Mental Health and Crisis Services in ________ County

This page must be specifically prepared for each course location and included in the Crisis File (Number page at the bottom: Crisis File – 1)

Crisis team number ______________________________

Local mental health agency number ______________________________

Local mental health caseworker services number ______________________________

Local hospital number ______________________________

Local police number ______________________________

State police number ______________________________

Any other information you feel would be of benefit.

Other:

NAMI State Organization number ______________________________
NAMI Affiliate office number ______________________________

Local Support Group Facilitator's # ______________________________

State Department of Mental Health # ______________________________

The Crisis

Sooner or later, if a family member is diagnosed with schizophrenia or a major mood disorder, it is likely that some sort of crisis will occur. When this happens, there are some actions which you can take to help diminish or avoid the potential for disaster. Ideally, you need to reverse any escalation of the symptoms and provide immediate protection and support to the individual with mental illness.

People seldom suddenly lose total control of thoughts, feelings and behavior. Family members or close friends will generally become aware of a variety of behaviors which give rise to mounting concern: sleeplessness, ritualistic preoccupation with certain activities, suspiciousness, unpredictable outbursts, and so on.

During these early stages a full-blown crisis can sometimes be averted. Often the person has stopped taking medications. If you suspect this, try to encourage a visit to the physician. The more psychotic the patient, the less likely you are to succeed.

You must learn to trust your intuitive feelings. If you are feeling frightened or panic-stricken, the situation calls for immediate action. Remember, your primary task is to help your family regain control and keep everyone safe. Do nothing to further agitate the scene.

It may help you to know that your loved one is probably terrified by the experience of loss of control over thoughts and feelings. Furthermore, the "voices" may be giving life-threatening commands; messages may be coming from the light fixtures; the room may be filled with poisonous fumes; snakes may be crawling on the window. You have no way of knowing what they are experiencing.

Accept the fact that your loved one is in an "altered reality state." In extreme situations he or she may "act out" the hallucination, e.g., shatter the window to destroy the snakes. It is imperative that you remain calm. If you are alone, contact someone to remain with you until professional help arrives. In the meantime, the following guidelines will prove helpful:

- **Don't threaten**. This may be interpreted as a power play and increase fear or prompt assaultive behavior by the patient.
- **Don't shout**. If the mentally ill person seems not to be listening, it isn't because he or she is hard of hearing. Other "voices" are probably interfering or predominating.
- **Don't criticize**. It will only make matters worse; it can't possibly make things better.
- **Don't squabble with other family members** over "best strategies" or allocations of blame. This is no time to prove a point.

- **Don't bait your family member** into acting out wild threats; the consequences could be tragic.

- **Don't stand over your family member** if he or she is seated since this may be experienced as threatening. Instead seat yourself. On the flip side, if an ill relative is getting increasingly upset and stands up, consider standing up so that if they escalate to the point of becoming more threatening, you can quickly leave the room.

- **Avoid direct, continuous eye contact or touching your family member.** Comply with requests that are neither endangering nor beyond reason. This provides the patient with an opportunity to feel somewhat "in control."

- **Don't block the doorway**. However, do keep yourself between your family member and an exit. If possible, convey calm. Although no one should feel that they need to stifle their emotions at all times in order to help an ill relative, research suggests that strong expressions of negative emotion may further destabilize individuals with mental illness.

Assistance with this section was provided by Al Horey, Western State Hospital, and Dr. Anand Pandya, MD NAMI.

In the final analysis, your family member may have to be hospitalized. Try to convince him or her to go voluntarily; avoid patronizing or authoritative statements. Explain that the hospital will provide relief from the symptoms, and that he or she will not be kept if treatment can be continued at home or outside the hospital in some other protected environment. Do not be tempted to make ultimatums such as "Either go to the hospital or leave the house." This invariably intensifies the crisis and may send the message that getting treatment is a form of punishment. It is better to discuss the behavior and the treatment as two separate results from the disease getting worse which is no one's fault. Being hospitalized often makes people feel powerless and threatened so whenever it is safe to do so, point out where your family member can make choices. For example, if there are safe alternative ways to go to the hospital, you may ask how they prefer to get there. Or if there is more than one reasonable option, ask them which hospital they would prefer.

During these crisis situations try to arrange to have at least two people present. If necessary, one should call the County-Designated Mental Health Professional while the other remains with the person in crisis.

If indicated, call the police but instruct them NOT TO BRANDISH ANY WEAPON. Explain that your relative or friend is in need of a psychiatric assessment and that you have called them for help. Tell the officer that the patient has or has not been hospitalized before, does or does not have access to any weapons. In short, try to prepare the officers for what to expect. Remember— Things always go better if you speak softly and in simple sentences.

"Long ago, when my son was little, our family had gone camping. In the middle of the night, he developed a raging fever. As we raced through the dark, unfamiliar roads of the forest looking for lights and searching for a hospital, a police station, a doctor, a telephone, I clutched his burning body. I remember feeling terrified, helpless and overwhelmed with panic. I thought that he was going to die in my arms and that there was nothing I could do to stop it. Years later, during the terrifying days of his first psychotic episode, I felt the same terror, the same helplessness, the same fear that he was dying, literally dying, in front of my eyes, and there was nothing, nothing, nothing that I could do to stop it."

- Mother of a son with schizophrenia
NAMI Washington Connections, by Eleanor Owen.

Identifying a Good Psychiatrist

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

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

Modified by Carol Howe: NAMI Threshold, Bethesda, MD

Ask the Psychiatrist: Sample Questions

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

What are the risks associated with the medication? How soon will we be able to tell if the medication is effective, and how will we know?

16. Are there other medications that might be appropriate? If so, why do you prefer the one you have chosen?

17. Are you currently treating other patients with this illness? (Psychiatrists vary in their level of experience with severe or long-term mental illnesses, and it is helpful to know how involved the psychiatrist is with treatment of the kind of problem that your relative has.)

18. When are the best times, and what are the most dependable ways for getting in touch with you?

19. How do you monitor medications and what symptoms indicate that they should be raised, lowered or changed?

20. How familiar are you with the activities of the NAMI and our NAMI State Organization?

If the doctor raises the issue of confidentiality, refer to the document describing HIPAA Regulations included in the Additional Resources in Class 3.

Getting Satisfactory Results: Some Dos and Don'ts

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

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

Things to Do:

1. Keep a record of everything. List names, addresses, phone numbers, etc. Nothing is unimportant. Every date, time, etc., may come in handy. Make notes of what went on during conferences. Keep all notices, letters, etc. Make copies of everything you mail. Keep a notebook or file of all contacts. Don't throw anything away.

2. Be polite. Keep all conversations to the point. Ask for specific information.

3. If your family member is 18 years of age or older, request their permission to review all documents. Many places will request written permission from the person with the illness, so consider asking your relative for this before their illness affects their ability to cooperate with signing a release of information.

4. Get the name of the physician who is coordinating the care. In some cases, you may have the right to request a different doctor who has privileges at that hospital. Get the name of the staff member on the ward who is working most closely with your family member. This is usually a psychiatric nurse, but may be a therapist, a social worker, a psychiatric resident or a case manager. Ask for an appointment to meet with this person; make it at their convenience. Come prepared with a list of specific questions. Some sample questions are:

   - "What are the specific symptoms about which you are most concerned?"

   - "What do these indicate? How are you monitoring them? Who is documenting in the chart? How often is the medication being monitored? What, specifically, is he/she getting? How much? How often? Has the patient been informed on medication side- effects? When can I look at the record book or chart? When can we meet to plan the transition back home?"

5. Keep the meeting short. If you come with a list of questions you will be able to get all the information you need in less than half an hour.

6. Write letters of appreciation when warranted; write letters of criticism when necessary. Send these to the head of the hospital (or unit—or both), and send copies to anyone else who may be involved, including the Governor. Just as there are certain actions to take in order to be effective, there are some things which tend to be counter-productive. Keep in mind that most professionals want to do a good job. Most of the direct staff (people who work directly with the patients—social workers, case managers, hospital attendants, practical nurses, doctors, nurses, therapists, etc.) are over-scheduled. Usually, there are too few staff for the number of community mental health centers, jails, etc. Thus, it is important to maintain some perspective on what one can reasonably expect.

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

- Do not come late to appointments.

- Do not accept repeated "cancellations."

- Do not make excessive demands on staff, i.e., don't harass the staff with special requests, do not have long phone conversations filled with unnecessary details, etc.

- Do not accept vague answers or statements which seem confusing. If a clinician says, "we are observing your daughter carefully," recognize that this is a statement which provides you with no information. Do not accept it without further clarification. Ask who is doing the observing, what is being observed (exactly), how is the information being documented, when can you view the progress of the observation, etc.

- Do not feel that you "should know" and therefore inhibit yourself from asking for substantive information.

- If your loved one is in a state mental hospital and you have permission to look at the record book, set up an appointment with a staff member who can review what information they have recorded. Be clear that you are not trying to find fault with their care, and that your only goal is to make sure that they have the correct and complete information about your family member.

  Ask to review your relative's Individualized Treatment Plan. This is legally mandated and must be carried out. You can ask to participate in the development of the plan. The patient has the right to have his/her wishes taken into account.

- When you ask how the staff is implementing the Treatment Plan, do not accept answers which imply that the patient is responsible for his/her own progress. Persist in finding out exactly what actions staff are taking, i.e., how often are they taking the patient for walks, which staff person is in charge of group therapy, how consistent is the treatment, i.e., does each member know what others are doing?

- Do not allow yourself to be intimidated.

- If your relative is in a group home, CCF, ICF, or any facility receiving public funds, you are entitled to inquire about personnel qualifications, etc. Do not permit unqualified personnel to continue to work without a formal complaint to the Department of Social & Health Services.

- Finally, do not be afraid or ashamed to acknowledge that you are related to a person with mental illness.

- Keep your family member informed about everything you plan to do. He/she might disapprove of your action or may wish to modify your plan.

- Finally, be assertive! As a taxpayer, you are entitled to information, respect, and courtesy. Your taxes go to public employees. You are not asking for gratuities. You are simply helping to get the job done.

Source: NAMI Washington Connections, by Eleanor Owen

Dual Diagnosis and Integrated Treatment of Mental Illness and Substance Abuse Disorder

What are dual diagnosis services?

Dual diagnosis services are treatments for people who live with co-occurring disorders—mental illness and substance abuse. Research has strongly indicated that to recover fully, a person with co-occurring disorders needs treatment for both problems—focusing on one does not ensure the other will go away. Dual diagnosis services integrate assistance for each condition, helping people recover from both in one setting, at the same time.

Dual diagnosis services include different types of assistance that go beyond standard therapy or medication: assertive outreach, job and housing assistance, family counseling, even money and relationship management. The personalized treatment is viewed as long-term and can be started at whatever stage of recovery the person is in. Positivity, hope and optimism are at the foundation of integrated treatment.

How often do people with severe mental illnesses also experience a co-occurring substance abuse problem?

There is a lack of information on the numbers of people with co-occurring disorders, but research has shown the disorders are very common. According to reports published in the Journal of the American Medical Association (JAMA):

- Roughly 50 percent of individuals with severe mental disorders are affected by substance abuse.
- Thirty-seven percent of alcohol abusers and 53 percent of drug abusers also have at least one mental illness.
- Of all people diagnosed with mental illness, 29 percent abuse either alcohol or drugs.

What are the consequences of co-occurring severe mental illness and substance abuse?

For the individual, the consequences are numerous and harsh. Persons with co-occurring disorders have a statistically greater propensity for violence, medication noncompliance and failure to respond to treatment than people living with just substance abuse or a mental illness. These problems also extend out to the families, friends and co-workers of these individuals.

Purely health-wise, simultaneously having a mental illness and a substance abuse disorder frequently leads to overall poorer functioning and a greater chance of relapse. These individuals are in and out of hospitals and treatment programs without lasting

success. People with dual diagnoses also tend to have tardive dyskinesia (TD) and physical illnesses more often than those with a single disorder, and they experience more episodes of psychosis. In addition, physicians often don't recognize the presence of substance abuse disorders and mental disorders, especially in older adults. Socially, people with mental illness often are susceptible to co-occurring disorders due to "downward drift." In other words, as a consequence of their mental illness people may find themselves living in marginal neighborhoods where drug use prevails. Having great difficulty developing social relationships, some people find themselves more easily accepted by groups whose social activity is based on drug use. Some may believe that an identity based on drug addiction is more acceptable than one based on mental illness.

Individuals with co-occurring disorders are also much more likely to be homeless or jailed. An estimated 50 percent of homeless adults with serious mental illnesses have a co-occurring substance abuse disorder. Meanwhile, 16 percent of jail and prison inmates are estimated to have severe mental and substance abuse disorders. Among detainees with mental disorders, 72 percent also have a co-occurring substance abuse disorder.

Consequences for society directly stem from the above. Just the back-and-forth treatment alone currently given to non-violent persons with dual diagnosis is costly. Moreover, individuals with violent or criminal tendencies, no matter how unfairly afflicted, are dangerous and also costly. Those with co-occurring disorders are at high risk to contract AIDS, a disease that can affect society at large. Costs rise even higher when these persons, as those with co-occurring disorders have been shown to do, cycle through healthcare and criminal justice systems again and again. Without the establishment of more integrated treatment programs, the cycle will continue.

Why is an integrated approach to treating severe mental illnesses and substance use problems so important?

Despite much research that supports its success, integrated treatment is still not made widely available to people. Those who struggle both with mental illness and substance abuse face problems of enormous proportions. Mental health services tend not to be well-prepared to deal with patients having both conditions. Often only one of the two problems is identified. If both are recognized, the individual may bounce back and forth between services for mental illness and those for substance abuse, or they may be refused treatment by one or the other system. Fragmented and uncoordinated services create a service gap for persons with co-occurring disorders.

Providing appropriate, integrated services for these individuals will not only allow for their recovery and improved overall health, but can ameliorate the effects their disorders have on family, friends and society at large. By helping these individuals stay in treatment, find housing, gain employment and develop better social skills and judgment, we can potentially begin to substantially diminish some of the most devastating societal problems: crime, HIV/AIDS, domestic violence and more.

There is much evidence that integrated treatment can be effective. For example, research shows that when individuals with dual diagnosis successfully overcome alcohol addiction, their response to treatment improves remarkably. With continued education on co-occurring disorders, hopefully, more treatments and better understanding are on the way.

Reviewed by Robert Drake, M.D.

Dealing with the Criminal Justice System

When persons with mental illness or their families are confronted with the criminal justice system, the pressure and intimidation can be overwhelming. This fact sheet offers some basic, helpful pointers. More detail can be found in the NAMI publication, A Guide to Mental Illness and the Criminal Justice System. This may be ordered online through the NAMI Store or by calling the NAMI Helpline to request a current Resource Catalog.

What should you know first about criminal law?

In criminal law, the outcome of a case depends as much on the facts of the case and the procedures followed in developing that case as it does on the actual substantive law. Individuals involved in criminal cases will be most affected by the procedural steps governing these cases from the time of arrest to the end of the case. It is, therefore, essential to have a good criminal lawyer to direct you through any encounter with the criminal justice system.

What is the difference between a misdemeanor and a felony?

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

When does an arrest take place?

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

What is booking?

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

What should the family do during the interrogation?

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

How do you find a lawyer?

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

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

What are your constitutional rights?

- The Fourth Amendment guarantees the right against unreasonable searches and seizures. Usually a warrant is required. The exclusionary rule prevents the prosecution from placing into evidence any evidence that was obtained unreasonably.

- The Fifth Amendment guarantees the right against self-incrimination, which is the well-known right to remain silent.

- The Sixth Amendment guarantees the right to a speedy trial. Every defendant in a criminal case has a constitutional right to have the charges against him or her decided quickly so that he or she can move on with life. The Sixth Amendment also guarantees the right to a public trial and a jury trial. The right to confront witnesses, a compulsory process for obtaining witnesses, and the right to assistance of counsel are also protected by this amendment.

- The Eighth Amendment protects people from cruel and unusual punishment. In addition, it protects the right to treatment for acute medical problems, including psychiatric problems.

Who decides to file charges?

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

What is jail diversion?

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

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

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

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

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

Source: NAMI Web Site www.nami.org , search word "criminal justice"

A Guide to Mental Illness and the Criminal Justice System can also be found at this internet address:

http://www.nami.org/Template.cfm?Section=Issue_Spotlights&template=/ContentManagement/ContentDisplay.cfm&ContentID=60725

Suicide: What can you do to help?

Recognize signs of depression and suicide risk

- Change in personality - (such as) - sad, withdrawn, irritable, anxious, tired, indecisive, apathetic.
- Change in behavior - can't concentrate on school, work, routine tasks.
- Change in sleep pattern - oversleeping or insomnia, sometimes with early waking.
- Change in eating habits - loss of appetite and weight, or overeating.
- Loss of interest in friends, sex, hobbies, and activities previously enjoyed.
- Worry about money, illness (either real or imaginary).
- Fear of losing control, going crazy, harming self or others.
- Feelings of overwhelming guilt, shame, self-hatred.
- No hope for the future, "it will never get better, I will always feel this way."
- Drug or alcohol abuse.
- Recent loss—through death, divorce, separation, broken relationship, or loss of job, money, status, self-confidence, self-esteem.
- Loss of religious faith.
- Nightmares.
- Suicidal impulses, statements, plans; giving away favorite things; previous suicide attempts or gestures.
- Agitation, hyperactivity, restlessness may indicate masked depression,

Do not be afraid to ask: "Do you sometimes feel so bad that you think of suicide?"

Just about everyone has considered suicide, however fleetingly, at one time or another. There is no danger of "giving someone the idea," in fact, it can be a great relief if you bring the question of suicide into the open, and discuss it freely, without showing shock or disapproval. Raising the question of suicide shows you are taking the person seriously and responding to the potential of his/her distress.

If the answer is "yes, I do think of suicide," you must take it seriously.

Have you thought about how you'd do it? Do you have the means? Have you decided when you would do it? Have you ever tried suicide before? What happened then? If the person has a defined plan, if the means are easily available, if the method is a lethal one, and the time is set, the risk of suicide is very high. Your response will be geared to the urgency of the situation as you see it. Therefore, it is vital not to underestimate the danger by not asking for detail.

How Can I Know if Someone is Suicidal?

Ask these questions—in this order—to find out if the person is seriously considering suicide. Many of the answers to these questions may be upsetting, especially if your family member does not identify you or other family members as a reason to live. However it is important to reserve judgment at least initially so that you can continue to get candid answers.

1. **"Have you been feeling sad or unhappy?"**

   A "Yes response" will confirm that the person has been feeling some depression.

2. **"Do you ever feel hopeless? Does it seem as if things can never get better?"**

   Feelings of hopelessness are often associated with suicidal thoughts.

3. **"Do you have thoughts of death? Does it seem as if things can never get better?"**

   A "Yes response" indicates suicidal wishes but not necessarily suicidal plans. Many depressed people say they think they'd be better off dead and wish they'd die in their sleep or get killed in an accident, however, most of them say they have no intention of actually killing themselves.

4. **"Do you ever have any actual suicidal impulses? Do you have any urge to kill yourself?"**

   A "Yes" indicates an active desire to die. This is a more serious situation.

5. **"Do you have any actual plans to kill yourself?"**

   If the answer is "Yes," ask about their specific plans. What method have they chosen? Hanging? Jumping? Pills? A gun? Have they actually obtained the rope? What building do they plan to jump from? Although these questions may sound grotesque, they may save a life. The danger is greatest when the plans are clear and specific, when they have made actual preparations, and when the method they have chosen is clearly lethal. If the person has access to whatever they need to execute their plan, the situation is more dangerous. After you finish gathering information, one of your first tasks will be to limit access to the things that they need to complete their plan. This may mean taking away a gun or the keys to their car, or simply taking the person to the hospital where they would not be able to follow through on their plans.

6. **“When do you plan to kill yourself?”**

   If the suicide attempt is a long way off, say, in five years, the danger is less imminent. If they plan to kill themselves soon, the danger is grave.

7. **“Is there anything that would hold you back, such as the effect on a pet or someone in our family, or your religious convictions?**

   If the person says that people would be better off without them and if they have no deterrents, suicide is much more likely.

8. **“Have you ever made a suicide attempt in the past?”**

   Previous suicide attempts indicate that future attempts are more likely. Even if a previous attempt did not seem serious, the next attempt may be fatal. All suicide attempts should be taken seriously. Although some mental health professionals differentiate between “suicide attempts” (where the person intended to die) and “suicidal gestures” (where the person’s primary intention was not to die but to send a message or achieve some other goal), it is important to note that suicide gestures can be more dangerous than they seem, since some people do accidentally kill themselves when attempting to only make a gesture.

9. **“Would you be willing to talk to someone or ask help if you felt desperate? Whom would you talk to?”**

   If the person who fears suicidal is cooperative and has a clear plan to reach out for help, the danger is less than if they are stubborn, secretive, hostile, and unwilling to ask for help. If they report a plan to reach out to a specific person, make sure that they have the person’s telephone number and, if possible, make sure that they have discussed the fact that they have suicidal thoughts at times with the person who they identify as the one they would most likely talk to if they were desperate. If they have not felt comfortable discussing these thoughts with that individual yet, or are reluctant to raise the subject at this time, it is less likely that they will feel comfortable enough to broach the subject with that person when they are in crisis.

Source: NAMI website `www.nami.org` , search word “criminal justice”

Limit Setting

Behaviors that should not be tolerated:

Even if they are part of the illness, the following behaviors should NOT be tolerated:

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

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

Behaviors that are typical symptoms of mental illness:

A. Trying to stop any of the following behaviors in someone who is mentally ill can be like trying to stop someone with a cold from sneezing:

   - Periodic departure from normal eating habits.
   - Unusual sleep/wake cycles. (Example: Sleeping all day and staying up all night.)
   - Delusions or disordered thinking.
   - Hallucinations.
   - Withdrawal to a quiet, private place.
   - Some inappropriate social behavior.

B. The reasons for these behaviors are much more complicated than attempts to manipulate. They are symptoms of an illness or attempts to cope with symptoms in which manipulation may play only a small role, if any.

C. Even if a behavior is a symptom or attempt to cope with a symptom, you should not tolerate it if it is destructive or severely disruptive (see above), or if it is driving you or someone else in the house to absolute distraction.

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

Managing Violent and Disruptive Behavior

What you can do to manage violent or disruptive behavior:

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

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

- Get to know and recognize cues that your relative is becoming violent or disruptive. (Your own uneasiness or fear is usually a good cue.)

- Tell your relative that his/her behavior is scaring you or upsetting you. This feedback can defuse the situation, but proceed with the next suggestion if it does not. Saying you are scared does NOT mean you act scared.

- If you (and other family members) have made a limit-setting plan, now is the time to carry out the consequences. If you have not already warned your relative of the consequences when he was calm, use your judgment and past experience to decide whether to warn him/her or to just go ahead with the plan without saying anything.

- Give your relative plenty of space, both physical and emotional. Never corner a person who is agitated unless you have the ability to restrain him/her. Verbal threats or hostile remarks constitute emotional cornering and should, therefore, be avoided.

- Give yourself an easy exit, and leave the scene immediately if he/she is scaring you or becoming violent.

- Get help! Just bringing in other people, including the police if necessary, can quickly defuse the situation.

- If you or someone else has witnessed your relative recently committing or planning a violent or dangerous act, that is grounds for involuntary commitment.

What you should NOT do:

- Do NOT try to ignore violent or disruptive behavior. Ignoring only leads your relative to believe that this kind of behavior is acceptable and "repeatable."

- Do NOT give your relative what s/he wants if the way s/he is trying to get it is through bullying you. Giving in reinforces this bullying behavior and makes it likely

that s/he will use it again. Only give in if it is the ONLY way out of a dangerous situation.

- Do NOT try to lecture or reason with your relative when s/he is agitated or losing control.

- NEVER be alone with someone you fear.

  Example: Do not drive him/her to the hospital by yourself.

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

Principles to Remember when Dealing with Critical Periods in Mental Illness

1. In dealing with critical periods, it is essential to set limits on psychotic behavior and to have a plan for enforcing your ultimatum. You need to decide on the specific consequences, and you need to be prepared to back them up.

2. You must get help. No one can handle these devastating crises alone. Your plan should always involve other family members, public authorities, crisis workers, and professional assistance—notified ahead of time, if possible.

3. You must trust your instincts. If you are worried about violence or suicide, you can bet something is building up and that events are becoming overwhelming for your relative.

4. You can't keep your head in the sand about violence and suicide. You have to speak these fears directly and openly to your relative. You must show your reaction to these dangers: tell him or her that their behavior is making you feel afraid; ask point blank if he or she is contemplating suicide. In crisis, candor is essential. It reduces tension, "detoxifies" secret plans, and lets a lot of air into a sealed off, turbulent mind.

5. Even though your relative is scaring you to death or making you angry, you need to approach him or her with respect. All good crisis intervention is calm, purposeful, and respectful.

6. Acting to protect our relatives with mental illness is the highest form of caring for them, even if it involves force or involuntary commitment. And it is a difficult paradox to deal with: to keep them safe, we must let them go, even if they hate us for "locking them up," even if they break off with us, we move decisively to ensure their well-being. We cannot hang back because we think they will no longer love us. Mental illness can put people in mortal danger. In this situation, love acts!

7. Acting to keep ourselves clear of danger is the highest form of self-care. We are really saying we have no intention of letting mental illness rob us of our life, and if that danger looms, we are ready to separate ourselves from this threat. In a much less dramatic form, this is what we learn to do, over time, to survive this illness in others.