). Bupropion is also used to treat seasonal affective disorder and to help people stop smoking.

Older antidepressant medications include tricyclics, tetracyclics, and monoamine oxidase inhibitors (MAOIs), which may work best for some people.

How do people respond to antidepressants?

Antidepressant medications improve symptoms of depression and keep depression symptoms from coming back. Some people respond better to some antidepressant medications than to others. It is important to know that some people may not feel better with the first medicine they try and may need to try several medicines to find the one that works for them. Others may find that a medicine helped for a while, but their symptoms came back. It is important for patients to carefully follow a doctor's directions for taking medication at an adequate dose and over an extended period of time (often 4 to 6 weeks) for it to work.

Once a person begins taking antidepressants, it is important to keep taking them. Sometimes people taking antidepressants feel better and stop taking their medication too soon, and the depression may return. When it is time to stop the medication, the doctor will help the person slowly and safely decrease the dose. It's important to give the body time to adjust to the change. People don't get addicted (or "hooked") on these medications, but stopping them abruptly may also cause either physical or emotional withdrawal symptoms.

ANTI-ANXIETY MEDICATIONS

Anti-anxiety medications help reduce the symptoms of anxiety, such as panic attacks or extreme fear and worry. The most common anti-anxiety medications are called benzodiazepines. Benzodiazepines used to treat anxiety disorders include:

- Clonazepam (Klonopin)
- Alprazolam (Xanax)
- Lorazepam (Ativan)

Taking these medications for a short period of time can help the person keep physical symptoms under control and can be used "as needed" to reduce acute anxiety.

Buspirone (Buspar), which is unrelated to the benzodiazepine, is sometimes used for the long-term treatment of chronic anxiety. In contrast to the benzodiazepines, buspirone must be taken every day for a few weeks to reach its full effect. It is not useful on an "as-needed" basis.

How do people respond to anti-anxiety medications?

Anti-anxiety medications are effective in relieving anxiety. However, people can build up a tolerance to benzodiazepines if they are taken over a long period of time and may need higher and higher doses to get the same effect. Some people may even become dependent on them. To avoid these problems, doctors usually prescribe benzodiazepines for short periods, a practice that is especially helpful for older adults, people who have substance abuse problems and people who become dependent on medication easily. If people suddenly stop taking benzodiazepines, they may have withdrawal symptoms or their anxiety may return. Therefore, benzodiazepines should be tapered off slowly.

ANTIPSYCHOTICS

Antipsychotic medicines are primarily used to manage psychosis. The word "psychosis" is used to describe conditions that affect the mind, and in which there has been some loss of contact with reality, often including delusions (false, fixed beliefs) or hallucinations (hearing, seeing or smelling things that are not really there). It can be a symptom of a physical condition such as drug abuse or a mental disorder such as schizophrenia, bipolar disorder, or very severe depression (also known as "psychotic depression").

Older or first-generation antipsychotic medications are also called conventional "typical" antipsychotics or "neuroleptics." Some of the common typical antipsychotics include:

- Chlorpromazine (Thorazine)
- Haloperidol (Haldol)
- Perphenazine (Trilafon)
- Fluphenazine (Prolixin)

Newer or second-generation medications are also called “atypical” antipsychotics. Some of the common atypical antipsychotics include:

- Risperidone (Risperdal)
- Olanzapine (Zyprexa)
- Quetiapine (Seroquel)
- Ziprasidone (Geodon)
- Aripiprazole (Abilify)
- Paliperidone (Invega)
- Lurasidone (Latuda)

How do people respond to antipsychotics?

Certain symptoms, such as feeling agitated and having hallucinations, usually go away within days of starting an antipsychotic medication. Symptoms like delusions usually go away within a few weeks, but the full effects of the medication may not be seen for up to six weeks. Every patient responds differently, so it may take several trials of different antipsychotic medications to find the one that works best. Often, it becomes a side effect/benefit issue for the patient—whether the symptom removal compensates for the side effects. Families and patients may have different feelings about this issue.

Some people may have a relapse—meaning their symptoms come back or get worse. Usually relapses happen when people stop taking their medication, or when they only take it sometimes. Some people stop taking the medication because they feel better or they may feel that they don’t need it anymore, but no one should stop taking an antipsychotic medication without first talking to his or her doctor. When a doctor says it is okay to stop taking a medication, it should be gradually tapered off—never stopped suddenly, which causes a shock to the body. Many people must stay on an antipsychotic continuously for months or years to stay well; treatment should be personalized for each individual.

MOOD STABILIZERS

Mood stabilizers are used primarily to treat bipolar disorder, mood swings associated with other mental disorders, and in some cases, to augment the effect of other medications used to treat depression. Lithium, which is an effective mood stabilizer, is approved for the treatment of mania and the maintenance treatment of bipolar disorder. Mood stabilizers work by decreasing abnormal activity in the brain and are also sometimes used to treat:

- Depression (usually along with an antidepressant)
- Schizoaffective disorder
- Disorders of impulse control
- Certain mental illnesses in children

Anticonvulsant medications are also used as mood stabilizers. They were originally developed to treat seizures, but they were found to help control unstable moods as well. One anticonvulsant commonly used as a mood stabilizer is valproic acid (also called divalproex sodium). For some people, especially those with “mixed” symptoms of mania and depression or those with rapid-cycling bipolar disorder, valproic acid may work better than lithium. Other anticonvulsants used as mood stabilizers include:

- Carbamazepine (Tegretol)
- Lamotrigine (Lamictal)
- Oxcarbazepine (Trileptal)

Information about medications changes frequently. Check the U.S. Food and Drug Administration (FDA) website (http://www.fda.gov/Safety/MedWatch/) for the latest warnings, patient medication guides, or newly approved medications.

Source: Excerpts from NIMH (https://www.nimh.nih.gov/health/topics/mental-health-medications/index.shtml) Last Revised: October 2016

Section

5

Substance-Related and Addictive Disorders

SUBSTANCE-RELATED AND ADDICTIVE DISORDERS

There are eight varieties of classes of substances that can impact individuals in negative and self-destructive ways. These are categorized as mild, moderate and severe:

1. ***Alcohol*** – in many ways the most dangerous because sudden detoxification can lead to heart attacks/cardiac arrest
2. ***Cannabis or weed*** – more potent than it was in the '70's and remains in the blood and brain for one week or more because it is fat soluble (unlike other drugs)
3. ***Hallucinogens*** (LSD or angel dust) – causes the user to become disoriented and 'see' things that are not there (i.e. hallucinate)
4. ***Phenylene*** – (ketamine) another class of hallucinogen developed as an animal tranquilizer, causing heavy sedation
5. ***Inhalants*** – such as sniffing glue, paint &/or paint remover; very poisonous when ingested, damaging to the Central Nervous System (CNS)
6. ***Opioids*** – heroin and synthetic prescription painkillers (i.e., oxycontin, fentanyl, flakka); approximately 75% of people addicted to oxy and fentanyl develop a heroin habit as heroin delivers a similar feeling for a fraction of the price. Opioids reduce the perception of pain but can also produce drowsiness, mental confusion, euphoria, nausea and constipation, depending upon the amount of drug taken. It can also depress respiration. Some people experience a euphoric response to opioid medications, and it is common that people misusing opioids try to intensify their experience by snorting or injecting them. These methods increase their risk for serious medical complications, including overdose. Since 1999, overdose deaths have increased 265% among men and 400% among women. In 2014, an estimated 1.9 million people had an opioid use disorder related to prescription pain relievers and an estimated 586,000 had an opioid use disorder related to heroin use. This has become a serious and sometimes fatal crisis for young people on Cape Cod and elsewhere.
7. ***Sedatives*** – relaxes CNS, induce sleep, reduce anxiety, promote calm; very difficult and long-term detox.
8. ***Stimulants*** – cocaine, amphetamines, meth are central nervous system stimulants; abuse can cause cell death, heart attack/ failure, weight loss, dementia, paranoia, psychosis, hallucinations. Stimulants increase alertness, attention, and energy, as well as elevate blood pressure, heart rate, and respiration. They include

a wide range of drugs that have historically been used to treat conditions such as obesity, attention deficit hyperactivity disorder (Ritalin) and, occasionally, depression. In 2014, an estimated 913,000 people ages 12 and older had a stimulant use disorder because of cocaine use, and an estimated 476,000 people had a stimulant use disorder due to using other stimulants besides methamphetamines. In 2014, almost 569,000 people in the United States ages 12 and up reported using methamphetamines in the past month.

The common denominator of the abuse of these substances is that they are taken in excess (swallowed, snorted, smoked or injected); they engage the brain's pleasurable reward system, which is their attraction. Because of the intense stimulation of the brain's pleasure center, normal responsibilities typically become neglected as the importance and demands of the drug take over thinking, feeling, acting.

Use of alcohol and other drugs are often begun recreationally and/or medically. Gradually their attractiveness and appeal grow, and the individual takes more and more of the drug to recapture the original 'high', which leads to a vicious cycle that doesn't end until withdrawal. They are also used to "self-medicate" symptoms of anxiety, depression, etc.

Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.

The diagnostic criteria for each of the eight classes of substances are similar:

This description noted above relates to the drug or substance taking over one's thinking, feeling and acting as the key to understanding addictions: the person's thoughts, feelings and actions become very distorted and can become dangerous to the person or others to the point that relatives and friends no longer recognize him/her.

The substance-related disorders are split into two levels or degrees: (1) substance **use** disorders; and (2) substance-**induced** disorders. The specific conditions classified as substance-induced disorders include detoxification, withdrawal, and other substance/medication-induced mental disorders. The difference between substance use and substance-induced disorders is in classifying the intensity of the ingestion.

ALCOHOL:

Excessive alcohol use can increase a person's risk of developing serious health problems in addition to those issues associated with intoxication behaviors and alcohol withdrawal symptoms. According to the Centers for Disease Control and Prevention (CDC), excessive alcohol use causes 88,000 deaths a year.

The definitions for the different levels of alcohol use are:

	Men	**Women**
Moderate	2/day	1/day
Binge Drinking	5+ in one day in the past 30 days	
	5 Drinks in 2 hours	4 Drinks in 2 hours

B.A.C. (Blood Alcohol Concentration) .08 g/Dl

Heavy Drinking as defined by The Substance Abuse and Mental Health Services Administration (SAMHSA): 5+ drinks on one occasion in past 30 days

However, different body weights and tolerance affect these levels.

An alcohol use disorder is characterized as compulsive and habitual use as defined by two of the following within a 12-month period:

- The individual drinks over a longer period of time or in larger quantities than he/she intended
- A persistent desire to cut back fails continually
- The drinker spends great efforts to secure, intake or recover from the effects of alcohol
- There are cravings (preoccupation) to use alcohol
- Ingestion of alcohol so impairs an individual that he/she fails to meet responsibilities at school, work, and/or home
- Alcohol continues to be ingested despite persistent interpersonal problems
- Using alcohol in risky/hazardous conditions such as driving or using machinery
- Alcohol use continues despite awareness of persistent problems caused by or increased due to drinking
- Tolerance occurs: increased amounts of alcohol needed to gain intoxication

Withdrawal:

- Sweaty hands or increased pulse rate
- Hand tremors
- Insomnia
- Nausea
- Hallucinations (visual, tactile, auditory)
- Psychomotor agitation
- Anxiety

The severity of an alcohol problem is defined by the presence of a given number of symptoms:

Mild	= 2-3 symptoms
Moderate	= 4-5 symptoms
Severe	= 6+ symptoms

CANNABIS DISORDER

Two of the following problems occurring within a 12-month period. Many of these are much like those for alcohol disorder:

- The individual ingests over a longer period of time or in greater quantities than intended
- A desire to cut back fails continually
- The smoker/eater (edibles) invests great efforts to secure, intake or recover from the effects of cannabis
- There are cravings/urges to use cannabis; preoccupation
- Recurrent use results in failure to meet responsibilities of work, family, school
- Continued use despite negative impact on social/interpersonal relationships.
- Using in dangerous situations that impair judgment such as driving, using machinery
- Tolerance occurs–increased amounts are needed to get 'high'

WHAT CAUSES ADDICTION?

There are multiple elements that impact an individual's affinity for alcohol & drugs:

- Genetics – inheritance from parents/grandparents. The correlation between an individual's affinity for alcohol and drugs is generally thought to be approximately 40%.
- Age of first ingestion – prior to 21 years of age. Alcohol & drugs ingested during the teenage years may set the stage for future alcohol and/or drug abuse because a teen's prefrontal cortex of the brain is underdeveloped until after age 21, and these substances can powerfully alter the brain's chemistry & development.
- Amount & frequency of use – getting drunk and/or high as a teen can also predispose a teen to future substance abuse issues.
- The individual's social network – 'using' is encouraged, social/peer pressure is strong
- Mental health factors – high levels of stress, anxiety, depression, chronic pain
- Lack of parental guidance and support, poor family cohesion, poor role models

CO-OCCURRING (DUAL-DIAGNOSIS) DISORDERS

People with mental health disorders are more likely than people without mental health disorders to experience an alcohol or substance use disorder. Co-occurring disorders can be difficult to diagnose due to the complexity of symptoms, as both may vary in severity. In many cases, people receive treatment for one disorder while the other disorder remains untreated. This may occur because both mental health and substance use disorders can have biological, psychological, and social components. Other reasons may be inadequate provider training or screening, an overlap of symptoms, or other health issues that need to be addressed first. In any case, undiagnosed, untreated, or undertreated co-occurring disorders can lead to a higher likelihood of experiencing homelessness, incarceration, medical illnesses, suicide, or even early death.

People with co-occurring disorders are best served through integrated treatment. With integrated treatment, practitioners can address mental health and substance use disorders concurrently, often lowering costs and creating better outcomes. Increasing awareness and building capacity in service systems are important in helping identify and treat co-occurring disorders. Early detection and treatment can improve recovery outcomes and the quality of life for those who need these services.

TREATMENTS FOR SUBSTANCE USE DISORDERS

The treatment system for substance use disorders comprises multiple service components, including the following:

- Individual and group counseling
- Inpatient and residential treatment
- Intensive outpatient treatment
- Partial hospital programs
- Case or care management
- Medication
- Recovery support services
- 12-step fellowship
- Peer supports

A person accessing treatment may not need to access every one of these components, but each plays an important role. These systems are embedded in a broader community, and the support provided by various parts of that community also play an important role in supporting the recovery of people with substance use disorders.

INDIVIDUAL AND GROUP COUNSELING

Counseling can be provided at the individual or group level. Individual counseling often focuses on reducing or stopping substance use, skill building, adherence to

a recovery plan, and social, family, and professional/educational outcomes. Group counseling is often used in addition to individual counseling to provide social reinforcement. Counselors provide a variety of services including assessment, treatment planning, and counseling. Some common therapies include:

- **Cognitive-behavioral therapy (CBT)** teaches individuals to recognize and stop negative patterns of thinking and behavior. For instance, CBT might help a person be aware of the stressors, situations, and feelings that lead to substance use so that they can avoid them or act differently when they occur.
- **Contingency management** is designed to provide incentives to reinforce positive behaviors, such as remaining abstinent from substance use.
- **Motivational enhancement therapy** helps people with substance use disorders build motivation and commit to specific plans to engage in treatment and seek recovery. It is often used early in the process to engage people in treatment.
- **12-step facilitation therapy** seeks to guide and support engagement in 12-step programs such as Alcoholics Anonymous or Narcotics Anonymous.

Some forms of counseling are tailored to specific populations. For instance, young people need a different set of treatment services to guide them toward recovery and often involve a family component. Two models for youth that are often used in combination and have been supported by SAMHSA grants are the Adolescent Community Reinforcement Approach (ACRA) and Assertive Continuing Care (ACC). ACRA uses defined procedures to build skills and support engagement in positive activities. ACC provides intensive follow-up and home-based services to prevent relapse and is delivered by a team of professionals.

INPATIENT AND RESIDENTIAL SETTINGS

Treatment can be provided in inpatient or residential programs. This happens within specialty substance use disorder treatment facilities, facilities with a broader behavioral health focus, or specialized units within hospitals. Longer-term residential treatment has lengths of stay that can be as long as 6-12 months and is relatively uncommon. These programs focus on helping individuals change their behaviors in a highly structured setting. Shorter-term residential treatment is much more common, and typically has a focus on detoxification (also known as medically managed withdrawal) and provides initial intensive treatment and preparation for a return to community-based settings.

An alternative to inpatient or residential treatment is partial hospitalization or intensive outpatient treatment. These programs have people attend very intensive and regular group treatment sessions multiple times a week early in their treatment for an initial period. After completing partial hospitalization

or intensive outpatient treatment, individuals often step down into regular outpatient treatment which meets less frequently and for fewer hours per week to help sustain their recovery.

MEDICATION

Using medication to treat substance use disorders is often referred to as Medication-Assisted Treatment (MAT). In this model, medication is used in combination with counseling and behavioral therapies. Medications can reduce the cravings and other symptoms associated with withdrawal from a substance by occupying receptors in the brain associated with using that drug (agonists or partial agonists), blocking the rewarding sensation that comes with using a substance (antagonists), or inducing negative feelings when a substance is taken. MAT is primarily used for the treatment of opioid use disorder but is also used for alcohol use disorder and the treatment of some other substance use disorders.

RECOVERY SUPPORT SERVICES

Recovery support services are non-clinical services that are used with treatment to support individuals in their recovery goals. These services are often provided by peers or others who are already in recovery. Recovery support can include:

- Transportation to and from treatment and recovery-oriented activities
- Employment or educational supports
- Specialized living situations
- Peer-to-peer services, mentoring, coaching
- Spiritual and faith-based support
- Parenting education
- Self-help and support groups
- Outreach and engagement
- Drop-in centers, clubhouses, respite/crisis services, or warmlines (peer-run listening lines staffed by people in recovery themselves)
- Education about strategies to promote wellness and recovery

PEER SUPPORTS

Peers are individuals in recovery who can use their own experiences to help others working toward recovery. Peer supports are a critical component of the substance use disorder treatment system. Many people who work in the treatment system as counselors or case managers are in recovery, and peers are central to many recovery support efforts.

Peers also play a powerful role as a part of mutual-support groups. These groups, including Alcoholics Anonymous, Narcotics Anonymous and other 12-step programs, provide peer support for ending or reducing substance use. They provide an international support network that is relied upon by many

people in recovery from substance use disorders. Mutual-support groups are often intentionally incorporated into treatment plans and can provide a ready community for individuals who are trying to change their lifestyles to get away from alcohol and other drugs. While mutual-support groups do not work for everyone and are not a necessary part of recovery, they are a fundamental component of the substance use disorder treatment system, even if they are not considered formal treatment.

Section 6

Considerations for Family Members: The Importance of Self-Care

CONSIDERATIONS FOR FAMILY MEMBERS: THE IMPORTANCE OF SELF-CARE

Once your loved one has been diagnosed with a mental illness (or if they are in the process of assessment/evaluation related to their mental health symptoms) try to educate yourself about their diagnosis and/or psychiatric symptoms. Think about the progression (and changes to) their symptoms and behaviors over the course of their life, and read about different symptoms and diagnoses. Once a diagnosis is established, research the best approved treatment options. Talk to social workers, doctors, therapists, etc. who are involved in your family member's care to inquire about recommendations regarding how to approach your family member and help support them in their treatment and recovery. Ask to be involved in treatment planning meetings, and inquire about the doctors, and therapists' treatment recommendations. (See section on HIPAA laws)

Ask your loved one about his/her own treatment goals/plans, and about how you can help them in their recovery. Consider your own goals for your loved one's recovery. Consider how your loved one may interpret your suggestions. Sometimes focusing on the desired outcomes of treatment (alleviation of symptoms, ability to work and stay out of the hospital, etc.) can be more helpful than focusing on "compliance" with treatment (taking medications, etc). If you start with a focus on the outcome (living a healthy life in the community, without the distress of symptoms, or the consequences related to acute symptoms/ behaviors), you can often move easily into the conversation about what is going to lead to the desired outcome (medications, sobriety, therapy, etc).

THE VALUE OF SELF-CARE (OFTEN REFERRED TO AS "PUT THE OXYGEN MASK ON YOURSELF FIRST"):

Make a list of all the activities you can undertake that will support your sense of well-being and your health (social, emotional and physical). To be supportive of your loved one, you need to take good care of yourself so that you do not "burn out." In doing this you will be taking care of your loved one. Trying to "control" or "manage" a loved one's illness (especially when they do not see the benefits of following their treatment plan) can be exhausting, particularly if you do not practice a rigorous self-care program. Without it, you may become discouraged and depressed yourself, lose your sense of life and humor, and "burn out," reducing the effectiveness of your efforts to be of help to your loved one.

Here are some suggestions for creating your own self-care program:

a. Maintain your friendships or develop some new ones

b. Indulge and nurture your hobbies, such as: exercising (walking/running with friends, biking, gym workouts), reading fun books, seeing movies, building things/woodworking, cooking/baking, knitting/quilting, eating out

c. Accept all invitations for parties and celebrations; do not isolate yourself

d. Join and share in appropriate Family-to-Family or 12-step programs

e. Identify and express your feelings through journaling

f. Seek out therapy to gain insights and expression

g. Make getting enough sleep a priority

h. Eat healthy foods

i. Seek out support from those in or who were in your same situation

j. Pray for strength and the wellness of your relative

k. Attend church to develop your connection to your 'Higher Power' (You are not alone…unless you choose to be), meditate, become actively involved in the life of your church/synagogue/mosque.

Section 7

Department of Mental Health (DMH) Community Services

DEPARTMENT OF MENTAL HEALTH (DMH) COMMUNITY SERVICES

APPLICATION, ELIGIBILITY AND APPEAL

DMH provides a range of services for approximately 25,000 adult clients per year. These services include inpatient continuing care, emergency services, case management and other community and rehabilitative services, such as Community Based Flexible Supports (CBFS), Program for Assertive Community Treatment (PACT), Clubhouse and Respite. Effective July 1, 2018 Adult Community Clinical Services (ACCS) is scheduled to replace CBFS.

APPLYING FOR COMMUNITY MENTAL HEALTH SERVICES

Who May Apply?

An applicant, or an applicant's legally authorized representative (LAR), may apply for DMH services.

A program or facility may sign and submit an application on behalf of an adult under one of the following circumstances:

1) The program or facility notifies the applicant that an application is being submitted on his or her behalf, and the applicant does not object.
2) The program or facility believes that the applicant is incapacitated and has filed a petition for guardianship of person with the court.

Where Can Application Forms Be Obtained and Completed Applications Submitted?

Information can be obtained from the DMH Area Office:

Cape Cod & The Islands	Phone:	(508) 957-0900
181 North Street	Fax:	(508) 957-0965
Hyannis, MA 02601	TTY:	(508) 771-3907

Towns Served: Barnstable, Bourne, Brewster, Chatham, Chilmark, Cotuit, Dennis, Eastham, Edgartown, Falmouth, Gay Head, Harwich, Hyannis, Mashpee, Nantucket, Oak Bluffs, Orleans, Osterville, Provincetown, Sandwich, Tisbury, Truro, Vineyard Haven, Wellfleet, West Tisbury, Woods Hole, Yarmouth

Application forms and appeals guidelines may also be found at: http://www.mass.gov/eohhs/gov/departments/dmh/service-application-forms-and-appeal-guidelines.html

*What Are the Clinical Criteria for Adults?**

To meet clinical criteria for DMH services, the applicant must have a qualifying mental disorder as the primary disorder requiring treatment and meet functional impairment and illness duration criteria.

An adult applicant must have a serious and long-term mental illness that has resulted in functional impairment that substantially interferes with or limits one or

more major life activities.

Serious and long-term mental illness is a disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior and capacity to recognize reality, and that results in an inability to meet the ordinary demands of life.

Qualifying mental disorders:

- Schizophrenia and other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Dissociative Disorders
- Eating Disorders
- Borderline Personality Disorder

Co-Occurring Disorders: An individual with a substance abuse disorder may be authorized for DMH services if he or she is determined to have a qualifying mental disorder, meets impairment and duration criteria, requires DMH services and has no other means for obtaining them, and DMH has available capacity to provide the services. To meet functional impairment criteria, the impairment does not have to be solely attributed to an individual's qualifying mental disorder.

Functional Impairment: Difficulties resulting from a primary major mental illness must persistently and substantially interfere with or limit role functioning in one or more major life activities and be expected to do so in the succeeding year.

Major life activities include basic daily living skills (e.g., eating, bathing, dressing, maintaining a household, managing money, accessing generic community services, taking prescribed medication) and functioning in social, family, and vocational/educational contexts. Risk of harm to self or others is also recognized as an index of functional impairment.

Duration of Qualifying Disorder: The qualifying mental, behavioral, or emotional disorder must have lasted for, or be expected to last for, at least one year.

What Happens if the Applicant Does Not Meet the Clinical Criteria?

DMH will notify the applicant that the application has been denied and the clinical criterion or criteria that were not met will be specified. The applicant will be notified of the right to appeal.

How Does DMH Determine Whether or Not There Is a Need for at Least One DMH Service?

If it is determined that the applicant meets the clinical criteria, DMH will then determine whether the applicant requires services and what kind of access to appropriate community services may be available to the applicant.

What Happens if DMH Determines the Applicant Needs DMH Services and the Needed Services Are Available?

DMH will notify the applicant and provide contact information for the applicant to access the authorized service(s).

What Happens if the Applicant Does Not Need DMH Services?

If DMH determines that the applicant does not need DMH services, that the applicant is able to obtain needed services through insurance or medical entitlement, that another entity is appropriately serving the applicant, or that other public or private services are available to meet the applicant's needs, the request for services is not approved.

What Happens if the Needed DMH Service Is Not Available?

If DMH determines that the applicant needs DMH services, but the needed services are not available, the applicant will be informed that the request for service cannot be approved because the needed services do not have available capacity.

DMH will contact the applicant at least monthly to inquire about the applicant's status and continued need for DMH service(s). At such time that the service becomes available, the individual will be offered a referral to such service.

If, after six months, the needed service remains unavailable, the applicant will be required to re-apply for DMH services.

How Long Does the Finding of Meeting the Clinical Criteria Last?

Six-month rule: If an applicant reapplies within six months from the date the request for services was not approved, the finding that the applicant met clinical criteria would remain in effect.

**There are separate clinical criteria for children and adolescents under age 19.*

APPEAL GUIDELINES: CLINICAL

Who May File an Appeal?

A determination by DMH that an applicant is not approved for DMH services based on clinical criteria may be appealed by an applicant, the applicant's LAR, if any, or a person designated by the applicant when there is no LAR using the procedures established by the Department and outlined below. DMH staff will provide the applicant with the necessary names, addresses and telephone numbers to initiate an appeal.

How Is an Appeal Filed?

An applicant wishing to appeal formally or informally should provide additional information to support the reversal of the denial decision:

An applicant wishing to appeal should:

1. Request an informal meeting with Area Director or designee within ten days of receiving the notification of denial to ask questions and resolve any issues or ask that this informal meeting be waived (the applicant may bring other persons to this meeting if desired);
2. If the informal meeting has been waived, or if the applicant is still dissatisfied with the decision, the applicant may file a written notice with Area Medical Director, a Request for Reconsideration by the Area Medical Director within ten days after the conclusion of the informal conference or the agreement to waive.

The Area Medical Director must render a decision on the Request for Reconsideration within twenty days of receipt of the request, unless the time is extended by mutual consent of the Area Medical Director and the person filing the Request for Reconsideration.

What Happens if the Area Medical Director Does Not Reverse the Denial of Eligibility and the Applicant Believes He or She Should Be Eligible?

If denial of the application is not reversed by the Area Medical Director, the applicant may appeal the Area Medical Director's decision by petitioning the DMH Commissioner or designee for a fair hearing pursuant to 104 CMR 29.16(5).

A petition for fair hearing must be submitted to the Commissioner within twenty days after receiving the Area Medical Director's decision regarding clinical criteria pursuant to 104 CMR 29.16(3). The hearing officer shall render a decision within 20 days of the close of the hearing. Within 15 days after receipt of the hearing officer's recommended decision, the Commissioner shall issue a decision.

Information Source: DMH Application for Mental Health Services (http://www.mass.gov/eohhs/consumer/behavioral-health/mental-health/applying-for-mental-health-services.html); DMH Service Application Forms and Appeal Guidelines (http://www.mass.gov/eohhs/gov/departments/dmh/service-application-forms-and-appeal-guidelines.html)

Section **8**

Legal Issues in Mental Health: Guardianship, Commitment to A Psychiatric Hospital and HIPAA Laws

LEGAL ISSUES IN MENTAL HEALTH: GUARDIANSHIP, COMMITMENT TO A PSYCHIATRIC HOSPITAL AND HIPAA LAWS

GUARDIANSHIP

A guardian may be appointed for an adult (18 years or older) who is deemed to be an "incapacitated person" by the Probate Court in the county in which the person resides. "Incapacity" is the legal standard in Massachusetts that essentially requires that the person have a clinically diagnosed condition that impairs decision-making to such an extent that the person is unable to "meet the essential requirements for physical health, safety or self-care." A guardian may be authorized to make decisions about the person's daily needs, residence and medical treatment.

It is important to recognize that there are limitations to guardianship powers. If the person has a health care proxy, the guardian cannot override predetermined medical decisions without the court's permission. The guardian cannot admit the person to a nursing home without court approval. With respect to mental health treatment, there are two important exceptions to a guardian's authority. Neither the guardian nor the Probate Court may admit an incapacitated person to a mental facility. An incapacitated person may only be admitted through the involuntary commitment process (see "Civil Commitment" below). Furthermore, a guardian cannot consent to administration of antipsychotic medication without a separate judicial proceeding in which the court must approve a treatment plan, which is known as a "Rogers Order" (see "Rogers Order" below).

While there are limitations on a guardian's authority, it may still be a useful tool for caregivers who are trying to help a relative or friend who lacks insight into their mental illness. In order to make informed health care decisions on the person's behalf, the guardian must have access to medical information. Thus, a health care provider is not bound by medical privacy laws, such as HIPAA (see below) when it comes to discussing the person's healthcare or medical needs with the guardian. Furthermore, the guardian may apply for benefits and services for the individual, as well as advocate and monitor the services that the person is supposed to receive.

Any person may file a petition (referred to as the "Petitioner") with the Probate Court to obtain guardianship for an "alleged incapacitated person" (referred to as the "Respondent"), along with a medical certificate, which must be completed by a physician, licensed psychologist, certified psychiatric nurse, or nurse practitioner. The court will provide a hearing date, which must be served upon the Respondent. The Respondent has a right to be present at the hearing and be represented by counsel. If the court grants guardianship, decisions made by the guardian on behalf of the incapacitated person must be in the person's best interest. The guardian must file a report with the court concerning the incapacitated person's care and treatment at least annually.

ROGERS ORDERS

In 1983, the Supreme Judicial Court of Massachusetts ruled that a person who refuses antipsychotic medication cannot be medicated over objection unless a court deems that the person is incompetent to make an informed decision about treatment. A court must also approve the administration of antipsychotic medication to an individual who consents, but lacks the capacity to make an informed decision about treatment. The standard that a court uses to determine whether it is appropriate to approve treatment is "substituted judgment," based on whether the person would accept treatment if he were competent. The court considers several factors, such as the patient's previous expressed interests, how the impact on the family would impact the patient's decision, possibility of side effects, prognosis without treatment and available alternatives.

The term "Rogers Order" is derived from the 1983 case *Rogers v. Dept. of Mental Health*. A request for a Rogers Order may accompany a petition for guardianship, if the patient is in the community. The request must be accompanied by a clinician's affidavit and a proposed treatment plan. The court will appoint a Rogers Monitor to ensure that the patient is being treated in accordance with the plan. If a patient is involuntarily committed to a hospital and does not already have a Rogers Order, the facility may file a petition with the District Court for authorization to administer antipsychotic medication.

ADMISSION TO PSYCHIATRIC FACILITIES

The term "section" is commonly used in reference to a person who is being held in custody (for a psychiatric evaluation) or has been involuntarily hospitalized for treatment. It refers to Section 12 of the Massachusetts law that governs involuntary commitment, which establishes the procedure for committing a person who is alleged to have a mental illness, when the failure to retain him in strict custody would create a 'likelihood of serious harm.' Any person may file an application with the District Court under Section 12 for a three-day commitment to a hospital. A medical or mental health professional, or a police officer, may also initiate the process. After an initial 3-day period, the facility director may apply to the court for an extension.

A person who has a mental illness and meets the requirements for civil commitment may be admitted to a psychiatric hospital without his consent. The legal standard for involuntary commitment is widely misunderstood. A person may be involuntarily committed if "the failure to retain him in strict custody would create a 'likelihood of serious harm,' which is not limited to suicidal or homicidal, as commonly believed. The conditions that meet the criteria under Massachusetts law are:

1. Substantial risk of physical harm to the person himself (suicide *or serious bodily harm*);

2. Substantial risk of physical harm to other persons (homicide *or other violent or behavior that places the person in reasonable fear of serious physical harm*); or
3. Very substantial risk of self-harm, based upon evidence that the 'person's judgment is so affected that he is unable to protect himself in the community and that reasonable provision for his protection is not available in the community'.

The third standard, which is based upon a person's inability to take care of himself in the community, is rarely applied in Massachusetts, although there is no reason that it cannot be used.

Contrary to popular belief, "imminent" does not mean "immediate" for purposes of determining the risk of harm to self or others, according to Massachusetts Supreme Judicial Court. That is, a "substantial risk" of harm does not require that the anticipated harm will occur immediately. Rather, it must be shown that there is a substantial risk that the harm will materialize in the ***reasonably short term—in days or weeks rather than in months.***

HIPAA & HEALTH INFORMATION PRIVACY LAWS AND POLICIES

Medical and mental health professionals cite HIPAA (the *Health Information Portability and Accountability Act*) when refusing to discuss a patient's health or treatment with family members. However, certain aspects of patient privacy and confidentiality of medical information existed under medical ethics and state statutes long before HIPAA became law. HIPAA is a federal law that applies to everyone. However, it is important to understand whether a state law may prohibit a disclosure that is allowed under HIPAA.

HIPAA and mental health treatment

HIPAA applies uniformly to all protected health information, whether an individual is receiving mental health or any other medical treatment. The only exception is that "psychotherapy notes" (personal notes of a therapist) cannot be shared. This is also the case under Massachusetts law.

Providing information to health care professionals

There is nothing in HIPAA or state law that prevents health care providers from listening to family members or other caregivers who may have concerns about the health and well-being of the patient, so the health care provider can factor that information into the patient's care. Providers are not required to disclose the information to the patient.

HIPAA and a patient's consent to disclosure of information

Under HIPAA, information may be shared with families who are involved in or pay for the patient's care under certain circumstances *if the patient does*

not object. Written authorization is not required. Additionally, consent can be implied, for example, when a family brings an individual to the emergency room and the individual does not ask the family to leave the room.

HIPAA and disclosure of information to families

U.S. Health and Human Services (HHS) issued a guidance document in 2017 that addresses the issues of concern to families. *www.hhs.gov/hipaaforindividuals/mental-health/index.html* The guidance provides examples in which a health care provider may share information with a family even if the individual objects:

1. The provider believes, based on professional judgment, that the patient does not have the capacity to agree or object to sharing the information, such as a patient who is suffering from temporary psychosis or is under the influence of drugs or alcohol.
2. The provider has a good-faith belief that the patient poses a threat to the health or safety of the patient or others, and the family member is reasonably able to prevent or lessen that threat. (The risk of harm need not be immediate. See "Admission to psychiatric facilities" above.)

The HHS guidance includes the following example:

> If a doctor knows from experience that, when a patient's medication is not at a therapeutic level, the patient is at high risk of committing suicide, the doctor may believe in good faith that disclosure is necessary to prevent or lessen the threat of harm to the health or safety of the patient who has stopped taking the prescribed medication, and may share information with the patient's family or other caregivers who can avert the threat.

HIPAA in no way prevents health care providers from listening to family members or other caregivers who may have concerns about the health and well-being of a patient, so the health care provider can factor that information into the patient's care.

Duty to warn in Massachusetts

HIPAA does not require that providers notify family members or law enforcement of a threat to health or safety.

In Massachusetts a licensed mental health professional (LMHP) has a duty to warn potential victims of harm if:

1. The licensed mental health professional knows that the patient has a history of physical violence and believes that there is a clear and present danger that the patient will attempt to kill or inflict serious bodily injury on a reasonably identified victim or victims.

2. The patient has communicated an explicit threat and has the intent and ability to harm a specific individual.

In such circumstances, the LMHP may also notify the appropriate law enforcement agency, arrange for the patient to be hospitalized voluntarily, and/or initiate proceedings for involuntary hospitalization.

HIPAA provides certain exceptions for withholding information about an individual's health information. However, these exceptions are permissive. In other words, a patient's verbal consent is sufficient under HIPAA, but a hospital policy may still require written consent. Still, it is important to understand what is allowed under HIPAA the next time a health provider says "I can't talk to you because of HIPAA."

Section **9**

Additional Resources for Families

ADDITIONAL RESOURCES FOR FAMILIES

GENERAL

NAMI CAPE COD & THE ISLANDS (National Alliance on Mental Illness)
5 Mark Lane, Hyannis
508-778-4277
info@namicapecod.org
www.namicapecod.org

Offering support, education and advocacy services including 12-week Family-to-Family Education programs and monthly support groups in towns across the Cape and Islands (see our website for more details)

NAMI ON NANTUCKET
508-221-6202
NamiOnNantucket@gmail.com

DEPARTMENT OF MENTAL HEALTH AREA OFFICE
181 North Street, Hyannis
508-957-0900

BARNSTABLE COUNTY DEPARTMENT OF HUMAN SERVICES
508-375-6626
Online health and human services directory:
Barnstable.ma.networkofcare.org

BAY COVE HUMAN SERVICES
270 Communication Way, Hyannis
Call Center: **800-981-4357**

VINFEN
109 Iyannough Road, Hyannis
508-815-5200
Provides Community Based Flexible Supports, Program of Assertive Community Treatment, Homeless Outreach, Recovery Connection Center, Community Crisis Stabilization Unit

INPATIENT SERVICES

CAPE COD HOSPITAL BEHAVIORAL HEALTHCARE
27 Park Street, Hyannis
508-862-5566 or ***800-513-4728***

FALMOUTH HOSPITAL
100 Ter Heun Drive, Falmouth
508-548-5300

DEPARTMENT OF MENTAL HEALTH AT POCASSET
830 County Road, Pocasset
508-564-9600

CRISIS STABILIZATION UNIT, A SIX-BED VOLUNTARY UNIT RUN BY VINFEN
270 Communication Way, Hyannis
508-790-4094

GOSNOLD ON CAPE COD
200 Ter Heun Drive, Falmouth
800-444-1554
Detox, rehab, residential and out patient services

MCLEAN HOSPITAL
115 Mill Street, Belmont
617-855-3141

Additional facility: McLean Southeast, 23 Isaac Street, Middleborough
617-855-3141

MCLEAN-FRANCISCAN CHILD & ADOLESCENT INPATIENT PROGRAM
115 Mill Street, Belmont
800-333-0338

HIGH POINT TREATMENT CENTER
1233 State Road, Plymouth
508-224-7701
Mental health and detox services

Additional facility:

52 Oak Street, Middleborough
774-213-8400

Continued next page

SOUTHEAST BEHAVIORAL HEALTH CENTER
581 Faunce Corner Road, Dartmouth
877-560-7275
120-bed inpatient hospital for adolescents and adults

All of the above inpatient organizations also have extensive Intensive Outpatient Programs following completion of inpatient services.

OUTPATIENT SERVICES

CAPE COD HOSPITAL BEHAVIORAL HEALTHCARE
27 Park Street, Hyannis
Partial hospitalization and aftercare groups
508-862-5644

CAPE COD HUMAN SERVICES (Cape Cod Behavioral Healthcare)
460 Main Street, Hyannis
508-862-5455

FONTAINE MEDICAL CENTER (Cape Cod Behavioral Healthcare)
525 Long Pond Drive, Harwich
508-432-4100

COMMUNITY HEALTH CENTER OF CAPE COD
107 Commercial Street, Mashpee
210 Jones Road, Suite 22, Falmouth (at Homeport)
123 Waterhouse Road, Bourne
508-477-7090
Behavioral health services in addition to primary care

GOSNOLD ON CAPE COD
Partial hospitalization, dual-diagnosis programs, outpatient clinics, recovery management, telepsychiatry and family support groups located in several areas on Cape Cod
800-444-1554

OUTER CAPE HEALTH SERVICES

Provincetown:	49 Harry Kemp Way	**508-487-9395**
Wellfleet:	3130 Route 6	**508-349-3131**
Harwich:	269 Chatham Road	**508-432-1400**

RELIEF HOME HEALTH SERVICES
24-HR Referral Line: **888-817-5656**

CAPE & ISLANDS COGNITIVE BEHAVIOR INSTITUTE
704 Main Street, Falmouth
508-457-3160

CAPE COD FAMILY RESOURCE CENTER
29 Bassett Lane, Hyannis
508-862-0600
www.CapeCodFamilyResourceCenter.org
All services are free

CAPE COD CHILD & FAMILY SERVICES
1019 Iyannough Road, Hyannis
508-778-1839

CAPE COD CHILDREN'S PLACE
10 Ballwic Road, Eastham
508-240-3310 1-800-871-9535

MASS DEPARTMENT OF CHILDREN & FAMILIES
500 Main Street, #2, Hyannis
508-760-0200

CAPE BEHAVIORAL HEALTH CENTER
310 Barnstable Road, #201, Hyannis
508-862-0514

DUFFY HEALTH CENTER
94 Main Street, Hyannis
508-771-9599
Services for the homeless or those at risk for homelessness

JUSTICE RESOURCE INSTITUTE
221 Willow Street, Yarmouth Port
508-771-2402
JRI offers a range of programs designed to support youth struggling with intensive acute symptoms including long-term intensive residential treatment programs as well as short-term stability support. JRI supports youth with both acute symptoms as well as with juvenile justice services. JRI also offers in-home behavioral visits

PARENT INFORMATION NETWORK
47 East Grove Street, Middleboro
508-947-8779
Support, information, groups for parents of children with serious behavioral or mental challenges

Continued next page

FAMILIES FOR DEPRESSION AWARENESS
Waltham **781-890-0220**
Educational website: www.familyaware.org
An excellent resource for information on depression, especially teen depression

LEGAL SERVICES*

LAWYER FOR A DAY
Barnstable Probate Court
Free legal services daily in the morning (arrive by 9:00 am)

MENTAL HEALTH LEGAL ADVISORS COMMITTEE
24 School Street, Suite 804, Boston
Phone **617-338-2345**
Toll-Free (MA only) **800-342-9092**
Fax **617-338-2347**
General Email **MHLAC@mhlac.org**
Intake Email **Intake@mhlac.org**

DISABILITY LAW CENTER, INC.
11 Beacon Street, Suite 925, Boston
617-723-8455 / **800-872-9992** Voice
Fax **617- 723-9125**

SOUTH COASTAL COUNTIES LEGAL SERVICES, INC.
460 Main Street, Hyannis
508-775-7020

CAPE ORGANIZATION FOR RIGHTS OF THE DISABLED (CORD)
106 Bassett Lane, Hyannis
508-775-8300 or **800-541-0282**
Fax **508-775-7022**
www.cilcapecod.org

WE CAN-WOMEN'S EMPOWERMENT THROUGH CAPE AREA NETWORKING
783 Route 28, Harwich Port
508-430-8111
info@wecancenter.org
Offering legal consultations and family law workshops (including grandparents legal workshop) and more

**NAMI offers limited legal advice with several pro bono attorneys.*

PEER SERVICES

PEER SUPPORT LINE 1-877-733-7563
OR 1-877-PEER-LNE (NO "I")
Answers calls 4-8 pm

WAVES OF WELLNESS RECOVERY CONNECTION CENTER
45 Plant Road
Hyannis, MA 02601
508-815-5219
www.southeastrlc.org

DANCE IN THE RAIN: A WHOLE PERSON APPROACH
PEER TO PEER COLLABORATION
145 Barnstable Road, Hyannis
508-364-4045
www.danceintherain-wpa.org

PIER (Positive Individuals Engaged In Recovery)
RECOVERY SUPPORT CENTER
209 Man Street (rear entrance)
Hyannis MA 02601
508-827-6150

THE DEPRESSION AND BIPOLAR SUPPORT
ALLIANCE OF CAPE COD (DBSA-CC)
Cape Cod Medical Center (across from the Cape Cod Psych Center)
40 Quinlan Way, Hyannis
Meets every Wednesday at 7:00 – 9:00 pm - Drop-In
For more info, call Paul at 508-221-5174

CLUBHOUSES

BAYBRIDGE CLUBHOUSE (OPERATED BY VINFEN)
278 Main Street, Hyannis
508-778-4234

COVE CLUB (OPERATED BY VINFEN)
383 Main Street/Route 28, Harwichport
508-432-7774

FAIRWINDS CLUBHOUSE (OPERATED BY FELLOWSHIP INC)
155 Katharine Lee Bates Road, Falmouth
508-540-6011

Continued next page

VETERANS SERVICES

CAPE & ISLANDS VETERANS OUTREACH
569 Main Street, Hyannis
508-778-1590

VET CENTER
474 West Main Street, Hyannis
508-778-0124

HOTLINES & CRISIS NUMBERS

911 OR YOUR LOCAL POLICE DEPARTMENT – ASK FOR A CCIT OR CIT-TRAINED OFFICER (TRAINED IN MENTAL HEALTH ISSUES)

BAY COVE CRISIS LINE
800-981-4357 (HELP)

NATIONAL SUICIDE PREVENTION HOTLINE
800-273-8255

SAMARITANS OF CAPE COD & THE ISLANDS
508-548-8900
800-893-9900
1-877-870-HOPE (4673) - STATEWIDE TOLL-FREE

MASSACHUSETTS SUBSTANCE ABUSE HOTLINE
800-327-5050

ELDER SERVICES HOTLINE
800-922-2275

Note: *This is by no means a complete listing of all mental health and human service agencies and programs in the area. It represents those agencies with whom NAMI CC&I has worked.*

Section

10

Personal Stories

PERSONAL STORIES

STORY 1: IT MAY FEEL LIKE A ROLLER COASTER RIDE, BUT PLEASE DON'T LET GO

"I am a survivor of stalking, fear of death threats/attempts, homelessness with two toddlers, and a woman Veteran. I am a mother of two children that have been exposed to domestic violence and were diagnosed with PTSD and still feel the pain. I am a daughter of a mother that had suffered severe trauma and was diagnosed with bipolar and a father that had severe trauma as a child and PTSD from Vietnam. My four siblings and mother actively supported me for twelve years before I finally left my abuser. I have seen my father's family stand by him throughout his continued illness and love him unconditionally. He is still alive and struggles even today but lives with his supportive and loving family. My mother's family disowned her because they didn't understand mental health concerns. They tried to stand by her but in the end couldn't help her and felt frustrated and hurt by many things she said and did. Her brother beat her over the head with his fists thinking to "snap" her out of it. My uncle came to me proudly at work when I was sixteen saying "your mother will be fine from now on." Of course, that was not the case. My mother's foundation of support was her family and the church. Unfortunately, the congregation felt that my mother's illness was too much for them to handle so they decided to excommunicate her on the grounds that she was committing adultery (despite being divorced from my father for 8 years). My mother was left alone to raise five children and was no longer able to continue working as a nurse due to self-medicating with marijuana and hence loss of her license. It was a long struggle without the crucial support she needed and she died at 58 years young from a heart attack. I want to convey to families that mental illness/trauma effects can last for a long time and living with family that suffers from it is a tremendous roller coaster ride, but continued support is so imperative to not only their wellbeing, but EVERYONE'S wellbeing. There is no quick fix. Please educate yourself about resources, support groups, and being emotionally available as the most vital support...natural supports. Receiving self-care is the highest priority; it re-energizes the soul to be able to continue a lifetime of love."

STORY 2: THE JOURNEY OF LISA AND HER FAMILY

Lisa's Sister:

"Hi,

My name is Lori and I am writing this regarding the care for my sister – Lisa.

My experience with the mental health system began when my sister required services. I was often her main contact as our mother passed away when she was 12 years old and I was her closest female relative and confidant. Through the ups and downs of her diagnosis and treatment, our relationship, her diagnosis, and my reaction and understanding of it, obviously created strains in our relationship that I am happy to say we have overcome. As I look back and consider her struggles and those of my family as we desperately tried to acquire services for her, I am incredibly grateful we were able to help her and help her ultimately succeed on her own merit.

I am familiar with NAMI and took one of their family support courses that I found invaluable.

1. The first obstacle we faced was trying to get my sister the mental health services she needed early on. When she was in her early 20s it was clear that she was struggling with anxiety and depression. At the time, even getting her into a program to help her was very difficult and she wanted to get help. There is no clear route to getting help for someone struggling with mental illness and this process is even more daunting for a person that doesn't even want to get out of bed let alone make phone calls and seek out services. She wanted help, but simply couldn't get it. We eventually got her into an inpatient program after several long hours in an ER. At this time we were only able to seek services for her as she had definitively contemplated suicide, had a plan and the materials needed to execute the plan. As her family, this was horrifying, we had tried to get her help, sought out programs for her (with her willing to participate in such programs) but we were unable to do anything until it was almost too late. The process to admit a patient into inpatient programs needs to be changed so that patients who are desperate and actively looking for help aren't left to feel their only option is suicide.
2. As a family, we once ran into an issue of providing information to doctors when my sister was taken into emergency care. At one point, we as a family knew she was taken into care, we had a pretty good idea of what hospital she was taken to, and simply wanted to provide the doctors there with her history. At the time she had specified that she did not want her location released to us and did not want us to have access to details regarding her care. Specifically, we wanted to share with her health care providers

information regarding the behavior leading up to her admission, as well as her history regarding medications and care previously received. We were not asking for confirmation as to her being in care or for them to reveal any information regarding her care, we simply wanted to provide them with necessary information that would help them provide care to her. A system should be put in place that allows families and/or friends to provide information regarding a patient without breaking HIPAA laws. Doctors could then access this information to best serve their patient.

3. Another issue we ran into with my sister was continuation of services after insurance changes. My sister is actually quite a responsible patient when it comes to taking her medication – until there is a change in insurance that requires a change in caregivers. To my knowledge, it has been such changes that have caused her to stop taking her medication and, consequently, fall down the slippery slope that follows. I think it is important to address this issue with the mental health care system. A patient with established care with people he/she trusts is critical to long term health. Adding provisions that allow a person to keep their mental health care providers even after they change insurance carriers is essential in my opinion.
4. Probably the most stressful component of my sister's care came when she was released from inpatient care. At that particular time, my sister did not have a place of her own and given her mental health history when living with family, we as a family felt she would be better served in a transitional setting that provided her with a safe shelter and services at the same time, but not with the regulations of an inpatient facility. We as a family had to find the services ourselves with no help – I mean NO help – from her inpatient facility. We were told she would have to go somewhere even if that meant a woman's shelter. I worked with my stepmother to find my sister a transitional setting – we researched places, we made phone calls until we found something. For my sister, this process was very bumpy. She moved first to a transitional mental health care setting that provided housing and outpatient care during the day. She was able to leave but had a curfew. Again, we found this facility and we were able to get her into it. When she was released from this program she went to a halfway house suited more for recovering addicts than someone solely struggling with a mental illness. We knew this was not a good fit for her so, again, as a family we made phone call after phone call until we found Fellowship Health Resources which provided her with housing and continued care. She did so well there that she eventually was offered a peer counselor position. I think there is a dangerous gap between inpatient care and transitional care. When a patient has hip or knee

surgery, they are usually sent directly to a rehabilitation facility once they are released from the hospital. Why should mental health treatment be any different? Mental health care needs to follow this model to provide their patients with long term success.

5. Overall, my sister is a success story when it comes to living with a mental illness. What is unfortunate is that her journey to this point had so many obstacles that might have prevented her success. My sister comments now that she knows she is lucky to have the family she had supporting her, but I also know that her success is due in a large part to her perseverance. Many of the places she lived during her transition to caring for herself and living in her own apartment were not without their challenges. She had to deal with roommates she did not choose whose behavior made her living situations uncomfortable. We are lucky that we were able to work together as a family to get her services. Many do not have this and they would very easily fall through the cracks of the system."

Lisa's Parents:

"Shortly after graduating from college, our daughter Lisa was diagnosed with bipolar disorder. Although my husband and I had an idea of what that was, we really did not know or understand the full depth of the illness. Our first priority was to get the critical help she needed. In those efforts, we quickly came to the realization that we needed to get educated about the disorder because we were totally uninformed. Our attempts to reach out to her often failed and we were looking desperately for someone or an organization to help us with the challenge of bridging the gap in our relationship that had become very strained because of the illness. Someone recommended that we look into NAMI (National Alliance on Mental Illness) because they could help us with support and services through a three month program. NAMI was our lifeline and a blessing for the twelve weeks we attended classes. We could not believe that after numerous months of spinning our wheels, we finally had made a breakthrough. We met other families who were in the same situation and we all shared our stories. The moderators also had their own experiences and were eager to help and educate the group. We became a family dependent on each other week after week. Upon conclusion of the classes, we left NAMI with our spirits lifted having been provided direction, unending support, and connection to families with similar challenges. Of most importance is that we learned our daughter could live well with her illness and has in fact flourished after coming to grips with her diagnosis. Words cannot adequately describe the extent of our appreciation to this outstanding organization for bringing sense to what was a frenzied situation. We are comforted by the fact they will always be there for us and so many others to offer support and help with an illness that has no boundaries and afflicts people from all walks of life."

– Robert and Louise

STORY 3: "VOICE OF HOPE"

"My son was diagnosed with a few different mental health conditions, all of which sounded surreal. How could this be happening to him? Him of all people? He was such a friendly guy, always seemed happy, the life of the party, the party planner in fact, always for the underdog, would give you the shirt off his back, helped people at every opportunity, got great grades, loved people, had an infectious smile and loved life. Or so it seemed.

We had no family history of mental health conditions so when my son was diagnosed with a mental health condition I was stunned. I had no idea what the signs were nor did I think I had reason to look for them. The signs were there. They were obvious and I wish I had recognized them.

About five years ago my son started to have trouble reading. This was very frustrating to him because he loved reading and was a fast reader. I noticed that he was stumbling through the words while he would read out loud. This was the very first sign that I missed. He was experiencing anxiety which is quite common with depression. At this same time, his grades began to fall which was highly unusual for him. I decided that the failing grades had something to do with his reading but I never connected the failing grades with anxiety. He became severely withdrawn from friends and activities that he loved. He stayed in his room all day. His friends became really worried about him. His appetite decreased. He began to have grandiose ideas and feelings. He was acting very unusual.

One night, after an argument with him, he attempted suicide right in front of us. We were stunned. We didn't realize that things had become so difficult for him. After a long chat and reassuring our love for him, I told him that we would pretend like that never happened and move forward. What a mistake that was! A couple weeks later he made another attempt at suicide. I immediately took him to the emergency room. From the emergency room they admitted him to a psychiatric hospital for intensive treatment. He stayed for three weeks then transitioned to an outpatient treatment.

During the outpatient treatments he was allowed to come home for the weekends but his behavior at home scared me. He had made a plan for his next attempt at suicide and told me. He had an extremely difficult time fighting off thoughts of suicide even with intensive treatment. We tried to do outpatient treatment for a couple of months with little success. We thought things were under control and would take him home for a few days. While he was at school his friends kept an extremely close watch on him. They would text me or call me to tell me when my son was behaving abnormally or when they were worried about him. They were lifesavers and I will forever be grateful for his friends! It was evident that he needed to be back in the hospital. The doctors told me he needed the next level of treatment. He was eventually transferred to the state psychiatric hospital. All in all, he stayed in the hospital for almost a year getting treatment and counseling.

Once he was admitted to the hospital I dedicated my time to learning everything I could about his mental health diagnoses. Some of the things I learned were quite overwhelming and distressful. It took quite a while for me to come to grips with the reality of our situation. I think I was in denial myself. The difficult part was talking to family members about what was happening. Everybody had different opinions, some of which were supportive and some were not. Some of the things I heard from doctors were not supportive either. It was all extremely overwhelming.

I remember the day I came to reality. I told myself that there was a very real, high probability that my son would take his life. I was doing all I knew to do to help him but his battle was great. I felt helpless. At that moment that I realized he could be gone I felt a sense of peace, which sounds very odd. At that moment the only thing I knew to do was to love him. If he left this world during his battle with mental illness he would know that I loved him. Instead of keeping up with my neverending learning of mental health issues I spent my time with him more at peace. My work was to make sure he knew I loved him. That turn of outlook gave me the greatest sense of peace. I could not stop my son at attempting suicide (as much as I tried!) but I could help him see how much I loved him.

We struggled greatly off and on for the next year. Things did settle. My son learned how to cope with life and his mental health issues. He eventually weaned off all drugs, which I thought would never happen. I thought the mental health diagnosis was a life term. It wasn't for him or us. He was able to serve as a volunteer missionary which was something he had always wanted to do. Today, five years later, he is back to himself and loving life. He has learned valuable skills to cope with stress and disappointment.

He has been able to speak publicly about his experiences with mental health. I have been amazed by the support he has received in sharing some of his experiences. It seems like sharing these things is powerful, both for the person sharing and the person hearing.

Our road to recovery was rough and long. Many days seemed hopeless. What got me through the darkest days was my faith. I believe God walked with us in every step and so I give Him the credit for where we are today.

I didn't see or I ignored many of the signs of a mental health issue my son faced. We could have gotten help much sooner if I had known what to look for. I have learned so much from the experiences we had. I want to help other people who may be going through similar situations and circumstances. I want to be a voice of hope. I want people to know that there is help. There are people who care. There are people who understand. There are people who love. I want people to know also that a mental health issue is not always a life sentence but if it is, there are things we can do to find peace."

NAMI National Alliance on Mental Illness | Cape Cod & The Islands

WHAT IS NAMI CC&I?

NAMI CC&I (National Alliance on Mental Illness – Cape Cod & The Islands) is an affiliate of NAMI National and NAMI Massachusetts. The mission of NAMIs everywhere is to provide education and support and to advocate for those individuals who suffer from mental/behavioral health issues and their families, caretakers, and friends. Although we are an affiliate of a national organization, we are a self-supporting 501(c)(3) and all funds raised on the Cape and Islands are dedicated to local programming and events. All of our programming is open to everyone free of charge.

WHAT DOES NAMI CC&I DO?

FOR INDIVIDUALS AND FAMILIES:

- **Daily support and crisis calls** where we connect people to the resources they need.
- **Family-to-Family** – 12-week education course to help families understand and deal more effectively with their mentally ill loved one
- **Drop-in family support groups** located throughout the Cape and Islands
- **Borderline Personality Disorder** – 12-week course to help families understand and deal more effectively with their loved one with this disorder—taught in conjunction with the National Education Alliance for Borderline Personality Disorder.
- **Advocacy** – we have a **legal consultant** to advise us on specific client legal issues as well as monitor current legislation to improve the conditions of those with mental illness. We offer programs on issues such as "Telling your story more effectively" and special needs trusts.
- We provide a **monthly newsletter** to inform readers of NAMI events, advocacy efforts and mental health research. We have an extensive lending library of mental health books and magazines.

FOR THE COMMUNITY:

- **Community Crisis Intervention Team (CCIT) training** – NAMI has hosted two *"It Takes a Community"* five-day training sessions open to all police departments on Cape Cod as well as other first responders. As the police have become the front lines in mental health crises, this training is crucial in teaching them about mental health issues and de-escalation techniques and introducing them to available resources as well as how to access them. We currently have trained over 100 police officers and have seen the tremendous impact this has had on the treatment of the mentally ill and on jail diversion. The CCIT model also includes personnel from other agencies to participate in the classes along with the police thus strengthening collaborative opportunities. Training will continue in the spring of 2018.
- **Think:Kids**, a Collaborative Problem Solving (CPS) approach for handling challenging children developed by the Psychiatry Department of Mass General Hospital. We have offered specialized workshops for parents and mental health professionals and are embarking on a three-year program to train teachers in all school systems on Cape Cod and Islands in this evidence-based program.
- Mental health **education programs taught in Brazilian Portuguese** to the large Brazilian Portuguese population on the Cape.
- In 2018 we will be training caregivers of adults and the elderly in **Mental Health First Aid**.

WHAT IS NAMI CC&I MEMBERSHIP?

- NAMI CC&I membership shows your support for mental health and makes all of our voices stronger to advocate for better mental health services. Annual memberships are $40 for individuals and $60 for families. A limited-income membership is available for $5.

WHAT ARE THE VOLUNTEER OPPORTUNITIES AT NAMI CC&I?

- NAMI CC&I has a robust volunteer program. We look to volunteers to train to teach our classes and run support groups and help with fundraising events and other activities.

NAMI CC&I at 5 Mark Lane, Hyannis, MA 02601
508-778-4277 • info@namicapecod.org
www.namicapecod.org

YOU'RE NOT ALONE.

NAMI Cape Cod & The Islands serves individuals and their families who are affected by the broad spectrum of mental illness and neurological disorders through support, education and advocacy, and promotes mental wellness for all.

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National Alliance on Mental Illness
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