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# **New Hampshire Guidebook for Families of Adults with Serious and Persistent Mental Illness**



**NAMI New Hampshire**  
National Alliance on Mental Illness New Hampshire  
February 2014

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# Acknowledgements

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## Foreword

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**“We envision a future when everyone with a mental illness will recover.”**

New Freedom Commission on Mental Health, 2003

Treatment works and recovery is possible. According to the Substance Abuse and Mental Health Services Administration’s Center for Mental Health Services, recovery is “a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.”

Research has shown that family support is critical to successful recovery. Caring about someone with a mental illness can be physically, emotionally and spiritually challenging. Families must learn about the illness, available treatments, and how to navigate and effectively advocate for the needed services and supports. To be able to support a loved one with mental illness, family members must also attend to their own well-being.

This Guidebook will provide family members with practical, useful information that can be used to support the recovery of the adults with mental illness in their lives. In creating this Guidebook, we have drawn upon the knowledge, experience and expertise of persons with mental illness, family members and professionals. At the time of the printing of this Guidebook, there are anticipated changes in the funding of mental health services, policies and practices. We would encourage you to visit our website: **[www.naminh.org](http://www.naminh.org)** to keep abreast of changes as they occur.

Knowledge is power and it is essential that families are educated, supported and empowered as team members in their family member’s journey of recovery.

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# Chapter 1. Families and Serious Mental Illness

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## Chapter Overview

*The diagnosis of a serious mental illness in anyone's family is a life changing event. How you and your family respond to such a disruption will depend upon a number of factors. Understanding the normal and predictable emotional reactions you and your family may experience can help you cope better.*

*This chapter will help you understand common responses to a serious illness in a family, the importance of taking care of yourself so that you can take care of others, and resources and supports available to you and your family.*

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### The “No Casserole” Disease: Serious Mental Illness

The diagnosis of a serious illness or disease in any family is always a time of crisis, confusion, and varying emotion. Friends, co-workers, relations and even those who are barely acquaintances will offer support and assistance. Many families struggling in such times find themselves with a freezer full of casseroles, designed to help them get by during the difficult period after diagnosis and during treatment. Yet, when your loved one is diagnosed with a mental illness, too often, it seems to go unnoticed with no outpouring of support and casseroles. Often this leaves families feeling isolated, like no one else appreciates the stress of their situation.

Despite the fact that mental illness is, for a variety of reasons – most having to do with prejudice – largely ignored by our support network of friends, relations and co-workers, it is one of the most common types of disease in the United States. One in four adults will have a lifetime incidence of mental illness.<sup>1</sup> In New Hampshire an estimated 253,500 adults has a mental health disorder, or 26% of the adult population.<sup>2</sup> In truth, everyone knows someone who has a mental illness and someone who has a loved one living with mental illness.

In Chapter Three we will learn more about the different types of mental illness. For our purposes here a serious mental illness is defined as a medical condition that disrupts a person’s thinking, feeling, mood, ability to relate to others, and daily functioning. These brain disorders often result in a diminished capacity for coping with the ordinary demands of life.

### When Illness Comes Home

How families respond to the news of a serious illness in a family member depends upon a number of different factors:

- The extent of the family’s support system and their previous experience with or knowledge of the illness;
- The family’s ability to cope with the uncertainty, shock or disappointment as well as the financial strain illness may place on the family;
- The nature of the onset of the illness (whether sudden or gradual);
- The demands that the illness will place upon the family; and
- Questions about the quality of healthcare available to their loved one.

These factors are no different when the diagnosis is a serious mental illness. How the family responds is dependent upon the family’s understanding of mental illness and the understanding of those who make up the family’s social system. How does the family and their community view mental illness? Is it seen as a medical problem with known successful treatments and the hope of recovery? Or is it viewed as an indicator of human weakness, personal laziness or poor upbringing? The family’s response will depend upon how much they know about mental illness, and if they can access support and education to help dispel the myths, stereotypes, and stigmatized beliefs that have surrounded mental illness for so long.

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## Stages of Reaction to the Diagnosis of a Serious Mental Illness

The onset of a major illness, divorce, the loss of a loved one and other significant life events frequently result in a series of emotional responses that range from shock and disbelief to acceptance and peace of mind. This Stages of Grief or Change Model has for nearly four decades formed the basis for our understanding of how people react and respond to difficult life changes.<sup>3</sup>

Since 1990, this model has been used in NAMI's support and education programs to help families understand and cope with the stress resulting from the diagnosis of a severe mental illness in one of its members.<sup>4</sup> The model can be helpful in understanding the process but it is not a treatment strategy. The stages described below are not necessarily sequential or universal. Family members may repeat stages, pass through them at different times and/or "get stuck" in one particular stage. Each family member may respond differently to the mental illness, and members are often at different stages.

### Stage 1: Dealing with the Diagnosis

**Crisis/Chaos/Shock:** You feel overwhelmed, confused and lost. Something unbearable is happening and you do not fully understand it, nor know how to deal with it. Your sense of emotional togetherness is torn apart.

**Denial:** You want to protect yourself and give yourself time to process the events that have turned your life upside down. You want to believe this is not really happening, that there is another explanation for what is occurring, and that it will pass with time.

**Hoping Against Hope:** You think that if you just try hard enough, your life will go back to normal. This usually does not work, and another crisis or relapse startles you into seeing the illness will not just go away on its own.

#### **Strategies for Stage 1:**

*You need support from those you love and those who care about you. It is important to know that you are not alone, that other families have been through the same experiences and that there are resources available to help you. You need support and empathy from other families that have "been there before you." Remember, those trying to help your relative can also be invaluable support to you as you learn to cope and help your loved one.*

### Stage 2: Coping with the Reality

**Anger/Guilt/Resentment:** You distance yourself from the problem by blaming your relative with the illness, insisting that she or he must “snap out of it” and “get on with life.” You feel fed up and don’t want to deal with it any longer. At the same time you harbor tremendous guilt, feeling that it is really your fault. Then you compensate and become over-involved with the problem. You push the problem away and pull it towards you all at the same time. This ambivalence drains you.

**Recognition:** You begin to understand that someone you love has a serious, chronic illness. It is clear that something sad has occurred that has changed your lives. You begin to mark time as before or after the onset of the illness.

**Grief:** You mourn the loss of the time before the illness struck; you deeply feel that what has happened to your loved one is tragic; you grieve that the future for you and your loved one is uncertain. Over time you may find that such sorrow can be persistent and sometimes triggered by unexpected things.

#### **Strategies for Stage 2:**

*You need to express your feelings in safe places and to people who truly understand. You need to sustain your sense of hope and not give up. You need to learn about recovery from mental illness from people who have experienced it. You need to learn about mental illness in order to gain the insight necessary for your own emotional health and to help your loved one’s recovery. You need to take care of yourself. You need to let go of those things you cannot control, put your anger behind you, and find more positive uses for your energy.*

### Stage 3: Working with Your Strengths

**Understanding:** You begin to gain a sense of how your family member suffers and what they feel. With some of your fears behind you, you find you can grasp what the inner experience of illness is for your loved one: the pain, the fear, the anxiety, the anger, the sadness, the persecution, and the confusion. You gain respect for their courage and fortitude.

**Acceptance:** “Yes,” you finally say, “bad things do happen to good people.” You wish this illness had not come into your life, but it did, and you can accept that it has. It is not your fault; it is not your loved one’s fault. It is a difficult life experience, but you will hang in there and manage.



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**Advocacy/Action:** With a measure of acceptance, you now begin to focus your anger and grief and work to change the system that has often failed you and your loved one. You are ready to fight discrimination and to change a world that still does not understand mental illness, the people that it afflicts, and the families who love them. You learn to advocate for yourself and your loved one, you join public advocacy groups, you find your voice, and you become involved.

***Strategies for Stage 3:***

*You need to understand more. You need to understand how the system of care works and why it sometimes fails. You see the value of organized efforts to advocate for the needs of people with mental illness. You find “giving back to other families in need” is part of your own healing process. You recognize that it is healthy for you to focus on your own needs, to find joy and balance in your life even if your loved one is not well. You need to reach out to others and help them find their way through the pain you understand. You need to connect with others and advocate for a better way.*

***Important Points to Understand and Remember***

- These stages are neither right nor wrong, good nor bad. They are simply common human reactions that most of us experience when struggling to cope with critical disruptions in our lives. While the stages are frequently experienced as listed above, you may not experience them in the same sequence.
- The process of change is different for each individual, is an ongoing process and has its highs and lows. Like mental illnesses themselves, the process often is cyclical. When your loved one suffers a relapse or serious setback, you may find yourself lapsing back to a previous stage or feeling.
- Because each of us moves through the stages at our own pace, you may find there are often times when your other family members are at different places in the cycle. This is why you sometimes have difficulty understanding and communicating with each other and agreeing on what to do. *When you are at different stages, your needs are simply different.* Keeping this in mind can help you and your other family members improve communication and understanding.
- These are stages of reaction, **not** treatments. They are part of a very human and predictable process that you will experience in your own way. If you can accept this and identify where you are in the process you can be gentler with yourself. Many families have found that learning about the stages of change help give them a sense of **HOPE** – that going through the pain and grief leads to a place of understanding and acceptance.

## Maintaining Your Own Wellness as a Caregiver

Keeping yourself healthy is an important part of caregiving. Your mental health is just as important as your physical health for keeping your body and mind in a balanced state. When you are feeling well, you are better able to handle the stresses of caregiving, and to adapt to the often hectic pace as a caregiver.

The signs of illness are often obvious when coming down with a cold or flu; however, it is not always as easy to tell when your mental health is being affected by stress or illness. Caring for your own mental health can be more complex when caring for a loved one with mental illness.

**Carrah L. Jamese**

**Caring for Yourself While Helping a Loved One with a Mental Illness<sup>5</sup>**

### ***Taking Care of Your Mental Health***

1. Strengthen your sense of purpose and meaning beyond the role of caregiver by continuing to participate in activities you enjoyed before you became a caregiver.
2. Learn all you can about your loved one's illness. By doing so you can reduce the fear and uncertainty of the unknown; you will be less likely to be taken by surprise when a new or unusual symptom develops; and you can rid yourself of the guilt or shame you may feel about your loved one's illness for neither you or they are the cause of the illness.
3. Stay in touch with friends. Social isolation negatively impacts both your mental and physical health. Social interaction is vital to your health and well-being. Friends can help you clarify your concerns, plan for the future and help you get through just by listening.
4. Participate in a support group as a safe and helpful way to share your feelings. Some times just listening to others who have had similar experiences can help you gain perspective and by sharing your experiences you can be helpful to others in a similar situation.
5. Seek professional help when several of the following symptoms occur at the same time, last longer than two weeks, and interfere with your ordinary functioning:
  - chronic physical symptoms such as headache, stomach ache, or back pain;
  - dramatic changes in your sleeping or eating patterns;
  - excessive use of alcohol or drugs;
  - extreme fatigue or restlessness;
  - feelings of hopelessness;
  - lack of interest in activities you once enjoyed;
  - thoughts of harming yourself or others;
  - replaying events over and over in your mind; and
  - uncontrollable worry.

See *Appendix C. Local, State and National Resources, page 134*, for how to contact your local community mental health center for help.

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If you feel you may abuse your family member or you are being abused by your relative, seek professional mental health help immediately. **If you are in danger or threatened by your relative, call 911 immediately.** Prior to needing them, make sure that local law enforcement is aware of your situation.

### ***Taking Care of Your Physical Health***

1. Be sure to get enough sleep and rest. If you have trouble sleeping consult your primary care physician. Sleep deprivation can cause a number of health and psychological problems including depression.
2. Remember to maintain healthy habits and try to improve upon less healthy ones. Eating right and exercising regularly are essential to maintaining your health and managing stress. Limiting alcohol use and reducing or stopping smoking will help you stay healthier and better able to care for your family member.
3. Make and keep regular appointments with your primary care physician. Most physicians will make time for family members of patients newly diagnosed with a serious illness. At this time, your physician will most likely want to review the role stress plays in elevating blood pressure, increasing cholesterol, and causing insomnia.
4. If you have ongoing health issues and are taking medication, do not forget to take them.
5. Set aside time to do the things you enjoy and the things you need to get done.
6. Learn to monitor your own signs of stress. Long-term or chronic stress has been shown to significantly decrease an individual's immune system leaving your body more vulnerable to infection.

### ***Taking Care of Your Spiritual Health***

Spirituality has many definitions; but at its core, spirituality helps to give our lives context. It's not necessarily connected to a specific belief system or even religious worship. Instead, it arises from your connection with yourself and with others, the development of your personal value system, and your search for meaning in life. For many, this takes the form of religious observance, prayer, meditation or a belief in a higher power. For others, it can be found in nature, music, art or a secular community.<sup>7</sup>

1. Make use of the spiritual resources you are comfortable and in which you believe. Try prayer, meditation and relaxation techniques to calm and focus your inner thoughts. There is evidence that spirituality decreases the risk of early death and lowers levels of hypertension.
2. Nourish your sense of spirituality. When our spirits are cared for, we achieve our greatest potential for finding meaning in our role as a caregiver.

## Chapter 1. Families and Serious Mental Illness

3. Seek out a trusted friend who has had similar life experiences who can help you discover what is important to you in life.
4. Be open to new experiences. If your spirituality is more secular than religious, consider expanding your spiritual interests with new experiences in the arts or in nature.

### **How People Respond to Stress: Signs and Symptoms**

If you experience any or all of the signs and symptoms of stress below for any unreasonable or inexplicable length of time, see your healthcare provider.<sup>6</sup>

#### *Physiological Responses: How Your Body Reacts*

- rapid pulse
- increased perspiration
- pounding heart
- stomach ache
- tensing of muscles in arms and legs
- shortness of breath
- gritting of teeth
- clenching of jaw
- inability to sit still

#### *Psychosocial Responses: How Your Mind Reacts*

- racing thoughts
- inability to concentrate
- difficulty making simple decisions
- loss of self-confidence
- irritability or frequent anger
- insatiable cravings
- worry or anxiety
- irrational fear or outright panic

#### *Behavioral Responses: How You React*

- smoking or increased smoking
- increased use of medication
- nervous tics or mannerisms
- absent-mindedness
- accident proneness
- hair pulling, nail biting, foot tapping, pacing
- increased or decreased eating
- increased or decreased sleeping
- increased use of alcohol or drugs
- reckless driving
- inappropriate aggressiveness

## Caregiver Support in New Hampshire

Accessing the support you need to maintain a healthy balance in your own life and enable you to continue caring for your loved one is just as essential to a successful recovery process

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as is finding the right mental health professional to help your loved one. There are many agencies that can help support you, your family and your loved one living with a mental illness. *Appendix C. Local, State and National Resources, beginning on page 127*, contains contact information for many such organizations in New Hampshire and beyond.

### ***NAMI: The Nation's Voice on Mental Illness***

The National Alliance on Mental Illness (NAMI) is a non-profit, grassroots, self-help, support and advocacy organization with more than 220,000 individual members working through more than 1,000 local and state affiliates. NAMI Help Lines around the country field 250,000 calls each week; helping individuals and families to access services, learn more about mental illness and evidence-based treatments, and handling problems of discrimination. NAMI affiliates, with technical assistance and resources provided by the state and national offices, provide support and education to consumers, family members, professionals and the general public through more than 150 different educational programs. NAMI has an office in every state that is responsible for developing a comprehensive policy agenda in that state. Policy concerns include such issues as health insurance reform; homelessness and housing; challenges for children and aging adults with mental illness; Medicaid and Medicare funding; stigma and discrimination; as well as employment and criminal justice-related issues.

### ***NAMI NH Services & Programs***

NAMI NH is the New Hampshire chapter of the National Alliance on Mental Illness which provides support, education and advocacy for all Granite Staters whose lives are affected by mental illness. With a membership of over 500 families, NAMI NH promotes and helps sustain a statewide network of family education and support groups. In this role, NAMI NH works to empower family members to exercise their rights in order to improve the quality of their lives and the lives of their family members living with mental illness. NAMI NH teaches families culturally competent care for their family member and support for themselves. For over 30 years, NAMI NH has been recognized as the advocacy organization for families living with mental illness across the life span in New Hampshire.

"When the doctor told us that our son was not being difficult or moody, that his behaviors were a result of his having a mental illness, we were actually relieved. It was an illness; there were medications to treat it; take a pill and everything would go back to "normal." We had no idea we were embarking on a decade long recovery journey."

***Family-to-Family Participant***

"The first two years were the hardest – we kept expecting that with the right miracle pill all would be well. When our son complained about the side effects of his medication and would stop taking it, we'd get angry with him. Try to bribe and coerce him into being "treatment compliant." It was two years of hell. Then his doctor recommended we take NAMI's Family-to-Family course. For my wife and I, that was the best advice we ever received. After taking the course, everything didn't

***Continued***

just magically get better and return to “normal,” but we learned so much about mental illness, the cycling through ups and downs, and, most importantly, how to respond to our son when he wasn’t well without resorting to the anger or tears that left us all so terribly hurt. **Family-to-Family** saved our family.” *Family-to-Family Participant*

NAMI NH’s core support and education programs for families of adults with mental illness include:

**Information & Resource Line (I&R)** provides information on mental illness, treatments and services, education programs, support groups, and links to other resources. The I&R Line (1-800-242-6264, Ext. 4) connects callers with trained individuals who answer questions, help access information, and provide referrals to appropriate organizations. An on-site mental health/mental illness resource center area is open to the general public. NAMI NH members may borrow materials from the resource center.

**Family and Community Support Program** provides family members with one-to-one support and education about mental illness and resources. After working for a brief time, with the Family and Community Support Specialist, family members are then encouraged and supported to connect with other families through the NAMI NH education programs and support groups or with community resources.

**Family-to-Family Education**, NAMI’s program is taught throughout the country and available in NH. The program consists of a series of twelve classes that balance education and skills training with self-care, emotional support and empowerment. The course is co-taught by family members specially trained in teaching the program. The program is offered free to family members in several communities around the state. Many family members describe the impact of taking this course as “life changing.”

**Family Member Support Groups** are specifically designed to meet family members’ needs for support and education. The meetings are facilitated by family members who are trained to facilitate the NAMI National support group model. They offer “Caring and Sharing” nights, as well as free educational programs and encouragement for families to participate in advocacy efforts to help improve the quality of treatment for their loved ones and New Hampshire’s mental health service system. NAMI NH now offers live "online" support groups and message boards. NAMI NH maintains an active network of support groups throughout the state.

**“Life Interrupted”** was developed to provide families with a way to educate their communities about family recovery and how to reduce the stigma associated with mental illness. Presentations are made by trained family members who have a loved one living with mental illness. These families speak about their own recovery process; how they learned about, coped with, and promoted their own health, the health of their family, and that of their loved one with mental illness. Families share their own experiences to help open the minds of all members of their community; spreading the message that everyone has the ability to help promote recovery and wellness for those living with mental illness.



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***In Our Own Voice (IOOV)*** is a NAMI program that is offered nationally. Individuals in recovery participate in a training that teaches them how to use their story to provide educational presentations on mental illness and recovery. Presentations are designed to be brief, yet comprehensive and interactive, offering presenters the opportunity to gain self-confidence and self-esteem by serving as role models for the community. It is living proof that mental illness is nothing to be ashamed of and that recovery is an ongoing reality. The speakers are outstanding messengers to the community, carrying the message that people with mental illness achieve goals, combat stigma, and move on with their recovery.

***Connect Suicide Prevention Project*** is a comprehensive, community-based approach to suicide prevention, intervention and postvention (actions taken after a suicide) developed by NAMI NH. Using a public health approach and integrating key aspects of the National Strategy for Suicide Prevention, the program trains community members to play a critical role in suicide prevention. The program encourages the development of a community network of service providers and citizens. The network is developed, trained, and supported to recognize persons at-risk and connect those individuals in an integrated, systematic and comprehensive way with help.

***NAMI Connection*** is a consumer run peer support group designed to allow for members to “drop-in” or regularly attend and gain support for their recovery from mental illness. The groups are run at local community settings and are run by trained NAMI facilitators.

In addition, NAMI NH offers programs and resources for families with a child with an emotional disorder or older adult with mental illness. NAMI NH also provides professional training and hosts awareness raising events throughout the year. For more information on all NAMI NH programs and services, visit **[www.naminh.org](http://www.naminh.org)**.

## Pointers for Better Coping

The diagnosis of a family member or loved one with a serious illness is a time that many caregivers share a confusing and chaotic time. There is much to learn and many things to do. Try to remember these key points to help you cope with this stressful life event:

1. You are not alone. Many other families are experiencing the same issues as yours.
2. Recovery is possible. The road to wellness is not necessarily a straight or easy one, but it is there.
3. There are others who are happy to help you on your journey – others who have walked, or are walking, that path right now.
4. Not everyone experiences the same reactions to such a life event. Each individual’s experiences are real for them and will change over time.
5. Make time for social interaction; do not let yourself become isolated.
6. Take care of yourself. You will not be able to help anyone else, if you do not maintain your own health and well-being.

See *Appendix E. Suggested Reading, beginning on page 161*, for more information on coping with a serious illness in your family.

# Chapter 1. Families and Serious Mental Illness ---

## Chapter 1 Notes

1. Kessler, R; et al. *Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication (NCS-R)*. Archives of General Psychiatry, Vol. 62, pp. 593-602, June 2005.
2. Norton, Steve and Tappin, Ryan. *Adults and Mental Health in New Hampshire*. Concord, NH: New Hampshire Center for Public Policy Studies, 2007.
3. Kubler-Ross, Elisabeth. *On Grief and Grieving: Finding the Meaning of Grief Through the Five Stages of Loss*. New York: Simon & Schuster, Ltd., 2005.
4. Burland, Joyce, Director, Family Education. *Family-to-Family Education Program*. s.l.: National Alliance on Mental Illness, 1990.
5. James, Carrah L., *Caring for Yourself while Helping a Loved One with a Mental Illness*. **www.RosalynnCarter.org**. [Online] 2004.
6. Mayo Clinic. **www.mayoclinic.com/health/stress-relief/SR00035**. [Online]
7. Vancouver Coastal Health and Community Mental Health Service. *Stress Vulnerability Model*. **www.hopevancouver.com**. [Online]

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## Chapter 2. Families and Their Adult Relative

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### Chapter Overview

*An adult family member with a serious mental illness has the same rights and protections as an adult diagnosed with any other serious illness. Family members can play a key role in the recovery process, but only if the*

*individual with the illness wants them to do so. This chapter offers strategies to help improve communication and allow family members to support their loved one's road to recovery.*

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"I felt like no one was listening to me-she was my daughter. I realized that I had to learn how to communicate with her doctor and therapist. I also had to learn how to talk with my daughter if I was going to be able to help her." *Parent of an Adult*

### Communication between Families and Treatment Providers

Living with a serious mental illness is challenging; all too often individuals experience painful and adverse situations, as do those who love and care for them. Because mental illness is a brain disorder, family members and loved ones may have concerns, sometimes valid ones, that their loved ones are not able to make the best decisions for themselves and their own care. If your loved one's illness results in confused and illogical thinking, "or"-disagreements over his or her decisions and actions can create difficulties within the family – making the process of recovery even more challenging for everyone. In order to manage such tensions and disagreements, it is important to understand the laws in New Hampshire that protect a person's rights.

#### Consumer Rights

New Hampshire law places great emphasis on the rights of the individual. An adult has fundamental, personal, and treatment rights, all of which must be respected. Free speech, religious freedom, and personal liberty are fundamental rights with which we are familiar. Similarly, privacy and confidentiality of private information are personal rights to which all adults are entitled. Individuals also have the right to make informed decisions about their care and medical treatment.

An adult can only be provided with medical treatment if they consent to such treatment. They can refuse or withdraw from previously agreed upon treatment at any time – even if their medical provider does not agree. Individuals living with mental illness have these same rights. You can obtain a copy of New Hampshire's laws governing these rights from the state's Office of Consumer and Family Affairs at the Department of Health and Human Services' Bureau of Behavioral Health or the Disabilities Rights Center. See *Appendix C, Local State and National Resources, beginning on page 127*, for information on how to contact these offices.

#### Confidentiality

Like other healthcare providers, mental health professionals have a legal obligation under the federal Health Information Portability and Accountability Act (HIPAA) regulations to maintain the confidentiality of the consumers they serve. Yet, very often, families are necessarily involved in the direct care of their relative and feel they have important insights into the history and nature of their loved one's illness. There are ways that family members can be involved in their loved one's treatment without violating state or federal law.

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## ***Release of Information***

Mental health professionals will normally tell family members they are prevented by HIPAA regulations from discussing the treatment of their loved one. One of the ways to make communication possible between the family and mental health professionals is to have the individual sign a release of information form that specifies with whom the provider may communicate. Many mental health providers recognize the value and importance of communication with families and will offer and encourage your relative to sign the release of information form. It is important that any release of information your loved one signs clearly specifies what information may be released, or discussed, and with whom. A release that is too broad can, indeed, possibly compromise your loved one's privacy if it allows information to be shared with too many people.

In all cases, the disclosure and exchange of information with families should come only after there is a discussion between the mental health professionals and the consumer on the value of these communications and after obtaining the consumer's consent. If your loved one withholds consent to allow communication with the family, their mental health provider should work with the consumer in order to understand the reasons for their refusal and help the consumer understand the importance of their family's support in the recovery process and work to encourage it.

## ***What Information Do I, as a Family Member, Need to Have?***

As a caregiver of someone with a mental illness, it is helpful for families to have access to information essential to their role as caregivers, such as what medications are being prescribed, why they are being prescribed, how long it takes for the medications to take effect, what side effects might occur, and how to respond to them. Families should ask the mental health professional what signs or symptoms would indicate that their loved one's mental health may be declining and know to whom to communicate these changes. Any perceived potential for dangerous behavior to self or others should be discussed and a plan determined on how to manage the situation.

It is important to remember that confidentiality and the development of rapport between the person with mental illness and their mental health provider is essential to building a successful therapeutic relationship. As a family member, you should only be privy to information necessary to your role as caregiver and supporter. Details of conversations between mental health professionals and the person with mental illness should not be revealed unless there is an emergency and under those circumstances a provider can share basic information to families if the individual lives with them or they are involved in the day to day activities to maintain the individual in the community. RSA 135-C:19-a states:

### **135-C:19-a Disclosure of Certain Information:-**

1. Notwithstanding RSA 329:26 and RSA 330-A:32, a community mental health center or state facility providing services to seriously or chronically mentally ill clients may disclose information regarding diagnosis, admission to or discharge from a treatment facility, functional assessment, the name of the medicine prescribed, the side effects of any medication prescribed, behavioral or physical manifestations which would result from failure of the client to take such prescribed medication,

## Chapter 2. Families and Their Adult Relative

treatment plans and goals and behavioral management strategies to a family member or other person, if such family member or person lives with the client or provides direct care to the client.

### ***What if My Family Member Will Not Sign a Release of Information?***

If your loved one refuses to allow their mental health professionals to communicate with you, there is no law, rule, or policy that prevents you from giving information to the provider, either by phone, in person, or by letter. Remember, the provider will not be able to share any information with you, but they can listen. Because they are bound by legal and professional regulations from releasing information without the consumer's consent, it can be helpful **to preface any communication with the provider with the fact you understand they cannot talk to you, but you feel it is important that you share what you know with them to help your loved one receive the best treatment.** Families often can see when a loved one is making progress or experiencing difficulty. Sometimes families are the first to see or hear something that needs to be known by the professionals. Even if it is only a one way communication, your phone call may be very helpful. Some family members have found it effective to present their concerns in writing and deliver or fax them to the provider.

Many individuals with serious mental illness struggle with issues of trust and privacy. Because of this, it is almost always advisable to let your loved one know that you are going to contact their mental health provider because you love them and want the best for them even if they do not agree with you.

## **Understanding Mental Illness and Its Impact on Communication**

Individuals with serious mental illnesses may process information differently, depending upon the nature of their illness, its severity and symptoms. At times, communication may be difficult. Improving communication skills can help reduce stress and frustration in your family and lead to healthier interactions. Below are some suggestions to help you and your family communicate better with your loved one:<sup>1</sup>

### **Situation #1: When your loved one withdraws**

Sometimes your loved one may physically and/or emotionally withdraw because they feel overwhelmed. Some individuals with mental illness may have a limited capacity for communication (real or perceived) and may easily feel over-stimulated.

#### ***Suggestion:***

*Avoid taking the withdrawal personally. Try to remain available if your loved one wants to talk later.*



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**Situation #2: When social situations become too stressful**

Social situations can be very stressful for individuals with mental illness (especially for individuals living with schizophrenia, depression, post-traumatic stress disorder and other anxiety disorders). Groups or crowds may be perceived as threatening and/or anxiety-provoking.

***Suggestion:***

*Your loved one may feel more comfortable with only one or a few people around at a time. You may find limiting the length or frequency of group activities or interactions helps.*

**Situation #3: When your loved one has difficulty expressing emotion**

Individuals with mental illness may have an impaired ability to express their feelings. As a result, they may appear emotionally distant, disinterested or detached. Sometimes when they do express emotion it may appear inappropriate to the situation.

***Suggestion:***

*Remember that this emotional distance or inappropriate response is part of the illness, rather than a reflection of a problem in your relationship or some wrongdoing on your loved one's part.*

**Situation #4: When your loved one displays intense emotions**

Some people with mental illness may display intense, rapidly escalating and changing emotions. Individuals with a number of diagnoses, including post-traumatic stress disorder, bipolar disorder, depression, schizophrenia and anxiety may be prone to angry outbursts, which can be frightening to you and other observers.

***Suggestion:***

*Your loved one is responsible for his or her behavior, as is any other adult, and may have to face appropriate consequences for such behavior. (For example, an angry outburst in a public place may lead to their being asked to leave.) It is important for you and, when they are able, your loved one to recognize this heightened emotionality as a symptom of the illness.*

### Situation #5: When your loved one hears voices

People with thought disorders like schizophrenia often feel bombarded with information not only from the outside world, but also from within themselves in the form of auditory hallucinations or “voices.” These “voices” are so real that it is often a struggle for such individuals to sort out which information is coming from within and what is coming from outside them.

#### ***Suggestion:***

*If your loved one is experiencing auditory hallucinations, communication is most effective when it is straightforward, brief and includes calm repetition of key points. It is important to avoid arguing about the validity or existence of your loved one’s delusional beliefs or hallucinations, as the debate will be ineffective and may actually heighten tension.*

Sometimes we can just be sitting in church or at dinner and suddenly Alex will just start laughing. It’s actually a little scary – definitely for people who don’t know him. We used to all look at each other uncomfortably, not knowing what to do, and he’d keep doing it – laughing almost maniacally. Over time we’ve learned that it seems to help if one of us calmly and matter-of-factly asks him what he finds so funny. Usually, he’ll look surprised and say there wasn’t really anything. But then he’s calmer and better able to communicate appropriately for the time being.

***Family Member of an Adult with Mental Illness***

### **Additional Pointers for Improving Communication**

#### ***Do:***

- Keep your conversations brief and clear;
- Ask one question at a time; allow time for response;
- Minimize distractions by turning off the television, radio, etc.;
- Look for nonverbal forms of communication;
- Stay focused on present issues;
- Validate feelings when appropriate;
- Make decisions together; and
- Whenever possible, decide together on a regular time to talk.

#### ***Try to:***

- Avoid interrupting each other;
- Avoid giving advice unless asked for;
- Avoid raising your voice;
- Avoid generalizations;
- Avoid arguing over delusional or paranoid thinking;
- Avoid the expression of intense emotion;
- Avoid being condescending and belittling;
- Avoid generalizations in favor of focusing upon the specific; and
- Avoid personalizing your family member’s language and behavior.

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## Your Family Member's Recovery Journey

Recovery is a personal journey that requires multiple approaches in order to be successful. While significant advances have been made in the development of drugs to treat the symptoms of mental illness, rarely does medication alone lead to recovery. However, when symptoms are brought under some degree of control, individuals are better able to engage in the other types of treatment and supports necessary to their recovery.

In the following chapters, we will discuss a variety of treatments and support services, including medication, available in New Hampshire and which have proven to be highly effective in treating mental illnesses. While each of the treatments has its own unique focus and purpose, most of them involve a core set of principles which emphasize the importance of:

- Identifying meaningful, personal, self-determined, recovery-oriented goals;
- Breaking goals into smaller more manageable objectives;
- Identifying what prevents the person from obtaining these objectives;
- Recognizing and building on the person's unique strengths in working towards their goals; and
- Assisting the person in maximizing their strengths, learning the skills needed, and developing the supports necessary to overcome the barriers standing in the way of realizing their desired goals.

Such a process is difficult and time consuming, demanding both patience and a focus of all involved to keep your "eyes on the prize" and your feet on the path. The journey of recovery begins where your loved one is and focuses on traveling to the place where he or she wants to be.

Recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.<sup>2</sup>

### ***How Families Can Support This Journey***

1. Notice and celebrate your family member's strengths. It is important to notice and celebrate your loved one's existing talents and positive qualities. This approach goes a long way towards helping him or her improve their sense of personal value and self-worth. The old saying, "you find what you look for," applies here. If you're disappointed or annoyed with your family member, it's very easy to find fault. But if you take the time to recognize them doing something good (and learn to ignore the small issues that are not worth the conflict), you will create a situation where your family member can begin again to take pride in themselves and their accomplishments.
2. Support self-determined, long-term goals and short-term objectives. It is common for individuals with serious mental illness to struggle with finding a sense of purpose and meaning in their lives. This struggle can be compounded when your family member is unable to work or feels he or she cannot contribute in the outside world. It is very easy to become isolated and withdrawn. This can lead to increased depression

## Chapter 2. Families and Their Adult Relative

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and decreased motivation. In setting purposeful and meaningful goals, it is important to embrace and celebrate the accomplishment of small steps, knowing they will eventually lead to achieving the larger goals. Remember to acknowledge the effort involved in taking these steps forward regardless of their actual outcome.

3. You can accept that this journey of recovery is based on self-determined goals and objectives. It is hard to get really excited about goals that someone else sets for us unless those goals are truly consistent with our own. If you, as a family member, find yourself wondering why you are more upset than your loved one is with a failure to follow through with a given goal, then perhaps it is time to question if it was your goal or your loved one's goal. Research has shown that with "person-centered planning," individuals with serious mental illness actually make more progress and do better emotionally when they feel empowered to make their own choices and determine their own goals. These choices and goals may be different from what you might have chosen, but they are just as valid and the ability to make them is critical to your loved one's recovery journey.

To learn more about how to help your loved one on their recovery journey, see *Appendix E. Suggested Reading, beginning on page 161*.

### Chapter 2 Notes

1. Sherman, M.D. *SAFE Program: Mental Health Facts for Families. Support and Family Education*. <http://www.ouhsc.edu/Safeprogram/>. [Online] April 2008
2. SAMHSA's National Mental Health Information Center. Substance Abuse and Mental Health Services Administration. *National Consensus Statement on Mental Health Recovery*. <http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/>. [Online]

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## Chapter 3. Serious Mental Illness: A Closer Look

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### Chapter Overview

*The onset and diagnosis of a serious mental illness in the family can be an overwhelming time as decisions have to be made and family members have to learn to adjust to the reality their loved one has received a mental illness diagnosis. It is important for families to know about the wealth of information that is available to them on diagnosis and available treatment to effectively*

*navigate the treatment system. In this chapter we will focus on serious mental illness: its definition, how it is defined and an overview of diagnoses. More sources of information on mental illness diagnoses can be found in Appendix C. Local, State and National Resources, page 127, and Appendix E. Suggested Reading, page 161.*

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“When my daughter was diagnosed with bipolar disorder, we were devastated. We didn’t know where to turn or how to help her. She wasn’t accepting she had an illness and was very angry with us. We hoped the doctors were wrong. The Family-to-Family educational program helped us learn how to take care of ourselves and help our daughter.”

*Family member of an Adult with Mental Illness*

### Basic and Often Misunderstood Concepts

Mental illnesses are medical conditions that disrupt a person’s thinking, feeling, mood, ability to relate to others, and daily functioning. Just as diabetes is a disorder of the pancreas, mental illnesses are disorders of the brain that often result in a diminished capacity for coping with the ordinary demands of life.

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

In addition to medication, psychosocial treatments such as cognitive behavioral and interpersonal therapy, peer support activities, and other community-based services can also be components of a treatment plan designed to promote recovery. The availability of stable housing, transportation, diet, exercise, sleep, friends, and meaningful paid or volunteer activities contribute to one’s overall health, wellness, and recovery.

As family members, it is important we have accurate information about mental illness and learn how to navigate the mental health system to ensure our loved ones receive the supports and services necessary to facilitate their recovery.

#### ***Facts About Mental Illness & Recovery<sup>1</sup>***

- Mental illnesses are disorders of the brain that cannot be overcome through "will power" and are not related to a person's "character or intelligence."
- Mental disorders fall along a continuum of severity. Even though mental disorders are widespread in the population, the main burden of illness is concentrated in a much smaller number who suffer from a serious mental illness — about 6 percent, or 1 in 17 Americans. It is estimated that mental illness affects 1 in 5 families in America.
- The World Health Organization has reported that four of the 10 leading causes of disability in the US and other developed countries are mental disorders. The World Health Organization also estimates that by 2020, major depressive illness will be the leading cause of disability in the world for women and children.
- Mental illnesses usually strike individuals in the prime of their lives, often during adolescence and young adulthood. All ages are susceptible, but the young and the old are especially vulnerable.



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- Without treatment the consequences of mental illness for the individual and society are staggering: unnecessary disability, unemployment, substance abuse, homelessness, inappropriate incarceration, suicide, and wasted lives.
  - The best treatments for serious mental illnesses today are highly effective; between 70 and 90% of individuals have significant reduction of symptoms and improved quality of life with a combination of pharmacological and psychosocial treatments and supports.
  - With appropriate effective medication and a wide range of services tailored to their needs, most people who live with serious mental illness can significantly reduce the impact of their illness and find a satisfying measure of achievement and independence. A key concept is to acquire expertise in developing strategies to manage the illness process.
  - Early identification and treatment is of vital importance. By ensuring access to appropriate treatment and supports, recovery is accelerated and the further harm related to the course of illness is minimized.
  - Stigma erodes confidence that mental disorders are real, treatable health conditions. We have allowed stigma and an unwarranted sense of hopelessness to erect attitudinal, structural, and financial barriers to effective treatment and recovery. It is time to take these barriers down.

## What is the Definition of Serious Mental Illness?

In general, the term “serious mental illness” identifies those psychiatric illnesses which are extremely disabling to the person with the illness. “Serious” also implies the notion of duration or the length of time that the person experiences the debilitating effects of the illness. In short, a mental illness is considered “serious” if the person with the illness experiences significant impairment in his or her ability to function in life and experiences that impairment for a defined length of time.

When our loved one receives a mental illness diagnosis, most of us experience dread, fear and confusion. Usually, this is because mental illness is not something many of us know anything about until we are faced with it. As family members we are dealing with many unknowns, have many questions, and the terminology used by many of the professionals is foreign to us. The diagnoses explained in this section are from the system defined in the American Diagnostic and Statistical Manual (DSM V) which is used by mental health practitioners when making a diagnosis. The descriptions below come from the NAMI National website at [www.nami.org](http://www.nami.org).

### **Schizophrenia**

Schizophrenia is a serious and challenging medical illness that affects well over 2 million American adults, which is about 1 percent of the population age 18 and older. Although it is often feared and misunderstood, schizophrenia is a treatable medical condition.

Schizophrenia often interferes with a person's ability to think clearly, to distinguish reality from fantasy, to manage emotions, make decisions, and relate to others. The first signs of schizophrenia typically emerge in the teenage years or early twenties, often later for

## Chapter 3. Serious Mental Illness: A Closer Look

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females. Most people with schizophrenia contend with the illness chronically or episodically throughout their lives, and are often stigmatized by lack of public understanding about the disease. Schizophrenia is not caused by bad parenting or personal weakness. A person with schizophrenia does not have a "split personality." Almost all people with schizophrenia are not dangerous or violent towards others while they are receiving treatment.

### *What are the symptoms of schizophrenia?*

No one symptom positively identifies schizophrenia. All of the symptoms of this illness can also be found in other mental illnesses. For example, psychotic symptoms may be caused by the use of illicit drugs, may be present in individuals with Alzheimer's disease, or may be characteristics of a manic episode in bipolar disorder. However, when a doctor observes the symptoms of schizophrenia and carefully assesses the history and the course of the illness over six months, he or she can almost always make a correct diagnosis.

The symptoms of schizophrenia are generally divided into three categories – Positive, Negative, and Cognitive.

**Positive Symptoms** (or "psychotic" symptoms) include delusions and hallucinations because the patient has lost touch with reality in certain important ways. "Positive" refers to having overt symptoms that should not be there. Delusions cause individuals to believe people are reading their thoughts or plotting against them; that others are secretly monitoring and threatening them; or that they can control other people's minds. Hallucinations cause people to hear or see or smell or feel things that are not present.

**Negative symptoms** include emotional flatness or lack of expression; an inability to start and follow through with activities, speech that is brief and devoid of content, and a lack of pleasure or interest in life. "Negative" does not refer to a person's attitude, but to a lack of certain characteristics that should be there.

**Cognitive Symptoms** pertain to thinking processes. For example, people may have difficulty with prioritizing tasks, certain kinds of memory functions, and organizing their thoughts. A common problem associated with schizophrenia is the lack of insight into the condition itself. This is not a willful denial, but rather a part of the mental illness itself. Such a lack of understanding, of course, poses many challenges for loved ones seeking better care for the person with schizophrenia.

Schizophrenia also affects mood. While many individuals affected with schizophrenia become depressed, some also have apparent mood swings and even bipolar-like states. When mood instability is a major feature of the illness, it is called schizoaffective disorder, meaning that elements of schizophrenia and mood disorders are prominently displayed by the same individual. It is not clear whether schizoaffective disorder is a distinct condition or simply a subtype of schizophrenia.

### ***Bipolar Disorder***

Bipolar disorder, or manic depression, is a medical illness that causes extreme shifts in mood, energy, and functioning. These changes may be subtle or dramatic and typically vary greatly over the course of a person's life as well as among individuals. Over 10 million people in America have bipolar disorder; the illness affects men and women equally. Bipolar

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bipolar disorder is a chronic and generally life long condition with recurring episodes of mania and depression that can last from days to months. The disorder often begins in adolescence or early adulthood, and, occasionally, even in childhood. Most people generally require some sort of life long treatment. While medication is one key element in successful treatment of bipolar disorder, psychotherapy, support, and education about the illness are also essential components of the treatment process.

### ***What are the symptoms of mania?***

Mania is the word that describes the activated phase of bipolar disorder. The symptoms of mania may include:

- either an elated, happy mood or an irritable, angry, unpleasant mood
- increased physical and mental activity and energy
- racing thoughts and flight of ideas
- increased talking, more rapid speech than normal
- ambitious, often grandiose plans
- risk-taking
- impulsive activity such as spending sprees, sexual indiscretion, and alcohol/ substance abuse
- decreased sleep without experiencing fatigue

### ***What are the symptoms of depression?***

Depression is the other phase of bipolar disorder. The symptoms of depression may include:

- loss of energy
- prolonged sadness
- decreased activity and energy
- restlessness and irritability
- inability to concentrate or make decisions
- increased feelings of worry and anxiety
- less interest in, or less pleasure from, activities usually enjoyed
- feelings of guilt and hopelessness
- thoughts of suicide
- change in appetite (either eating more or eating less)
- change in sleep patterns (either sleeping more or sleeping less)

### ***What is a "mixed" state?***

A mixed state is when symptoms of mania and depression occur at the same time. During a mixed state depressed mood accompanies manic behavior.

### ***What is rapid cycling?***

Sometimes individuals may experience an increased frequency of episodes. When four or more episodes of illness occur within a 12-month period, the individual is said to have bipolar disorder with rapid cycling.

## Chapter 3. Serious Mental Illness: A Closer Look

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### ***Major Depression***

Major depression is a serious medical illness affecting 15 million American adults, or approximately 5 to 8 percent of the adult population in a given year. Unlike normal emotional experiences of sadness, loss, or passing mood states, major depression is persistent and can significantly interfere with an individual's thoughts, behavior, mood, activity, and physical health. Among all medical illnesses, major depression is the leading cause of disability in the U.S. and many other developed countries.

Major depression, also known as clinical depression or unipolar depression, is only one type of depressive disorder. Other depressive disorders include dysthymia (chronic, less severe depression) and bipolar depression (the depressed phase of bipolar disorder).

### ***What are the symptoms of major depression?***

The onset of the first episode of major depression may not be obvious if it is gradual or mild. The symptoms of major depression characteristically represent a significant change from how a person functioned before the illness. The symptoms of depression include:

- persistently sad or irritable mood;
- pronounced changes in sleep, appetite, and energy;
- difficulty thinking, concentrating, and remembering;
- physical slowing or agitation;
- lack of interest in, or pleasure from, activities that were once enjoyed;
- feelings of guilt, worthlessness, hopelessness, and emptiness;
- recurrent thoughts of death or suicide; and
- persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders, and chronic pain.

When several of these symptoms occur at the same time, last longer than two weeks, and interfere with ordinary functioning, professional treatment is needed.

### ***Post-Traumatic Stress Disorder***

Post-traumatic stress disorder (PTSD) is a disorder that can occur after someone experiences a traumatic event that caused intense fear, helplessness, or horror. PTSD can result from personally experienced traumas (e.g., rape, war, natural disasters, abuse, serious accidents, and captivity) or from the witnessing or learning of a violent or tragic event.

While it is common to experience a brief state of anxiety or depression after such occurrences, people with PTSD continually re-experience the traumatic event, avoid individuals, thoughts, or situations associated with the event, and have symptoms of excessive emotions. People with this disorder have these symptoms for longer than one month and cannot function as well as they did before the traumatic event. PTSD symptoms usually appear within three months of the traumatic experience; however, they may sometimes occur months or even years later.

### ***What are the symptoms of PTSD?***

Although the symptoms for individuals with PTSD can vary considerably, they generally fall into three categories:

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- Re-experience – Individuals with PTSD often experience recurrent and intrusive recollections of, and/or nightmares about, the stressful event. Some may experience flashbacks, hallucinations, or other vivid feelings of the event happening again. Others experience great psychological or physiological distress when certain things (objects, situations, etc.) remind them of the event.
  - Avoidance – Many who live with PTSD will persistently avoid things that remind them of the traumatic event. This can result in avoiding everything from thoughts, feelings, or conversations associated with the incident to activities, places, or people that cause them to recall the event. In others, there may be a general lack of responsiveness signaled by an inability to recall aspects of the trauma, a decreased interest in formerly important activities, a feeling of detachment from others, a limited range of emotion, and/or feelings of hopelessness about the future.
  - Increased arousal – Symptoms in this area may include difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, becoming very alert or watchful, and/or jumpiness or being easily startled.

It is important to note that those with PTSD often use alcohol or other drugs in an attempt to self-medicate and may develop substance use disorders. Individuals with this disorder may also be at an increased risk for suicide.

### ***Borderline Personality Disorder***

Borderline Personality Disorder (BPD) is a most misunderstood, serious mental illness characterized by pervasive instability in moods, interpersonal relationships, self-image, and behavior. It is a disorder of emotion dysregulation. This instability often disrupts family and work, long-term planning, and the individual's sense of self-identity. While less well-known than schizophrenia or bipolar disorder, BPD is as common, affecting up to 2% of the general population.

### ***What are the Symptoms of Borderline Personality Disorder?***

While a person with depression or bipolar disorder typically endures the same mood for weeks, a person with BPD may experience intense bouts of anger, depression, and anxiety that may last only hours, or at most a day. These may be associated with episodes of impulsive aggression, self-injury, and drug or alcohol abuse. Distortions in cognition and sense of self can lead to frequent changes in long-term goals, career plans, jobs, friendships, gender identity, and values. Sometimes people with BPD view themselves as fundamentally bad or unworthy. They may feel unfairly misunderstood or mistreated, bored, empty, and have little idea who they are. Such symptoms are most acute when people with BPD feel isolated and lacking in social support, and may result in frantic efforts to avoid being alone.

People with BPD often have highly unstable patterns of social relationships. While they can develop intense but stormy attachments, their attitudes towards family, friends, and loved ones may suddenly shift from idealization (great admiration and love) to devaluation (intense anger and dislike). Thus, they may form an immediate attachment and idealize the other person, but when a slight separation or conflict occurs, they switch unexpectedly to the other extreme and angrily accuse the other person of not caring for them at all. Even with family members, individuals with BPD are highly sensitive to rejection, reacting with

## Chapter 3. Serious Mental Illness: A Closer Look

anger and distress to such mild separations as a vacation, a business trip, or a sudden change in plans. These fears of abandonment seem to be related to difficulties feeling emotionally connected to important persons when they are physically absent, leaving the individual with BPD feeling lost and perhaps worthless. Suicide threats and attempts may occur along with anger at perceived abandonment and disappointments.

People with BPD exhibit other impulsive behaviors, such as excessive spending, binge eating and risky sex. BPD often occurs together with other psychiatric problems, particularly bipolar disorder, depression, anxiety disorders, substance use disorders, and other personality disorders.

### ***Obsessive-Compulsive Disorder***

Obsessive-Compulsive Disorder, OCD, is an anxiety disorder and is characterized by recurrent, unwanted thoughts (obsessions) and/or repetitive behaviors (compulsions).

**Obsessions** are intrusive, irrational thoughts – unwanted ideas or impulses that repeatedly well up in a person's mind. Again and again, the person experiences disturbing thoughts, such as:

- "My hands are contaminated – I must wash them."
- "I may have left the gas stove on."
- "I am going to injure my child."

On one level, the sufferer knows these obsessive thoughts are irrational. But on another level, he or she fears these thoughts might be true. Trying to avoid such thoughts creates great anxiety.

**Compulsions** are repetitive rituals such as hand washing, counting, checking, hoarding, or arranging. An individual repeats these actions, perhaps feeling momentary relief, but without feeling satisfaction or a sense of completion. People with OCD feel they must perform these compulsive rituals or something bad will happen.

Most people at one time or another experience obsessive thoughts or compulsive behaviors. An individual who has Obsessive-Compulsive Disorder experiences obsessions and compulsions for more than an hour each day, in a way that interferes with his or her life.

I first realized my wife had a problem a week before our wedding. We were supposed to go to her parents for dinner and go over the final plans for the wedding, but my fiancée couldn't leave the apartment until she had taken every book off every shelf, dusted it inside and out, dusted the shelves, polished them, and then put each book back, according to size and color. She literally could not make herself stop. I finally called her family and told them we couldn't come to dinner. The next day I went with her to see her doctor who prescribed something for anxiety and she made it through the wedding.

Over time, I realized her problem was really an illness. When things got so bad she couldn't leave the house, I went with her to see a psychiatrist. With medication and therapy, she's now able to work and enjoy doing things.

*Family member*



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## ***Panic Disorder***

A person who experiences recurrent panic attacks, at least one of which leads to at least a month of increased anxiety or avoidant behavior, is said to have panic disorder. Panic disorder may also be indicated if a person experiences fewer than four panic episodes but has recurrent or constant fears of having another panic attack.

Doctors often try to rule out every other possible alternative before diagnosing panic disorder. To be diagnosed as having panic disorder, a person must experience at least four of the following symptoms during a panic attack:

- sweating,
- hot or cold flashes,
- choking or smothering sensations,
- racing heart,
- labored breathing,
- trembling,
- chest pains,
- faintness,
- numbness,
- nausea,
- disorientation, or
- feelings of dying, losing control, or losing one's mind.

Panic attacks typically last about 10 minutes. During the attack, the physical and emotional symptoms increase quickly in a crescendo-like way and then subside. A person may feel anxious and jittery for many hours after experiencing a panic attack.

Panic attacks can occur in anyone. Chemical or hormonal imbalances, drugs or alcohol, stress, or other situational events can cause panic attacks, which are often mistaken for heart attacks, heart disease, or respiratory problems.

## ***Phobias***

Phobias are irrational, involuntary, and inappropriate fears of (or responses to) ordinary situations or things. People who have phobias can experience panic attacks when confronted with the situation or object about which they feel phobic.

Phobias are usually chronic (long-term), distressing disorders that keep people from ordinary activities and places. They can lead to other serious problems, such as depression. In fact, at least half of those who suffer with phobias and panic disorders also have depression. Alcoholism, loss of productivity, secretiveness, and feelings of shame and low self-esteem also occur with this illness. Some people are unable to go anywhere or do anything outside their homes without the help of others they trust.

## ***Eating Disorders***

An eating disorder is marked by extremes. It is present when a person experiences severe disturbances in eating behavior, such as extreme reduction of food intake or extreme overeating, or feelings of extreme distress or concern about body weight or shape.



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A person with an eating disorder may have started out just eating smaller or larger amounts of food than usual, but at some point, the urge to eat less or more spirals out of control. Eating disorders are very complex, and, despite scientific research to understand them, the biological, behavioral and social underpinnings of these illnesses remain elusive.

The two main types of eating disorders are anorexia nervosa and bulimia nervosa. A third category is "eating disorders not otherwise specified (EDNOS)," which includes several variations of eating disorders. Most of these disorders are similar to anorexia or bulimia but with slightly different characteristics. Binge-eating disorder, which has received increasing research and media attention in recent years, is one type of EDNOS.

Eating disorders frequently appear during adolescence or young adulthood, but some reports indicate that they can develop during childhood or later in adulthood. Women and girls are much more likely than males to develop an eating disorder. Men and boys account for an estimated 5 to 15% of patients with anorexia or bulimia and an estimated 35% of those with binge-eating disorder. Eating disorders are real, treatable medical illnesses with complex underlying psychological and biological causes. They frequently co-exist with other psychiatric disorders such as depression, substance use disorders, or anxiety disorders. People with eating disorders also can suffer from numerous other physical health complications, such as heart conditions or kidney failure, which can lead to death.

### ***Anorexia Nervosa***

Anorexia nervosa is characterized by emaciation, a relentless pursuit of thinness and unwillingness to maintain a normal or healthy weight, a distortion of body image and intense fear of gaining weight, a lack of menstruation among girls and women, and extremely disturbed eating behavior. Some people with anorexia lose weight by dieting and exercising excessively; others lose weight by self-induced vomiting, or misusing laxatives, diuretics or enemas.

Many people with anorexia see themselves as overweight, even when they are starved or are clearly malnourished. Eating, food and weight control become obsessions. A person with anorexia typically weighs herself or himself repeatedly, portions food carefully, and eats only very small quantities of only certain foods. Some who have anorexia recover with treatment after only one episode. Others get well but have relapses. Still others have a more chronic form of anorexia, in which their health deteriorates over many years as they battle the illness.

According to some studies, people with anorexia are up to ten times more likely to die as a result of their illness compared to those without the disorder. The most common complications that lead to death are cardiac arrest, and electrolyte and fluid imbalances. Suicide also can result.

Many people with anorexia also have coexisting psychiatric and physical illnesses, including depression, anxiety, obsessive behavior, substance abuse, cardiovascular and neurological complications, and impaired physical development.

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### ***Bulimia Nervosa***

Bulimia nervosa is characterized by recurrent and frequent episodes of eating unusually large amounts of food (e.g., binge-eating), and feeling a lack of control over the eating. This binge-eating is followed by a type of behavior that compensates for the binge, such as purging (e.g., vomiting, excessive use of laxatives or diuretics), fasting and/or excessive exercise.

Unlike anorexia, people with bulimia can fall within the normal range for their age and weight. But like people with anorexia, they often fear gaining weight, want desperately to lose weight, and are intensely unhappy with their body size and shape. Usually, bulimic behavior is done secretly, because it is often accompanied by feelings of disgust or shame. The bingeing and purging cycle usually repeats several times a week. Similar to anorexia, people with bulimia often have coexisting psychological illnesses, such as depression, anxiety and/or substance use disorders. Many physical conditions result from the purging aspect of the illness, including electrolyte imbalances, gastrointestinal problems, and oral and tooth-related problems.

### ***Binge-Eating Disorder***

Binge-eating disorder is characterized by recurrent binge-eating episodes during which a person feels a loss of control over his or her eating. Unlike bulimia, binge-eating episodes are not followed by purging, excessive exercise or fasting. As a result, people with binge-eating disorder often are overweight or obese. They also experience guilt, shame and/or distress about the binge-eating, which can lead to more binge-eating.

Obese people with binge-eating disorder often have coexisting psychological illnesses including anxiety, depression, and personality disorders. In addition, links between obesity and cardiovascular disease and hypertension are well documented.

## **What are Co-Occurring Illnesses and Disorders?**

Co-occurring disorders (or dual diagnoses) refer to disorders that occur in a person at the same time. In the realm of mental health, there are two pairs of disorders that are commonly referred to as co-occurring: mental illness and substance use disorder; and mental illness and developmental disability.

### ***Mental Illness and Developmental Disability***

Just as mental illness may co-occur with other disorders, a small percentage of people with mental illness also have a developmental disability, such as mental retardation, cerebral palsy, epilepsy, or autism. Every region of New Hampshire has an area agency to meet the needs of people with developmental disabilities, just as there are community mental health centers in every region to serve people with mental illness. If an adult is eligible for both agencies, and these organizations work collaboratively, a comprehensive treatment plan can be developed to help ensure that the person's needs are appropriately addressed. Two of New

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Hampshire's ten regions (Regions I and X) actually have one agency which fulfills both of these roles. Area agency contact information can be found in *Appendix C. Local, State and National Resources* page, 138.

### ***Mental Illness and Substance Use Disorder***

Traditionally, substance use disorders and mental illness have been treated separately by different agencies. Treating one illness first and then the other is called sequential treatment. Treating both illnesses at the same time through different systems is called parallel treatment. Using one treatment provider and system to maximize continuity in treatment and understanding of the impact each disorder has on the other is called integrated treatment. Integrated treatment is the most effective method of treatment for these co-occurring disorders. Finding providers who understand both mental illness and substance use disorders maximizes success in addressing both issues. See *Chapter 7, Navigating the Treatment System*, page 69 regarding Integrated Treatment.

For more complete information on these and other mental illness diagnosis including recommended treatment modalities contact the NAMI NH Information & Resource Line 1-(800) 242-6264, Ext. 4 to receive a free National Institute on Mental Illness brochure.

### **Chapter 3 Notes**

1. National Alliance on Mental Illness. *What is Mental Illness: Mental Illness Facts*. [http://www.nami.org/Content/NavigationMenu/Inform\\_Yourself/About\\_Mental\\_Illness/About\\_Mental\\_Illness.htm](http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Mental_Illness.htm). [Online]

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## Chapter 4. Mental Health Medications

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### Chapter Overview

*One of the most common elements of any treatment plan is psychotherapeutic medication. It is also the treatment that raises the most questions for individuals and their families. As with any other treatment component, it is essential that your loved one communicate with their mental health provider, asking questions and providing open feedback so that*

*the provider can determine the best medication regimen for your loved one.*

*This chapter offers a snapshot of the four major categories of psychotherapeutic medications, the illnesses and symptoms which they treat, the desired benefits they hope to produce, and the potential risks they pose and side effects they may cause.*

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### Medication as Part of the Treatment Plan

Psychotherapeutic medications are usually prescribed by a psychiatrist or psychiatric nurse practitioner and can be an important part of your loved one's treatment plan. If medication is the only treatment being offered to your loved one, he or she should ask their treatment team why other forms of therapy or support are not being used.

It is important to understand the type of medication being prescribed, what symptoms it will be addressing and any possible side effects. The prescriber should present information about the risks and benefits of medication to your loved one. He or she should have opportunities to ask questions and share their views and opinions. This sharing of information and conversations will enable the "team" (individual with mental illness and providers) to make quality healthcare decisions.

Your loved one might want to consider keeping a Medication Log. A sample Medication Log can be found in *Appendix D. Forms You Might Find Useful, page 157*. This record should include the name of the medication, dosage, date when prescribed, and name of prescriber. Make sure your loved one updates the log when medications are adjusted or discontinued and notes the reasons for any changes. The Medication Log can be shared with other healthcare providers to help ensure appropriate integrated care. Also, the Medication Log provides a concise history that can be quickly referred to when questions arise.

When our son was first diagnosed with major depression five years ago, we thought they would put him on an anti-depressant and everything would be fine. Yeah, right. After the fifth medication change, my wife started writing them all down in a special notebook. It was a good thing she did. Sometimes we go to the doctor and he'll ask if my son has tried a certain medication in the past and my wife can find it in her notebook faster than the doctor can in the medical chart!

It was hard, watching our son go through all those different medications. There were side effects with each of them. I would get angry sometimes, thinking the doctor was experimenting on our son. But, now, he has been doing well on a combination of medications for the past 9 months. We have our fingers crossed that these meds keep working for him.

*Family-to-Family Participant*

### Types of Psychotherapeutic Medications

Generally, psychotherapeutic medication is divided into four categories: antipsychotic, antimanic, antidepressant, and antianxiety. The following is a brief overview based upon information from the National Institute on Mental Health's publication *Medications for Mental Illness*.<sup>1</sup>

#### ***Antipsychotic Medications***

As the name implies, antipsychotic medications are used to treat the symptoms of psychotic illnesses such as schizophrenia. People afflicted with this type of illness may hear voices

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other people don't hear, or they may believe that others are reading their minds, controlling their thoughts, or plotting against them. They may not make sense when they talk, may sit for hours without moving or talking, or may seem perfectly fine until they talk about what they are really thinking. They may also neglect personal hygiene and appearance, not bathing or changing clothes.

There are a number of antipsychotic medications available. These medications affect neurotransmitters (such as dopamine) that allow communication between nerve cells. All these medications have been shown to be effective for schizophrenia. The main differences are in the potency – that is, the amount prescribed to produce therapeutic effects and the side effects experienced. Unlike some prescription medications which must be taken several times during the day, some antipsychotics can be taken just once a day and some can be injected once or twice a month.

The use of antipsychotic medications was first introduced in the 1950s and these early medications helped many individuals with psychosis lead more normal and fulfilling lives by alleviating such symptoms as visual and auditory hallucinations and paranoid thoughts. However, these early medications, such as chlorpromazine (Thorazine), thioridazine (Mellaril), thiothixene (Navane), and trifluoperazine (Stelazine), were often accompanied by unpleasant side effects – muscle stiffness, tremor, and abnormal movements – leading researchers to continue their search for better medications.

During the 1990s several new drugs for psychotic illnesses were developed. These medications are known as “atypical” or “second generation” antipsychotics and have fewer side effects than their older counterparts. The first atypical to be developed was clozapine (Clozaril) and continues to be the drug of choice for individuals with treatment-resistant schizophrenia. Other atypical antipsychotics include risperidone (Risperdal), olanzapine (Zyprexa), quetiapine (Seroquel), ziprasidone (Geodon), and aripiprazole (Abilify).

Each atypical has a unique side effect profile, but, in general, these medications may be better tolerated than their earlier counterparts. One common side effect of the atypical antipsychotics is weight gain, which is sometimes accompanied by increased high blood sugar and the possibility of developing diabetes. If a person is gaining weight at a rapid rate, the prescriber may consider changing the medication. The side effects of atypical antipsychotics may also lead to increased cholesterol and triglyceride levels, increasing the risk of cardiovascular disease. It is important that individuals be tested regularly for elevated blood sugar, cholesterol and triglyceride levels.

### ***Antimanic Medications***

Antimanic or mood stabilizer medications are used to treat the symptoms of bipolar disorder or manic-depressive illness. This illness is characterized by cycling mood changes ranging from: severe highs (mania) to deep lows (depression). Episodes may be predominantly manic or depressive, with normal mood between episodes. Mood swings may follow each other very closely, within days (rapid cycling), or may be separated by months to years. The “highs” and “lows” may vary in intensity and severity and can co-exist in “mixed” episodes.

When people are in a manic “high,” they may be overactive, overly talkative, have a great deal of energy, and need much less sleep than normal. They may switch quickly from one topic to another, as if they cannot get their thoughts out fast enough. Their attention span is

## Chapter 4. Mental Health Medications

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often short, and they can be easily distracted. Sometimes people who are “high” are irritable or angry and have false or inflated ideas about their position or importance in the world. They may be very elated and full of grand schemes that might range from business deals to romantic sprees. Often, they show poor judgment in these ventures. Untreated mania may worsen to a psychotic state.

In a depressive cycle the person may have a “low” mood with difficulty concentrating, lack of energy, slowed thinking and movements, changes in eating and sleeping patterns (usually increases of both in bipolar depression), feelings of hopelessness, helplessness, sadness, worthlessness, guilt, and sometimes, thoughts of suicide.

### ***Lithium***

The medication used most often to treat bipolar disorder is lithium. Lithium evens out mood swings in both directions – from mania to depression, and depression to mania – so it is used not just for manic attacks of the illness but also as an ongoing maintenance treatment for bipolar disorder.

Although lithium will reduce severe manic symptoms in about 5 to 14 days, it may be weeks to several months before the condition is fully controlled. Antipsychotic medications are sometimes used in the first several days of treatment to control manic symptoms until the lithium begins to take effect. Antidepressants may also be added to lithium during the depressive phase of bipolar disorder. If given in the absence of lithium or another mood stabilizer, antidepressants may provoke a switch into mania in people with bipolar disorder.

A person may have one episode of bipolar disorder and never have another, or be free of illness for several years. But for those who have more than one manic episode, prescribers usually give serious consideration to maintenance (continuing) treatment with lithium.

### ***Anticonvulsants as an Alternative to Lithium***

Some people with symptoms of mania who do not benefit from lithium have been found to respond to anticonvulsant medications commonly prescribed to treat seizures.

Valproic acid, or divalproex sodium (Depakote), is the main alternative therapy for bipolar disorder. It is as effective in non-rapid-cycling bipolar disorder as lithium and appears to be superior to lithium in rapid-cycling bipolar disorder. Because in some cases valproic acid has caused liver dysfunction, liver function tests should be performed before therapy and at frequent intervals thereafter, particularly during the first six months of therapy. Other anticonvulsants used for the treatment of bipolar disorder include carbamazepine (Tegretol), lamotrigine (Lamictal), gabapentin (Neurontin), and topiramate (Topamax).

### ***Antidepressant Medications***

Antidepressant medications are used to treat the symptoms of major depression. Major depression is a condition that lasts two weeks or more, and interferes with a person’s ability to carry on daily tasks and enjoy activities that previously brought pleasure. Episodes of depression may be triggered by stress, difficult life events, and side effects of medications,



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medication/substance withdrawal, or even viral infections that can affect the brain. Depressed people will seem sad, or “down,” or may be unable to enjoy their normal activities. They may have no appetite and lose weight. They may sleep too much or too little, have difficulty going to sleep, sleep restlessly, or awaken very early in the morning. They may speak of feeling guilty, worthless, or hopeless; they may lack energy or be jumpy and agitated. They may think about killing themselves and may even make a suicide attempt. Some depressed people have delusions (fixed, false beliefs that have no basis in reality) about poverty, sickness, or sinfulness that is related to their depression. Often feelings of depression are worse at a particular time of day, for instance, every morning or every evening.

Not everyone who is depressed has all these symptoms, but everyone who is depressed has at least some of them, co-existing, on most days. Depression can range in intensity from mild to severe. Depression can co-occur with other medical disorders such as cancer, heart disease, stroke, Parkinson’s disease, Alzheimer’s disease, and diabetes. In such cases, the depression is often overlooked and is not treated. If the depression is recognized and treated, a person’s quality of life can be greatly improved.

### ***Tricyclic Antidepressants***

Developed between 1960 and 1990, this category of antidepressant medications was the first line of treatment for major depression for three decades. Most of these medications affected two chemical neurotransmitters, norepinephrine and serotonin. Though the tricyclics are as effective in treating depression as newer antidepressants, their side effects are usually more unpleasant; thus, today tricyclics such as imipramine (Tofranil), amitriptyline (Elavil), nortriptyline (Pamelor), and desipramine (Norpramin) are used as a second- or third-line treatment.

### ***Monoamine Oxidase Inhibitors (MAOIs)***

Introduced during this same period of time, this category of antidepressant medications can be effective for some people with major depression who do not respond to other antidepressants. They are also effective for the treatment of panic disorder and bipolar depression. MAOIs approved for the treatment of depression are phenelzine (Nardil), tranlycypromine (Parnate), and isocarboxazid (Marplan). Because substances in certain foods, beverages, and medications can cause dangerous interactions when combined with MAOIs, people on these agents must adhere to dietary restrictions. This has deterred many clinicians and patients from using these effective medications, which are, in fact, quite safe when used as directed.

### ***Selective Serotonin Reuptake Inhibitors (SSRIs)***

Medication in this third category of antidepressants, introduced in the late 1980s, works as well as the older ones but has fewer side effects. Some of these medications primarily affect one neurotransmitter, serotonin. These include fluoxetine (Prozac), sertraline (Zoloft), escitalopram (Lexapro), fluvoxamine (Luvox), paroxetine (Paxil), and citalopram (Celexa).

## Chapter 4. Mental Health Medications

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### *Other Newer Antidepressants*

The late 1990s ushered in new medications that, like the tricyclics, affect both norepinephrine and serotonin but have fewer side effects. These new medications include venlafaxine (Effexor), nefazadone (Serzone), and duloxetine (Cymbalta). Other newer medications chemically unrelated to other antidepressants are the sedating mirtazepine (Remeron) and the more activating bupropion (Wellbutrin). Wellbutrin has not been associated with weight gain or sexual dysfunction, but is not used for people with, or at-risk for, a seizure disorder.

### *Antianxiety Medications*

Everyone experiences anxiety at one time or another. “Butterflies in the stomach” before giving a speech or sweaty palms during a job interview are common symptoms of anxiety. Other symptoms include irritability, uneasiness, jumpiness, feelings of apprehension, rapid or irregular heartbeat, stomach ache, nausea, faintness, and breathing problems. Anxiety is often manageable and mild, but sometimes it can present serious problems. A high level or prolonged state of anxiety can make the activities of daily life difficult or impossible. People may have generalized anxiety disorder (GAD) or more specific anxiety disorders such as panic, phobias, obsessive-compulsive disorder (OCD), or post-traumatic stress disorder (PTSD).

Both antidepressants and antianxiety medications are used to treat anxiety disorders. The broad-spectrum activity of most antidepressants provides effectiveness in anxiety disorders as well as depression. The first medication specifically approved for use in the treatment of OCD was the tricyclic antidepressant clomipramine (Anafranil). The SSRIs – fluoxetine (Prozac), fluvoxamine (Luvox), paroxetine (Paxil), and sertraline (Zoloft) – have now been approved for use with OCD. Paroxetine has also been approved for social anxiety disorder (social phobia), GAD, and panic disorder; and sertraline is approved for panic disorder and PTSD. Venlafaxine (Effexor) has been approved for GAD.

Antianxiety medications include the benzodiazepines, which can relieve symptoms within a short period of time. They have relatively few side effects with drowsiness and loss of coordination being the most common. Fatigue and mental slowing or confusion can also occur. These effects make it dangerous for people taking benzodiazepines to drive or operate some machinery.

Benzodiazepines vary in duration of action in different people; they may be taken two or three times a day, sometimes only once a day, or just on an “as-needed” basis. Dosage is generally started at a low level and gradually raised until symptoms are diminished or eliminated. The dosage will vary a great deal depending on the symptoms and the individual’s body chemistry.

It is wise to abstain from alcohol when taking benzodiazepines because the interaction between benzodiazepines and alcohol can lead to serious and possibly life-threatening complications. It is also important to tell the doctor about other medications being taken.

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People taking benzodiazepines for weeks or months may develop tolerance for and dependence on these drugs. Abuse and withdrawal reactions are also possible. For these reasons, the medications are generally prescribed for brief periods of time – days or weeks – and sometimes just for stressful situations or anxiety attacks.

## Common Questions Asked About Medications

The following questions are among those most commonly asked about medications used in the treatment of mental illness. The “Rules of Thumb” provided below are intentionally broad in their response and are not a substitute for direct conversation between your loved one and the professional prescribing their medication.

### Why are medications used in treating mental illness?

#### **Rule of Thumb #1:**

Psychotherapeutic medications do not cure mental illness, but rather are used to treat the symptoms of mental illness. Significant factors which prevent someone from successfully engaging in mental health treatment are the symptoms of the mental illness itself. By decreasing or eliminating those symptoms, psychotherapeutic medications may make other kinds of treatment more effective.

*For example: Antipsychotic medications can turn off the “voices” heard by some people with psychosis and help them to see reality more clearly. Antidepressants can lift the dark, heavy moods of depression.*

*Someone who is too depressed to talk may have difficulty communicating during psychotherapy or counseling, but the right medication may reduce the symptoms so the person can respond. For many patients, a combination of psychotherapy and medication can be an effective method of treatment.*

### Are psychotherapeutic medications safe to take with other medications?

#### **Rule of Thumb #2:**

Any medication, including psychotherapeutic medication, may produce unwanted effects when taken in combination with another medication. Therefore, your prescriber(s) should be told about all drugs being taken, including prescription medications; over-the-counter medications; vitamin, mineral, and herbal supplements; and the extent of alcohol and/or “street drug” use.

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*For example: Some antipsychotic medications interfere with antihypertensive medications (taken for high blood pressure) and anticonvulsant medications (taken for epilepsy). Diuretics – substances that remove water from the body – increase the level of the antimanic agent lithium and can cause toxicity. Alcohol (wine, beer and hard liquor) or street drugs can reduce the usefulness of antidepressants. When an SSRI antidepressant is combined with other medications that affect serotonin, a potentially serious or fatal medical condition known “serotonin syndrome” may result.*

### **How long will it take for the medication to work?**

#### **Rule of Thumb #3:**

Many psychotherapeutic medications work quickly, while others, particularly antidepressants, must be taken regularly at adequate doses for at least 6 to 8 weeks before the full therapeutic effect occurs.

*For example: If there is little or no change in symptoms after 6 to 8 weeks, the prescriber will likely suggest trying a different medication. There is no way of knowing beforehand which specific medication will be most effective. Prescribers make the decision to prescribe medications on the basis of their understanding of the presenting symptoms, their knowledge of current medication trials, and their experience with treating other clients.*

### **If I choose to take medication for my mental illness, will I experience side effects?**

#### **Rule of Thumb #4:**

Most individuals do experience side effects from psychotherapeutic medications; often they are mild and many of the common ones lessen or disappear after the first few weeks of treatment.

*For example: Side effects common to psychotherapeutic medications include drowsiness, nervousness, dizziness and rapid heartbeat. Some people experience a decrease in sexual ability or interest. Some people gain weight while taking medications and need to pay extra attention to diet and exercise to control their weight. Side effects which become intolerable and/or disruptive to normal functioning should be reported to the prescriber as soon as possible.*

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### Can I stop my medication when I start to feel like my old self?

#### Rule of Thumb #5:

The reason you may feel like your old self, or at least are experiencing relief from your symptoms, may be because the medication you are taking is working. **Before making a decision to stop taking medication, talk with the prescriber to get the information needed to make a good decision. If the decision is to discontinue the medication, the prescriber will help discontinue it in the safest manner.**

## Family Supports

Many individuals with mental illness and their families struggle with the questions of when and how to use medication treatment. These questions do not have easy answers. Help in finding information is available in many ways. NAMI NH offers support and education programs which can be accessed on our website at **www.naminh.org** or by calling our Information & Resource Line at 1-(800) 242-6264, Ext. 4. There are many excellent overviews on the subject of medications for the treatment of mental illness. Information on specific medications is also readily available through various online resources. For more information see *Appendix C. Local, State and National Resources, beginning on page 127* and *Appendix E. Suggested Reading, which begins on page 161*.

### Chapter 4 Notes

1. National Institute of Mental Health. *Mental Health Medications*. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, NIH Publication No. 08-3929, 2008.

## Chapter 4. Mental Health Medications

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## Chapter 5. Integrated Health Care

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### Chapter Overview

*In 2006, a major national study found that individuals with serious mental illness suffer higher rates of co-morbid health conditions and die on average of 25 years before their peers in the general population. Despite these alarming statistics, nearly all the co-morbid health conditions identified in the study are treatable and the risk factors for them are modifiable. All*

*that is required is that individuals with serious mental illness have access to primary healthcare and that their care is well-coordinated with their mental healthcare providers.*

*In this chapter we will learn about the need for integrated healthcare and how we as family members can assist our loved ones with accessing, or if necessary, creating such care.*

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### The Inseparability of Mind and Body

Our minds and bodies are always together in our lives, except when we enter the healthcare system. There they are often separated, and totally distinct specialties take over.

**Cynthia Watson, MD <sup>1</sup>**

The connection between mind and body is one even a child understands. All of us experience at some point in our lives the effects of our mind over our body. Think of the “butterflies” you feel in your stomach when nervous, the “stress headache,” going out for a walk or a run “to clear your head.” In today’s world, you cannot turn on the television, surf the internet, read a magazine or a newspaper without learning about how caring for your whole self – body and mind – is essential to overall health. Yet, our healthcare system is designed with separate tracks for treating mental and physical health. This design flaw is proving to have very serious repercussions – especially for those living with serious mental illnesses.

In October 2006 the National Association of State Mental Health Program Directors issued its landmark report: *Morbidity and Mortality in People with Serious Mental Illness*.<sup>2</sup> The report found that rates of overall health problems (morbidity) and premature death (mortality) among individuals with serious mental illnesses are not only alarmingly high in comparison to those in the general population, but that these rates are increasing.

**Of primary concern were the findings that, on average, individuals with serious mental illness die 25 years earlier than the general population:**

- While suicide and injury account for about 30-40% of this excess mortality, 60% of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular disease, hypertension, diabetes (including related conditions such as kidney failure), respiratory disease (including pneumonia and influenza), and infectious diseases (including HIV/AIDS).
- More broadly, schizophrenia, bipolar disorder, and major depressive disorder have all been associated with medical causes of death at rates 2 to 3 times higher than in the general population.
- Increased morbidity and mortality are largely due to preventable and treatable medical conditions that are caused by modifiable risk factors such as smoking, poor nutrition, lack of exercise, excessive weight gain, substance abuse, “unsafe” sexual behavior, and inadequate access to medical care.
- Symptoms associated with serious mental illnesses also complicate the treatment of physical illnesses: paranoid thoughts can cause fear of seeking medical treatment; impaired communication skills make it difficult to effectively tell medical professionals what is wrong; decreased motivation and learned helplessness leads to disinterest and unwillingness; and disorganized thinking makes independently following medical advice more difficult.

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- The newer “atypical” or “second generation” antipsychotic medications which held out the promise of fewer and milder side effects when first introduced are highly associated with weight gain, diabetes, increased cholesterol and triglyceride levels, insulin resistance, and metabolic syndrome.

While the findings in the Morbidity and Mortality Report are disturbing, they should also be somewhat reassuring: every condition is treatable and every risk factor modifiable. The real question raised is why do people with mental illness not receive the primary healthcare necessary to treat these conditions? **Nearly every major policy statement on mental health in the last decade has begun with the tenet that mental health is central to overall health.**

**U. S. Surgeon General’s Report on Mental Health in 1999:**

Considering health and illness as points along a continuum helps one appreciate that neither state exists in pure isolation from the other. In another but related context, everyday language tends to encourage a misperception that ‘mental health’ or ‘mental illness’ is unrelated to ‘physical health’ or ‘physical illness.’ In fact, the two are inseparable.<sup>2</sup>

**President’s New Freedom Commission on Mental Health in 2003:**

Research demonstrates that mental health is key to overall physical health. Therefore, improving services for individuals with mental illnesses requires paying close attention to how mental healthcare and general medical care interact. While mental health and physical health are clearly connected, a chasm exists between the mental healthcare and general healthcare systems in financing and practice.<sup>3</sup>

**New Hampshire Commission to Develop a Comprehensive State Mental Health Plan in 2008:**

American medicine has historically separated the treatment of minds and bodies, and some medical care providers are uncomfortable and under prepared when confronted with emotional problems in their patients. The training of healthcare providers is changing. Annual physicals by primary care physicians now usually include assessments of stress, substance use and depression. But there is still significant work to be done in improving public recognition that good mental health is fundamental to overall health.<sup>4</sup>

Despite over ten years of recognition of the need for integrated mental and physical healthcare; as a society, we have made very little progress toward attaining this goal. Very recently, however, some change has begun to occur within the medical field and in public health policy.

### What is Integrated Healthcare?

While each of the reports cited above have their own unique perspectives, they all share a similar vision of what the healthcare system should look like. First, it should be a system of healthcare in which both mental and physical illnesses are treated with the same dignity, urgency, and quality of care. A system in which both physical and mental healthcare are easily accessible to anyone who needs them.

It is also a place where the physical and mental healthcare providers have been cross-trained in the fundamentals of quality healthcare and the impact of that care upon human behavior and emotion. It is an environment in which all professionals involved with the patient take the time to communicate and collaborate with each other. Then coordinate their care with those responsible to support and manage that care in the community. It is, in short, a system of care which places the person at the very center of the process and embraces the principles of recovery and personal wellness.

### Building a Personal Integrated Healthcare Model

There are many things that can be done now to build individual and personal integrated healthcare models. They begin with embracing two guiding principles:

#### **1. *Overall Health is Essential to Achieving and Maintaining Mental Health***

Engaging in the treatment of serious mental illness is hard and demanding work; for such treatment to succeed requires a physically healthy and involved consumer. It is the responsibility of our loved one and his or her treatment providers to ensure they are monitoring and addressing those physical health issues that siphon off the time, energy, and personal resources necessary for a successful recovery journey.

Colds, influenza, exhaustion and other reasons keep people home instead of going to work, and they will also keep individuals with a mental illness home instead of engaging in treatment. To successfully recover and maintain one's mental health, one must begin by taking care of the body.

Individuals who do decide to take their physical health seriously and become more physically active, get more sleep, reduce their use of tobacco and alcohol, and begin to lose weight frequently experience a renewal of self-confidence, a better sense of self-worth/self-esteem, and an improvement in their quality of life and emotional well-being. They also report having more friends and engaging in more rewarding social and recreational activities.

One model program found in New Hampshire which has successfully integrated physical fitness and health with the treatment of serious mental illness is "In SHAPE Health Promotion Intervention." Originally developed by Monadnock Family Services, the community mental health center serving Keene and its surrounding communities, In SHAPE is a wellness program that aims to improve physical health and quality of life, and reduce the risk of preventable diseases in individuals with severe mental illnesses.

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Participants in the program are assigned a health mentor who assesses individual lifestyle habits and health status, works with the individual to identify personal goals for lifestyle change, and serves as a motivator and physical trainer. The In SHAPE program also includes a fitness plan consisting of individualized fitness goals and diet and exercise objectives, membership in a local fitness program, rewards for engagement in physical activity, and group health education and motivational events.

In its pilot, In SHAPE participants showed significant improvement in their overall health, as well as startling improvement in their mental health. As a result of this success, In SHAPE is being implemented in several other community mental health centers in New Hampshire, Maine and Massachusetts. To learn more about the In SHAPE program, see *Appendix C. State and National Resources*, page 143 for contact information of the NH Department Health and Human Services Bureau of Behavioral Health.

## **2. Overall Health is Key to a Life of Recovery and Personal Wellness**

Making healthy choices and lifestyle changes that promote personal recovery and wellness is essential to overall health. While the Morbidity and Mortality report identified multiple strategies to address this problem, most of those strategies involved formal partnerships within the general healthcare system. The authors of the report had the insight, however, to state that “for any of these strategies to be successful, our principle partnership must be with the people we serve.”

Ways must be found to help people with serious mental illness become empowered to take personal responsibility for the lifestyle changes and health choices that will or will not promote their personal recovery and wellness. Individuals in recovery must be provided with information and support to make the health choices and life style changes that can prevent co-morbid conditions and reduce the risk of early death.

The Morbidity and Mortality report contains specific recommendations on what individuals with serious mental illness, their families and providers can do now to advance person-centered integrated healthcare.

- We can share information so the mental health and primary care communities are more aware of co-morbid physical health risks and integrated care approaches.
- We can encourage integrated physical and behavioral healthcare as a high priority for individuals with mental illness, similar to employment, housing and avoiding criminal justice system involvement.
- We can champion those provider agencies and clinicians who meaningfully support personal empowerment and individual responsibility.
- We can champion those provider agencies and clinicians who truly improve comprehensive healthcare evaluations.
- We can champion those provider agencies that assure that there is a specific practitioner in their system of care who is responsible for addressing and coordinating each person’s physical healthcare needs.

### Practical Steps You and Your Loved One Can Take

#### 1. **Primary Care Provider**

Find a primary care provider (PCP) who will establish a medical baseline and will use this to monitor the health status of your family member as he or she engages in mental health treatment. A PCP who is well-informed about mental illness and is willing to collaborate and coordinate care with mental health providers.

#### 2. **Physical Examination**

It is common medical practice to have a thorough physical examination at the start of most mental health treatment to rule out possible medical problems that may be presenting as psychiatric symptoms. This examination should be used as an opportunity to obtain baseline data on weight, body/mass index, blood pressure, cholesterol and triglyceride levels, blood sugar levels, and other key health indicators. Annual physical examinations are important especially for those who are taking psychiatric medications.

#### 3. **Medication Record**

Assist your family member in keeping an accurate record of all the prescribed medications he or she may be taking including over-the-counter drugs, and vitamin, mineral, and herbal supplements. It is important for your relative to include his or her use of alcohol and/or other substances. Make sure each of the medication prescribers, including his or her dentist, has a copy of this record. See *Appendix D. Forms You Might Find Useful*, page 157, for a sample of a Medication Log.

#### 4. **Releases of Information**

Make sure releases of information are in place with both your loved one's primary care provider and psychiatrist that will allow them to communicate and coordinate care with each other. It is important for your loved one to share with providers his or her wish that providers share relevant information.

#### 5. **Share Information**

Make sure the primary care provider has a copy of your relative's most recent psychiatric assessment and lab results; and that his or her psychiatrist has a copy of his or her most recent physical examination and other related information.

#### 6. **Preventative Care**

Make sure your loved one is scheduling and having annual physical examinations and routine preventative care. Support and encourage your family member in seeing his or her primary care provider when they are not physically feeling well.

#### 7. **Health and Wellness Goals within the Mental Health Treatment Plan**

Encourage your relative and his or her providers to include health and wellness goals in his or her mental health treatment plan. Increased physical exercise, nutritious eating, weight control, not smoking, and good sleep habits are all important goals – not only for one's physical health but also for one's mental health. They are, in fact, just as important as stable housing, finding a job, or going back to school. There are many resources available on understanding and promoting health and wellness. One excellent program, *Hearts and Minds*, is available through NAMI. For more information, see *Appendix C. Local, State and National Resources*, page 152.

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## 8. *Share the Work*

One of the key findings in the In SHAPE Program is the fact that individuals with serious mental illness, just like most of us, are much more likely to follow through with wellness activities and healthy lifestyle changes when they have a mentor – or buddy. One key way you can help is to either help your loved one find a “wellness buddy” or for you to be that buddy. Exercising, eating right, stopping smoking, etc. are activities that benefit all of us.

Help your family member find others who share his or her goal for personal recovery and wellness. Reaching his or her goals will be easier to tackle with the support of family and friends who believe in them and who want to see them be successful. Sometimes the strength your loved one needs to take the next step will come best from the support and encouragement they give to others.

To learn more about integrated healthcare and related topics, see *Appendix E. Suggested Reading, page 161*.

### Chapter 5 Notes

1. Sabourin, D. and Reynolds, K. *Raising the Bar: Moving Toward the Integration of Healthcare*. Washington, DC: National Council for Community Behavioral Healthcare, 2006.
2. National Association of State Mental Health Program Directors. *Morbidity and Mortality in People with Serious Mental Illness*. Alexandria, VA: National Association of State Mental Health Program Directors, 2006.
3. U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 1999.
4. New Freedom Commission on Mental Health. *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. Rockville, MD: U.S. Department of Health & Human Services, 2003. DHHS Pub. No. SMA-03-3832. 5. Mental Health Commission. *Fulfilling the Promise: Transforming New Hampshire's Mental Health System*. Concord, NH: State of New Hampshire, 2008.





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## Chapter 6. Where to Go for Help

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### Chapter Overview

*Just as when you are seeking treatment for a serious physical illness, finding the right professional or team of professionals to help is essential to the recovery process for a person with serious mental illness. Knowing where to go for such help can be confusing – does your loved one need to see a psychiatrist? A psychologist? A counselor? What’s the difference?*

*In this chapter we will provide family members with an overview of types of providers and facilities available to help your loved one. It is important to remember that not only are you seeking a professional with the appropriate credentials to help your family member, but also one who is a good “fit” – someone your loved one can feel comfortable with and rely upon for support and embraces the Values and Principles of Recovery.*

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“Appointments with my doctor are what I call “mini-seminars”. If I need a change in medications or I have a new symptom or if there has been new research, he is always careful to explain fully. I feel like a valued partner in treating the depression.”

*Patricia, Consumer*

### Types of Mental Health Organizations

New Hampshire’s community-based mental health system is divided into two sectors: private practices and public services such as community mental health centers. The two sectors do intersect, but tend to serve different populations and are financed through two very different funding streams. These differences affect policy and procedural standards for both sectors.

Private practices generally serve individuals whose mental and emotional problems are more temporary in nature and whose difficulties can be adequately addressed in a shorter time period. Accessing most private practices requires the individual have the resources to pay for services or have insurance or some combination of both.

The system of community mental health centers was created to serve individuals whose mental health problems are more persistent in nature, who need a variety of treatments and supports, and who may require significant time to recover and reclaim meaningful and lasting roles in life. This system largely depends upon public funding and health insurance in the form of Medicaid and Medicare.

#### ***Private Practices and Practitioners***

Private practices vary significantly in size and focus. Some mental health professionals prefer to work alone in their own private practice. Others prefer to work with a colleague in a small group practice. Still others prefer to practice with a larger group of colleagues and are sometimes called “counseling centers.”

Private mental health professionals have some basic characteristics in common:

- They are almost always independently licensed or are working under the close supervision of someone who is licensed.
- They all have the training to treat basic mental health difficulties such as depression and anxiety.
- Many have pursued advanced training and have developed specialized skills in such areas as eating disorders, marital problems, family dynamics, anger management, trauma, etc.

As noted above most professionals in private practice are funded primarily through private insurance companies and managed care organizations, and/or their client’s ability to pay for their services out of pocket. Some private professionals choose not to accept direct payments from private insurance and clients must submit their claims themselves in order to be reimbursed by their health insurance carrier.

Most private insurance companies and managed care organizations establish limits on how much money or how many sessions of mental health treatment they will pay for on an annual basis. For this reason, private mental health professionals generally treat individuals

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whose mental health difficulties are less disabling in nature, and more likely to respond to time limited or solution-focused treatment approaches.

When private mental health professionals realize that an individual under their care requires longer term treatment and/or specialized forms of community support, they will often refer that client to the local community mental health center. Sometimes, the community mental health center will assess an individual who has a need that lies outside their scope of expertise such as an eating disorder or a substance use problem and will refer that client, or that part of the client's treatment, to a private practitioner who has the required expertise.

Some community mental health centers have staff in specific departments that operate much like the private practices described above. The centers offer such services both to help them fulfill their mission to serve the mental health needs of the community, as well as to help reduce their reliance upon state and federal funding dollars.

### ***Community Mental Health Centers (CMHCs)***

Unlike private practices, community mental health centers are structured and funded to provide a comprehensive array of short and long-term treatment and community support services to those individuals who meet the state's eligibility criteria for being a child with a serious emotional disorder or an adult with a serious and persistent mental illness. See *Chapter 8, Paying for Services, page 77*, for more on the state's eligibility criteria.

New Hampshire is divided into ten mental health regions or catchment areas. Within each region, the NH Department of Health and Human Services designates and contracts with one agency to be that region's Community Mental Health Center. Each CMHC offers a comprehensive range of office and community-based services, employs a variety of mental health professionals and paraprofessionals, and devotes considerable resources for the treatment of the long-term mental health needs of some of New Hampshire's most vulnerable citizens.

Because the CMHCs are designated by, and contract with, the NH Department of Health and Human Services through its Bureau of Behavioral Health, they are similar in mission, governance, and organizational structure. Each CMHC is required to adhere to the same state and federal regulations as well as health insurance industry standards.

Each CMHC:

- Is governed by a locally controlled Board of Directors;
- Employs a board certified or board eligible Medical Director;
- Offers a comprehensive array of mental health services to children, adolescents, adults and older adults; and
- Provides 24-hour emergency services

In providing services to adults with severe and persistent mental illness, each Center uses the same eligibility determination standards for state-supported services and offers:

- Psychiatric evaluation and medication management;
- Targeted case management;
- Individual and group therapy and education;
- Community-based outreach, support, and skill teaching
- Education and employment;
- Housing assistance; and
- Family support and education.

## Chapter 6. Where to Go for Help

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The ten CMHCs are not, however, identical in scope and service. Each CMHC is a private, not-for-profit agency, with its own distinct name, and its own particular strengths and challenges. The individuality of each center reflects the unique characteristics of the communities they serve. At the time this guidebook is being published, the most decentralized center is found in the largest and most rural of the ten regions. The most culturally diverse and multi-lingual of the ten centers is found in the region which has experienced the largest growth in minority populations. The center with the greatest access to psychiatry is the center that serves the region where Dartmouth Medical School is located. The center with the most comprehensive array of services and, thus, the largest annual budget of the ten centers exists in the region with the largest urban population. See *Appendix C. Local, State and National Resources, page 134*, for a listing of CMHCs and their contact information.

### ***Psychiatric Hospitals and Inpatient Units***

The Community Mental Health Centers Construction Act of 1964 had two main initiatives: to close down the nations overcrowded psychiatric hospitals and to create a community-based mental health system that would significantly reduce, if not eliminate, the need for inpatient hospitalization. Over the past five decades, New Hampshire has been working toward that vision: the state's public psychiatric hospital which once housed close to 2,700 patients is now a 160 adult bed acute care facility and the public mental health system rests on the shoulders of the ten CMHCs which serve over 40,000 individuals a year.

Despite the advances in the treatment of mental illness, the need for 24-hour-a-day acute psychiatric care and supervision has not been fully eliminated. Individuals who experience first-time mental health crises, individuals who have not yet fully engaged in treatment, and even individuals who have made real progress in their recovery process still, on occasion, require the attention, safety, and supervision of acute short-term psychiatric inpatient stays.

In New Hampshire today there are four main types of psychiatric inpatient facilities:

- A publicly funded state hospital;
- A privately funded free standing psychiatric hospital;
- Six psychiatric inpatient units attached to full service general hospitals; and
- One Acute Psychiatric Residential Treatment Facility (APRTF) attached to a CMHC.

### ***New Hampshire Hospital (NHH)***

New Hampshire Hospital, located in Concord, is the state's publicly funded psychiatric hospital providing inpatient services for children and adolescents with serious emotional disorders in the Anna Philbrook Unit and units for adults and older adults with severe mental illnesses. Organized under the NH Department of Health and Human Services, NHH works closely with the community mental health center system and plays an important role in the state's wide range of mental healthcare. Most people are admitted to NHH on what is called an Involuntary Emergency Admission (IEA) because they have been found to be dangerous to themselves or others. An IEA is done through a CMHC where the individual has been psychiatrically assessed and medically screened. A smaller number of individuals are admitted voluntarily or voluntarily by guardian. See *Chapter 11. Legal Terms, Considerations and Procedures, page 115* for more information on the IEA process.

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NHH provides a wide range of psychiatric services utilizing an Interdisciplinary Treatment Plan Model. A team of mental health professionals is assigned to each patient admitted. The team works with the patient, members of the patient's family, and the community treatment team to develop a treatment plan for that individual. In collaboration with the patient's CMHC, a comprehensive, individualized discharge plan is developed for each patient. Of the 2,400 inpatient admissions per year, half of those patients are discharged within eight days. Nearly 800 people staff New Hampshire Hospital and a full staff of Board Certified Psychiatrists work onsite through a contractual agreement with the Department of Psychiatry at Dartmouth Medical School. At the time of this publication an individual in need of "admission to NHH may have a wait from hours to days and sometimes a week. Advocates continue to demand adequate access to services and implementation of the NH 10 Year Plan

### ***Private Hospitals and Inpatient Units***

In New Hampshire, there is one free-standing private psychiatric hospital – Hampstead Hospital ([www.hampsteadhospital.com](http://www.hampsteadhospital.com)) – and six private psychiatric inpatient units: Cheshire Medical Center in Keene ([www.cheshire-med.com](http://www.cheshire-med.com)), Concord Hospital ([www.concordhospital.org](http://www.concordhospital.org)), Dartmouth Hitchcock Medical Center in Lebanon ([www.dhmc.org](http://www.dhmc.org)), Elliot Hospital in Manchester ([www.elliethospital.org](http://www.elliethospital.org)), Portsmouth Regional Hospital ([www.portsmouthhospital.com](http://www.portsmouthhospital.com)), and Southern New Hampshire Medical Center in Nashua ([www.snhmc.org](http://www.snhmc.org)).

There are two specialized inpatient units devoted to the treatment of older adults, one at Frisbie Memorial Hospital in Rochester ([www.frisbiehospital.com](http://www.frisbiehospital.com)) and one at St. Joseph Hospital in Nashua ([www.stjosephhospital.com](http://www.stjosephhospital.com)).

The main difference between these facilities and NHH is that private psychiatric facilities do not accept involuntary emergency admissions. They focus on short-term treatment of individuals who are experiencing acute psychiatric distress and know they are able to provide them the level of care needed to return to their pre-crisis level of functioning. They also require that the individual have a residence to return to upon discharge. Admission to these facilities often requires prior approval from the individual's insurance company. Similar to the management of the private practices, these facilities work closely with the leading private insurance companies and managed care organizations. These facilities accept Medicare and Medicaid with the exception of Hampstead Hospital that accepts Medicare but does not accept NH Medicaid.

### ***Acute Psychiatric Residential Treatment Facility***

The Cypress Center is a 16-bed licensed Acute Psychiatric Residential Treatment Facility and Designated Receiving Facility which serves individuals in need of intensive 24-hour psychiatric supervision and support. Individuals age 18 and over may be admitted to this service. Unlike the private psychiatric in-patient units described above, this facility is owned and operated by the Mental Health Center of Greater Manchester ([www.mhcgmm.org](http://www.mhcgmm.org)) and does have the capacity to accept Involuntary Emergency Admissions.

The Cypress Center is staffed by psychiatrists, nurse practitioners, nurses, and mental health counselors who provide short-term, intensive crisis stabilization activities aimed at reducing acute mental and emotional disturbances. The length of stay in the Cypress Center is determined by several factors, and is assessed on an individual basis by the medical staff.

### *Designated Receiving Facility*

A Designated Receiving Facility is defined in the *Addressing the Critical Mental Health Needs of NH's Citizens: A Strategy for Restoration (2008)* as a hospital-based psychiatric inpatient unit or a non-hospital-based residential treatment program designated by the Commissioner of Department of Health and Human Services to provide care, custody, and treatment to persons involuntarily admitted to the state mental health services system. DRFs in local facilities allow people who are in need of emergent psychiatric inpatient care to be treated in their region, which reduces transportation costs and reduces length of stay because discharge planning and coordination are easier to accomplish locally. Currently there are two DRFs available to persons with mental illness who have either private insurance, Medicaid and/or Medicare. At the time of this publication the state has plans to expand the availability of beds.

## Types of Mental Health Practitioners

Mental health treatment can be provided by a variety of professional practitioners. Knowing “who is who” and “who does what” can be confusing. Because someone calls themselves a therapist, or a counselor, or a social worker does not mean they have the training or the experience that you would assume from these titles. It is important to know and understand what the initials that follow a practitioner’s name represent regarding their training, certification, and/or licensure.

Before deciding to use the services of any practitioner, an individual seeking treatment should consider:

- What license, education and training does the practitioner have?
- Do you have a reference from a person or agency you trust?
- What kind of specialty, doctor or therapist is needed?
- What type of person would you be comfortable with?
- What kind of philosophy do you want the practitioner to have?
- How do you want the practitioner to involve your family?

The first psychiatrist our daughter saw diagnosed her appropriately, gave her medication that helped her symptoms, and made sure she was connected with a case manager and other services at the mental health center. My husband and I actually thought the psychiatrist was almost too laid back – not assertive enough with our daughter. And she hated him.

Luckily for us, he was older and retired about a year after she started seeing him. The new psychiatrist to whose care she was transferred was much more assertive and confrontational with our daughter. We walked out of our first family meeting with him and I thought, “Uh oh, here it comes. If she didn’t like the other doctor, she’s going to really hate this guy.” But she loved him and still does.

*(Continued)*



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I realize now that the first doctor wasn't the right one for our daughter – he was a perfectly fine doctor, but not the right fit. I've learned that if a provider isn't a good fit, the treatment just won't work as well and it is okay to speak up and say so.

*Family-to-Family Participant*

### ***Psychiatrist (MD)***

Psychiatrists are medical doctors who after completing medical school, receive an additional four years of clinical training in mental health specialties. Psychiatrists treat emotional and mental health disorders and are licensed to prescribe medication.

In addition to psychopharmacologic treatment, these professionals *may* treat their patients with therapy and psycho-educational guidance. Psychiatrists who have successfully completed an approved training program and an evaluation process assessing their ability to provide quality patient care in a specialty and/or subspecialty are Board Certified by the American Board of Psychiatry and Neurology. Psychiatrists who have completed the training program but not the evaluation process are Board Eligible.

### ***Nurse Practitioner (NP) or Advanced Practice Registered Nurse (APRN)***

Nurse Practitioners are registered nurses who have completed specific advanced nursing education; been trained in the diagnosis and management of common, as well as complex, medical conditions; are authorized to function independently; and are allowed to prescribe medications from a well-defined formulary.

NPs and APRNs may perform physical examinations and diagnostic tests, develop and carry out treatment programs, and provide therapy. Over the past several years, NPs and APRNs have become more common in the field and perform a major role in both the public and private mental health system.

### ***Psychologist (PhD/PsyD)***

Doctors of Psychology have either earned their PhD in psychology or their PsyD in clinical psychology. Both degrees are recognized by the American Psychological Association and, following completion of postdoctoral clinical training, these professionals are eligible for licensure as psychologists.

The major difference between the two degrees is a matter of training and emphasis. PhD programs place a stronger emphasis on research while PsyD programs place a stronger emphasis on clinical practice. While this difference exists, the licensing exam requirements are the same for both degrees and such individuals often do very similar work.

In addition to skills in assessment; diagnosis and treatment; psychologists are trained in the administration of psychological evaluations as well as intelligence, aptitude and achievement tests.



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### ***Clinical Social Worker (MSW/LICSW)***

Clinical Social Workers have earned their master's degree in social work (MSW). They may have also been licensed to practice independently (LICSW). Those who have received their MSW but are not licensed must receive weekly professional supervision from an LICSW. Clinical Social Workers provide individual, marital, couple's, family and group counseling and psychotherapy from a social work orientation. They are qualified to assess, evaluate, diagnose and treat a broad range of mental health conditions.

Clinical Social Workers can be found working throughout New Hampshire's private and public mental health system fulfilling a wide range of responsibilities and positions from administration, program direction, and clinical supervision, to the provision of direct care.

As used above, the term "social worker" is reserved for someone who has met strict standards, completed rigorous internship expectations, and passed licensing requirements. The term also has a more generic use to describe anyone working in the field of human or social services. When seeking mental health services from a social worker, you should ask for verification of their credentials to determine they have their MSW and/or LICSW.

### ***Clinical Mental Health Counselor (CMHC/LCMHC)***

Clinical Mental Health Counselors have earned their master's degree in clinical mental health counseling (CMHC). They may have also been licensed to practice independently (LCMHC). Those who have their CMHC but are not licensed must receive weekly professional supervision by a licensed clinician. Both CMHCs and LCMHCs are qualified to assess, evaluate, diagnose and treat a broad range of mental health conditions. They can provide individual, marital, couple's, family and group counseling.

Clinical Mental Health Counselors are relatively new to the field of professional mental health practitioners, but because their training is specific to mental health there are often more available for providing direct mental health services than their more diversified MSW peers.

### ***Licensed Alcohol and Drug Counselor (LADC/MLADC)***

Both LADCs and MLADCs provide combined alcohol and/or drug abuse counseling, counseling to families with substance abusing members, and counseling to children of alcoholics. An MLADC has earned their master's degree in a clinical mental health, clinical psychology, substance abuse treatment, social work, or human services discipline and is, therefore, not required to undergo as many hours of supervised alcohol and drug abuse work as a LADC (2,000 hours vs. 6,000 hours) in order to qualify for licensure.

The scope of practice for a LADC/MLADC includes the screening, assessment, diagnosis, treatment planning, and treatment of substance use disorders and the screening and referral of mental health disorders. The scope does not include the treatment of co-occurring mental health and substance use disorders, unless the LADC/MLADC is in an academic internship as part of a master's program in a mental health field or employed as a LADC/MLADC and working toward mental health licensure.

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### ***Dual Licensed Clinicians (LICSW/LADC or LCMHC/LADC)***

These clinicians are licensed as social workers or mental health counselors and licensed alcohol and drug counselors. Such clinicians have received the training, supervision and field training to treat the individual with co-occurring mental and substance use disorders. In New Hampshire, we are seeing a growing number of Dual Licensed Clinicians working in the field and research has shown this is an effective way to treat those who are struggling with co-occurring disorders. For a description of co-occurring disorders see *Chapter 3. Serious Mental Illness: A Closer Look*, page 31.

### ***Psychiatric Nurse (RNC or RN-BC)***

Psychiatric Nurses are registered nurses who have been board certified by the American Nurses Association's Credentialing Center as having expertise in psychiatric and mental health nursing practice. They have demonstrated an understanding of personality development theories, the behavior patterns involved in the treatment and case management of mental illness, and the expected effects of treatment on client behavior.

Psychiatric nurses provide numerous services in our community mental system including medication reviews, case management and psychiatric outreach; mental health education; program direction; and supervision.

### ***Other Licensed Practitioners***

Scattered throughout the mental health system are other licensed professionals who provide services in private practices and community mental health centers. While they are not yet in abundance, it is important to acknowledge their presence and contribution: Physician Assistants (PA), Licensed Marriage and Family Therapist (LMFT), and Licensed Pastoral Counselors (DMin).

### ***Case Managers, Benefit Specialists, Functional Support Workers, Vocational Specialist, Residential Counselors***

The work of providing support services in the community is done by a variety of paraprofessional and professional level practitioners. In many ways, these individuals are the very backbone of the Community Mental Health Centers for their primary work is performed in the places where their clients live, work, learn and socialize. The people who staff these positions have their Bachelor's degree in social work, rehabilitation, psychology, education, or a related human services field. They have received specialized training in the provision of evidenced-based practices, and receive regular supervision from senior staff members. Given the size of today's caseloads, psychiatrists and therapists rely heavily on these practitioners as their primary link to their clients between appointments.

## **Cultural Differences Bring Additional Challenges**

Families who are immigrants, members of racial or cultural minority groups, or whose lifestyles are different from most other families in their community, may face additional challenges when learning their loved one has a serious mental illness. Different cultural

## Chapter 6. Where to Go for Help

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groups have varying attitudes toward mental illness, the practice of medicine, and the sharing of private information with providers in order to receive care and support. Mental health professionals should acknowledge how cultural and language differences will impact your seeking support for yourself or loved one. Training for mental health professionals has begun to include awareness of the impact of a family's religious, language, ethnic, economic, gender, and sexual orientation. However, just because a professional or agency states they provide culturally-sensitive care does not guarantee that they do so. Many providers may, for example, offer language interpretation; yet this does not mean they have a true understanding of cultures different from their own and the impact of mental illness in other cultures.

Ideally, the mental health professional you and your loved one consults for care should demonstrate cultural sensitivity and competence by:

- Understanding the particular psychosocial stressors and traumas relevant for individuals from different populations including: war, trauma, violence, migration, socioeconomic status, political unrest, racism, discrimination, and culturally-based belief systems;
- Comprehending different thresholds of psychiatric distress in individuals from different cultures and tolerance of symptoms by their natural support systems;
- Understanding issues of stigma in cultural groups and their subgroups;
- Knowing the differences in the acceptability and effectiveness of various treatment modalities for individuals from various cultures;
- Recognizing natural community supports and other community resources for individuals within their own cultural group;
- Providing psycho-educational interventions which promote consumer and family voice and ownership in shaping the service delivery;
- Empowering and advocating for consumers, families and communities;
- Using consumers' preferred language and dialect to elicit the range and nuances of emotions, feelings and dynamics;
- Referring to providers who use the consumer's preferred language or dialect;
- Knowing when and how to use trained interpreters; and
- When indicated, appropriately addressing racial/ethnic issues in treatment.

It is important that the mental health professional helping your family and your loved one is a "good fit". Most providers want to know from you and your loved one how best to help. If they are not addressing the cultural, religious or language differences in your family, mention the differences to them and ask them to be sensitive to these differences, or to refer you to someone who can provide culturally-sensitive care. Such a request should be sufficient, but if it is not, contact the State of New Hampshire Office of Minority Health and Refugee Affairs, the New Hampshire Minority Health Coalition and NH Health and Equity Partnership listed in *Appendix C. Local, State and National Resources, page 136*.

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## Chapter 7. Navigating the Treatment System

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### Chapter Overview

*A serious mental illness affects many aspects of an individual's life – their mental and physical health, ability to relate to others, employment status, and housing stability. In order to address these various needs your loved one may require a wide range of services and supports.*

*In this chapter, we have provided an overview of the treatment process, community mental health system and*

*existing services in New Hampshire. It is important to remember that, even in the best of times, the demand for services is greater than the current capacity of the system. It is essential for you to know how the system works and what is available. It is critical to work with your loved one and their mental health providers to help ensure they receive, in a timely way, the services and supports they need.*

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Managing a mental illness is not a life; it's what you do so that you can have a life.  
*Unknown Author*

The Treatment Process

In New Hampshire’s Community Mental Health System, the treatment model used to care for individuals with serious mental illness combines clinical treatment (such as the use of psychotherapeutic medication and individual psychotherapy) with supportive community services (such as targeted case management, functional supports, psychoeducational programs, and Supported Employment). Such a model is usually referred to as “psychosocial” or “psychiatric rehabilitation.” It is important for us as family members to understand this process so we can be productive members of our loved one’s treatment team.

Assessment

Regardless of the fact that the problems and symptoms may seem self-evident, the first steps are clinical assessment and diagnosis. Diagnosis is very important, not only because it is used to help establish eligibility for state-supported services, but because it determines both the types of treatments and services that will be used. See *Chapter 8. Paying for Services, page 77* for more information on eligibility requirements.

Planning

A treatment plan (usually called an Individual Service Plan or ISP) is developed on the basis of the information obtained from the assessment. The primary purpose of the ISP is to serve as the link between the person’s only strengths, challenges, and functional impairments resulting from their mental illness; the treatment and recovery-oriented measurable goals and objectives; and the services to be provided. The ISP should be a “person-centered plan” written in a style that uses the individual’s own words and a language that the individual and other non-professionals understand. The individual must be given a copy of the ISP.

Treatment

Clinical interventions and community support services are delivered in accordance with the ISP. In many ways, the ISP is simply a prescription for services. It specifies goal and objective(s) and the interventions and services that will be provided, how long they will be provided, who will be responsible for delivering them, where they will be delivered, and how frequently they will be provided.

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## Re-evaluation

Re-evaluation or review of the ISP occurs every ninety days after treatment has begun or as needed in response to an emergency or a major change in the person's life. The purpose of these reviews is to:

- Monitor the progress made towards the achievement of the defined goals and objectives;
- Decide whether the treatments and services are helping;
- Determine whether to continue with the established course or to make modifications if appropriate;
- Discontinue services when goals are achieved; and
- Add goals, objectives and services to address new needs.

## Types of Community Mental Health Services

What follows is a brief description of the core services delivered by New Hampshire's Community Mental Health Centers (CMHCs). Some of these services are available to the general public, while others are reserved for those individuals who meet the eligibility criteria as an adult with a serious mental illness. For an explanation of the eligibility criteria, see *Chapter 8. Paying for Services*. All but one of these services (housing) are described in detail in New Hampshire's Code of Administrative Rules: He-M 426 Community Mental Health Services. For access to the current rules call (603) 271-5000 or visit <http://www.dhhs.state.nh.us/DHHS/BBH/LAWS-RULES-POLICIES/default.htm>.

### Targeted Case Management: He-M 426.15

Case Management is a state supported and regulated service for "eligible" clients. In the past two years, the federal government's Centers for Medicare and Medicaid Services (CMS) have narrowed the definition of case management services. Targeted Case Management is case management services targeted to specific population subgroups and is a covered CMHC service that "shall assist clients eligible under the state plan in gaining access to needed medical, social, educational and other services..." Medicaid is the only insurance that currently covers this service.

Case managers perform four major functions:

1. Assessment and periodic reassessment of an eligible individual to determine service needs, including:
  - **Medical service** such as the individual's need for primary healthcare, dental care, home healthcare, and assistance with activities of daily living (ADL).
  - **Educational service** such as the need for high school or advanced degrees, skill building programs, parenting education and other support groups.
  - **Social service** such as employment, housing and transportation.
  - **Other service** such as personal development, maintenance and support of social and familial relationships, and the pursuit of hobbies and interests.
2. Development and periodic revision of a specific and comprehensive care plan based on the information collected through the above assessment or reassessment. *Note: The care plan is not the same as an Individual Service Plan, but is "the case management plan" which is part of the Individual Service Plan.*



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3. Referral and related activities to help the eligible individual obtain the services identified and needed.
4. Monitoring and follow up activities and contacts that are necessary to ensure the care plan is effectively implemented and it adequately addresses the needs of the eligible individual.

### **Psychiatric Services**

Psychiatric services, provided by psychiatrists and nurse practitioners, are available to all CMHC clients. Medicaid, Medicare and most private insurance companies pay for these services. In general they fall into two categories:

#### ***Psychiatric Assessment and Evaluation: He-M 426.10***

Psychiatric assessment and evaluation are structured interview procedures which gather information from the client and the client's family. This information is used to make or confirm a psychiatric diagnosis, make recommendations regarding the possible benefits of psychotherapeutic medications, and to begin developing a comprehensive Individual Service Plan (ISP).

#### ***Medication Administration, Review and Monitoring: He-M 426.07***

Medication administration, review and monitoring are the processes used to prescribe, deliver, adjust, and monitor both the effectiveness of the medications prescribed (through the reduction of symptoms) and to ensure the medication is not causing unnecessary side effects nor posing any risk to the person's physical health. Those who prescribe the medications provide education and information that explains what the intended benefit of the medication is, and what side effects and adverse reactions to watch for, and what to do if they occur.

### **Psychotherapy (Counseling): He-M 426.08**

Psychotherapy (either individual or group) is available to all CMHC clients. Medicaid, Medicare and most private insurance companies pay for this service; however, it is important to check if your loved one's insurance has any coverage limits. See *Chapter 8. Paying for Services, page 75* for more information on insurance coverage limitations.

Simply put, psychotherapy is an ongoing conversation between two people where one of the individuals has something about their life they would like to change and the other individual is trained in helping people learn how to make such change. For a more technical definition, Lewis R. Wolberg wrote in his 1977 work, *The Technique of Psychotherapy*:

*Psychotherapy is the treatment, by psychological means, of problems of an emotional nature in which a trained person deliberately establishes a professional relationship with the patient with the object of (1) removing, modifying, or retarding existing symptoms, (2) mediating disturbed patterns of behavior, and (3) promoting positive personality growth and development.*

However we define it, psychotherapy or talk therapy, is a proven method of treatment for people with mental disorders by helping them understand their illness and to develop strategies to deal with stress as well as unhealthy thoughts and behaviors.



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### ***Illness Management and Recovery (IMR): He-M 426.12(g)***

Illness Management and Recovery (IMR) is a state supported and regulated service for “eligible” clients. IMR is one of the five evidenced-based practices (EBP) approved by the Substance Abuse and Mental Health Services Administration (SAMHSA). Medicaid is the only 3rd party payer or insurance that covers this service.

The primary aim of IMR is to empower clients to manage their illnesses, define their own goals for recovery, and make informed decisions about their treatment by teaching them the necessary knowledge and skills to manage the symptoms of their mental illness. It is a psycho-educational approach to treatment. IMR helps the individual become aware of their illness and how it affects their own lives and that of others and helps them to have more control over the symptoms of their illness. Research has shown that with appropriate knowledge and strategies, episodes of mental illness occur less often and are usually less severe in intensity and duration.

In short, IMR is the intervention used when a client answers “yes” to two straight forward questions:

- “Would you like to learn as much as possible about your mental illness?” and
- “Would you like to learn a set of skills which will help you manage that illness?”

The information and skills taught through IMR are organized into ten specific areas and are intended to be presented in this order to clients either individually or in a group setting. The content of the sessions focuses on the following ten topic areas:

- Recovery strategies;
- Practical facts about mental illnesses;
- The Stress-Vulnerability Model and treatment strategies;
- Building social supports;
- Using medication effectively;
- Drug and alcohol use;
- Reducing relapses;
- Coping with stress;
- Coping with problems and symptoms; and
- Getting your needs met by the mental health system.

### ***Functional Support Services (FSS): He-M 426.12(i)***

Functional Support Services (FSS) are state supported and regulated services for “eligible” clients. Medicaid is the only insurance that covers this service. There is a limit of hours of FSS per day, although this limit can be waived in certain cases. Check with your CMHC provider to determine current service limitations (subject to change due to budget shortfalls) and the waiver's procedure. (Note: the limitations and waiver procedure can be found in He-M 426.)

FSS are a broadly defined group of services designed to support a client’s ability to function at his or her best level. The key to FSS is to provide support the client needs to manage symptoms of his or her illness so he or she can successfully complete daily activities and tasks anywhere he or she needs to function: at home or work, while shopping for groceries or opening a banking account, in a doctor’s office or at the laundromat. FSS are not an evidenced-based practice; however, they have a clear relationship to the strategies and skills found in IMR.

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There are four general types of Functional Support Services:

1. ***Crisis intervention services*** are designed to stabilize and improve acute behaviors and symptoms that threaten the client's ability to remain in the community. These services include the use of such strategies and skills as "relapse prevention" and "symptom management."
2. ***Therapeutic behavioral services*** are specific and individualized, and are designed to enable the individual to develop, reinforce, or apply those skills and strategies that effectively reduce symptoms and behaviors which impair the person's ability to function. These services rely heavily upon the motivational, educational and cognitive behavioral methods found in IMR such as "building social supports" and "coping with stress."
3. ***Family support*** is designed to support and maintain the management of the client's mental illness. Its primary objective is the enhancement and promotion of the client's resilience and recovery. This functional support service focuses upon giving assistance to family members, caregivers or significant others in the delivery of a specific intervention directed to a particular behavior or symptom that the client presents in the home or in the community. The targeted behavior, the specific intervention, and the goal which the client is working toward are pre-planned and defined in the client's ISP.
4. ***Medication support*** is specific and individualized and is designed to support the individual in maintaining his or her medication regimen to promote the effective management of his or her mental illness. This intervention is modeled on the concept of "behavioral tailoring" which is based on the idea of incorporating medication into the individual's daily routine.

### ***Supported Employment (SE): (He-M 426.12(h))***

Supported Employment (SE) is a state supported and regulated service for "eligible" clients. SE is one of the evidenced-based practices' previously mentioned. At this time, Medicaid is the only insurance that covers this service.

SE is a well-defined approach to helping people with disabilities find meaningful jobs and provide them with ongoing support in order to maintain employment. SE is built on the belief that most individuals with serious mental illness want to work and feel work is an important goal in their recovery. When a client identifies work as a goal, he or she usually means competitive employment – that is, jobs available in the community any person can apply for and jobs paying, at the very least, the minimum wage.

There are seven basic principles that distinguish Supported Employment:

1. Eligibility is based on client choice – all the client needs is the desire to work in order to participate.
2. SE services are integrated with comprehensive mental health treatment.
3. Competitive employment is the goal.
4. Personalized benefits counseling is important to ensure well-informed and optimal decisions regarding state and federal benefits and health insurance.

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5. Job search starts soon after consumers express interest in working. Pre-employment assessment, counseling, training, and intermediate work experiences are not required.
  6. Follow-along supports are continuous and are provided to maintain employment for as long as the client needs and wants assistance.
  7. Client preferences are important. The type of work desired and the kind of support needed are specifically individualized and uniquely based on the client's preferences, strengths and experiences.

### **Emergency Services (ES): He-M 426.09**

Emergency Services are available to anyone who may be experiencing a mental health crisis. **(Note: an individual does not have to be a client of the CMHC to receive Emergency Services.)** Each CMHC provides 24-hour, 7 days a week Emergency Services and requires psychiatric coverage. Medicaid, Medicare and most private insurance companies pay for these services.

Each CMHC has an emergency services team that includes acute care/crisis stabilization clinicians and medical staff (either psychiatrists or nurse practitioners). Acute care/crisis stabilization clinicians are trained in emergency assessment, crisis stabilization, and suicide prevention. These mental health professionals are available 24-hours-a-day, 7-days-a-week.

During normal business hours, each CMHC has a capacity to see walk-in emergencies at their clinic sites. After hours, emergencies are almost always directed to the emergency room of the nearest general hospital where the person in crisis will be seen face-to-face. In rural areas, some hospitals may utilize telemedicine for faster access, allowing a provider to interact via audio and visual media with the patient in the emergency room. *If an individual is seen at the general hospital there is a medical cost incurred in addition to the CMHC fees.*

Most emergency contacts begin as telephone calls. The telephone call will usually be responded to by a master's level clinician within 15 to 20 minutes. Each clinician is backed up by an on-call psychiatrist or nurse practitioner. If the crisis cannot be resolved, the emergency team will have the individual come to the CMHC or the emergency room of a local hospital for a face-to-face assessment. Most CMHCs have formal agreements with their local hospitals to provide these services.

The clinician will determine if the individual is safe to leave with a follow-up care plan or requires inpatient care. If hospitalization is needed, the clinician, in consultation with medical staff, will arrange for a voluntary psychiatric hospitalization. In some situations, the clinician, in consultation with medical staff, will facilitate an Involuntary Emergency Admission (IEA) to New Hampshire Hospital. See *Chapter 11. Legal Terms, Considerations and Procedures, beginning on page 115* for more information on the IEA process.

### **Housing or Residential Services**

Funding for housing and residential services for individuals with mental illness is limited in New Hampshire. Yet, safe, stable housing is essential to anyone's mental and overall physical health. For individuals living with mental illness, a place to live can make the difference between simply surviving and actively recovering to live independent and fulfilling lives.

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Housing or Residential Services are state supported and regulated services for “eligible” clients. The state’s CMHCs collaborate with state and local housing agencies and providers to promote access to existing housing and to develop housing opportunities for persons with mental illness, including home ownership and rental options. All provide housing outreach programs which offer functional support services and assistance to individuals anywhere they live.

The State of New Hampshire has established three Continuums of Care (COCs) to coordinate services to prevent and end homelessness: Greater Nashua, Manchester and the Balance of State. COCs are also the entity through which the U.S. Department of Housing & Urban Development (HUD) funds its Homeless Assistance Supportive Housing Programs (SHP). All of the CMHCs belong to one or more COCs, based upon their region, working with their partners to help ensure that individuals with mental illness have access to appropriate housing and homelessness prevention services. Several CMHCs have worked with their local COC to establish both permanent and transitional housing programs for individuals with serious mental illness.

Some CMHCs operate one or more 8-person, 24-hour-a-day supervised community residences (“group homes”). Some CMHCs have worked with their local housing authorities and have developed scattered apartment programs. Others have used their own resources and created a variety of subsidized housing opportunities. While accessing affordable housing with the optimal level of service provision is a challenge, the case manager assigned to work with your family member can help find local resources and provide referrals to area housing providers. At the time of this printing the Bureau of Behavioral Health has received funding for a program call “Bridges” that can assist individuals with mental illness who are homeless in securing financial assistance for housing. Resources may be found by contacting the Office of Housing and Homelessness. See *Appendix C. Local, State and National Resources, page 144.*

### Emerging Practice

The clinical staff at the CMHCs has been trained to deliver evidenced-based practices (EBPs). These are services or treatments that have been determined to be effective based on the results of clinical research. The Substance Abuse and Mental Health Services Administration (SAMHSA), which is an agency of the U.S. Department of Health and Human Services, has approved five EBPs: Assertive Community Treatment (ACT), Family Psycho education (FP), Illness Management and Recovery (IMR), Supported Employment (SE), and Co-Occurring Disorders: Integrated Dual Disorders Treatment (IDDT).

Of the five EBPs listed above, only two are available in every CMHC in New Hampshire: Illness Management and Recovery (IMR) and Supported Employment (SE). There are a few CMHCs which have implemented Assertive Community Treatment (ACT) and Co-occurring Disorders: Integrated Dual Disorders Treatment (IDDT). In its 10-year plan, the state’s Bureau of Behavioral Health has committed to expanding the number of ACT teams statewide.<sup>2</sup>

To learn more about EBPs, see *Appendix E. Suggested Reading, beginning on page 161.*

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## ***Assertive Community Treatment (ACT)***

Assertive Community Treatment (ACT) is for individuals who experience the most severe symptoms of mental illness. Due to the severity of symptoms, people who receive ACT services often have problems taking care of even their most basic needs. Substance abuse, homelessness, and problems with the legal system are not uncommon. The Ten Year Plan identifies expanding ACT teams to more regions.

The goal of ACT is to help people stay out of the hospital and develop skills for living in the community so their lives are not driven by having a mental illness. ACT offers intensive services to address the person's needs: managing symptoms, housing, finances, employment, medical care, substance abuse, family life, and activities of daily living.

Some important features of ACT programs are:

- Services are provided by a team of practitioners so people can get a variety of services from the same staff members.
- Services are available whenever and wherever they are needed. Teams work with people in community settings and support is available 24-hours-a-day. There are no time limits on how long a person can receive services.
- Services are provided for as long as they are wanted and deemed “medically necessary.”

## ***Co-occurring Disorders: Integrated Dual Disorders Treatment (IDDT)***

Another EBP that is not yet a required practice in the CMHCs of New Hampshire, but has begun to be introduced in some is Co-occurring Disorders: Integrated Dual Disorders Treatment (IDDT) for individuals living with co-occurring mental health and substance use disorders.

IDDT is a treatment approach for individuals with co-occurring disorders which helps them to recover by offering mental health and substance use services together, in one setting, at the same time. In other words, the same clinicians (or team of clinicians) provide a person-centered treatment plan for both mental health and substance abuse problems.

A wide variety of services are offered in a stage-wise fashion because some services are important early in treatment while others are important later on. Individualized treatments are offered depending on what stage of recovery a person is in. Examples of services include basic education about the illnesses, case management, help with housing, money management, or relationships, and specialized counseling specifically designed for people with co-occurring disorders. This is a comprehensive and long-term approach to treatment that has hope and optimism as core beliefs. Services are offered in a positive atmosphere and people are encouraged to believe they can recover as many others have. Ultimately, the goal of IDDT is to help people learn to manage both their mental illness and substance use problems so they can pursue their own meaningful life goals.

### Consumer Run Programs

#### ***Peer Support Agencies (PSAs)***

Peer support is a philosophical concept that grew out of dissatisfaction with the professional side of mental health services in the early 1960s. Simply put, it was felt, that people with mental illness relating their feelings, issues, and needs to their peers could better promote wellness and recovery.

*Through peer support, people with mental illness have learned that recovery does not come only from without but taps into an inner life force. They have discovered that giving feels good because it nurtures a sense of self-worth. Self-worth is also developed in peer support by learning about one's strengths and weaknesses within a supportive environment. This process gives one power to change and to manage the challenges of everyday life. The mental health system tends to define caring as protecting rather than supporting people's efforts when they take chances, even if they fail. In peer support, failure is seen as a natural learning process in gaining power over one's life, rather than diminishing one's life.<sup>1</sup>*

Without PSAs in New Hampshire, there would be a definite lack of places for individuals with mental illness to share, programs to learn from, activities to participate in, and people to talk with who have similar experience and history.

#### ***A Personal Reflection***

By David Sawyer

These are just a few of the many feelings that peer support evokes for me:

It is here, at a PSA, that we are able to satisfy the need to put behavior and experience under a scientific, or at the least, a microscopic lens. I watch people and see what and how they move. I listen to people and hear what and how they speak. I am free, here, to live and learn from my fellow partners in this strange, but real, fish-bowl-of-a-diagnosis in which we find ourselves. Miraculously, I invariably come away with a resurgence of belief that there is health and wellness in everyone.

I truly believe that the social concepts of kindness, caring, flexibility, and warmth are evidenced in this small microcosm. It is a community, much like a family, within the greater community-at-large.

From such a center I can go back into the community-at-large and both bring to it and find there similar healthy concepts. In short, the small respite at the PSA revitalizes my belief in community, and in my fellow man. This experience is repeated in some way by every person who uses the Peer Support Agency. It allows us to live with the negatives that we feel relative to having a condition, and then to re-enter society where we have come to believe there exists



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misconceptions, erroneous notions, suppositions, and stereotypes about us that are not fact-based. If this helps us cope, we all win. If this helps us re-adjust to a sometimes hostile-feeling environment, then we all win. If this helps us be better individuals and citizens, we all win.

Peer Support Agencies (PSAs) can be found in all ten of the state's mental health regions. They are private, not-for-profit agencies that have contracted with the NH Department of Health and Human Services, Bureau of Behavioral Health (BBH), which provide funding through its federal Community Mental Health Services Block Grant. PSAs currently provide services to people with mental illness who are 18 years of age or older and who self-identify as a recipient, former recipient, or as having a significant chance of becoming a recipient of publicly-funded mental health services.

PSAs are consumer-run and operated. Services are provided by and for people with a mental illness, and are designed to assist people with recovery. Peer support consists of supportive interactions based on shared experience among people with mental illness (i.e., individuals who use mental health services), and are intended to help these people with mental illness to understand and achieve success with their personal goals. Interactions are based on inclusion, trust, respect, and shared support. PSAs accomplish this by providing choice, using non-medical approaches to help, challenging perceived self-limitations, and encouraging informed decision making about all aspects of people's lives.

PSA services may include, but are not limited to: face-to-face and telephone support, outreach, monthly educational events, activities that promote self-advocacy, wellness, and recovery, after hours warm line, and crisis respite (24-hour, short-term, non-medical crisis program).

### ***Granite Pathways***

Granite Pathways, a peer-support, self-help community in Manchester, NH provides hope, dignity, and support to adults recovering from mental illness. Granite Pathways is a "clubhouse" modeled after Fountain House in New York City and follows the accreditation standards of the International Center for Clubhouse Development (ICCD). The term "Clubhouse" refers to the specific model of peer support and recovery that has evolved from Fountain House and is now recognized as an evidence-based practice for achieving superior employment and recovery outcomes. The overarching goal of the program is to empower and support adults with mental illness to pursue their personal goals through education, employment, stable housing, rewarding achievements, and meaningful relationships. This "clubhouse" model is being explored in other regions and contact Granite Pathways to learn about other locations.

As family members, it is vital we continue to advocate for supports and services that can assist our loved ones in their recovery. To learn more about the mental health system and other related topics, please see *Appendix E. Suggested Reading, page 161*.



## Chapter 7. Navigating the Treatment System

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### Chapter 7 Notes

1. New Hampshire Department of Health & Human Services. *Addressing the Critical Mental Health Needs of NH's Citizens: A Strategy for Restoration*. Concord, NH: State of New Hampshire, 2008.
2. Clay, Sally. *On Our Own Together*. Nashville: Vanderbilt University Press, 2005.

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## Chapter 8. Paying for Services

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### Chapter Overview

*This chapter provides an explanation of the “eligibility criteria” for community-based mental health services through the community mental health system. This chapter also provides a brief overview of the available funding sources for individuals seeking or receiving mental health services in NH. Many individuals do not have insurance coverage or an ability to pay for mental healthcare.*

*There are options for coverage through private insurance, as well as federal and state insurance programs. Also, State and Federal programs do offer programs that provide cash payments to individuals who meet the eligibility criteria. An individual can also apply to the town or city where they live for temporary assistance. At the time this guidebook is going to print, NH legislature is considering Medicaid Expansion which will address the needs of many NH citizens.*

*It is also important to highlight that at the time of this publication, NH Department of Health and Human Services (NH DHHS) is also moving to a Medicaid Care Management Program which will be implemented beginning in the winter of 2013 and over the next*

*few years. NH DHHS has been working on two additional initiatives that are studying different service delivery quality assurance regulatory and funding models for individuals who are Medicaid recipients to determine new models for long-term care and those who are Medicaid recipients. These programs are: Systems Innovation Model (SIM) and the Balance Incentive Program (BIP). Information about these can be found on the NH DHHS website: <http://www.dhhs.nh.gov/> or by contacting the NH DHHS Division of Community-Based Care Services at (603) 271-9410. NAMI NH will post information on our website: [www.naminh.org](http://www.naminh.org) as it becomes available.*

*We encourage individuals to seek out someone who “knows the system” to assist them when applying for any benefit program. The Community Mental Health Centers, Granite State Independent Living and NAMI NH can provide assistance with understanding and navigating the benefit system. See Appendix C. Local State and National Resources beginning on page 127 for contact information.*

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I tried to get services and was told I needed to apply for Medicaid and SSI. Trying to do this was overwhelming and after several tries I was about to give up. Then I learned that there were people who could help me in filing my applications and working through this system. This saved my life!

*John, Consumer*

## Private Health Insurance

Private health insurance plans cover both physical and mental health services. It is important to know the types of mental health services that are covered by your family member's insurance plan and any coverage limitations. Private insurance plans usually cover psychiatric evaluations, medication monitoring, individual and group therapy, emergency services, and inpatient hospitalizations. **Be aware that most insurance plans are written with coverage limits** (such as 12 therapy sessions per year or \$1,800 for therapy each year). Depending on the insurance plan, an individual may be responsible to meet an established deductible in each calendar year. There may also be a co-pay that is expected to be paid at each appointment. Please note that in addition, the individual receiving services, or the insurance subscriber, may be responsible for charges above what the insurance plan considers "reasonable and customary fees".

Regarding insurance coverage for mental health services, the State of New Hampshire has "parity," which requires insurance plans to provide the same benefits for the treatment and diagnosis of the following mental illnesses as they do for physical illnesses. We are carefully watching to see the impact of the passage of federal parity and the healthcare reform legislation on private insurance plans' coverage. Basically, if written, plans must include coverage for mental health and substance use treatment services. However, all of these plans may be subject to the same managed care condition that exists for physical illness. You need to check carefully with your insurance carrier to know exactly what you are entitled to based on your insurance plan. The biologically based disorders that are covered under private insurance at this time are:

- Schizophrenia and other psychotic disorders,
- Schizo-affective Disorder,
- Major Depressive Disorder,
- Bipolar Disorder,
- Anorexia Nervosa and Bulimia Nervosa,
- Obsessive-Compulsive Disorder,
- Panic Disorder,
- Pervasive Developmental Disorder or Autism, and
- Chronic Post-traumatic Stress Disorder.

If you have questions about parity, contact the New Hampshire Insurance Department or NAMI NH. For contact information, see *Appendix C. Local, State and National Resources*, page 146.

## Chapter 8. Paying for Services

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Some insurance plans require prior authorization for services which means the individual or the service provider must contact the insurance carrier and provide certain medical information. Other insurance plans require a referral from one's primary care provider. Your loved one may also have to personally call his or her insurance carrier to access mental health services, especially if more long-term treatment is needed.

It is important to remember that unless your loved one has signed a release with the insurance company allowing you to speak with them on his or her behalf, he or she may have to be the one who contacts the insurance carrier – even if you are the subscriber. You can, however, make the call together so you can assist your loved one with the process. Some insurance carriers will allow the individual seeking services to give approval over the phone for you to speak with the carrier on their behalf for that phone call.

If your loved one is denied an authorization for services or payment, immediately contact the insurance carrier. They may require more information from the service provider. If the person you are speaking with is not able to assist you in resolving the situation, ask for the procedure to file an appeal. The insurance carrier must provide its subscribers with written information about their appeal process. If this is regarding payment, be sure the service provider is aware you and your loved one are trying to resolve the situation.

Keep a written record of all conversations with the insurance carrier, including dates, the person(s) with whom you and/or your loved one spoke and the content of the discussions.

### State-Supported Community Mental Health Services

"I thought I could go to the community mental health center or New Hampshire Hospital and the services would be free."

*Adult with Mental Illness*

As described in Chapters 6 and 7, New Hampshire has a Community Mental Health System that covers the entire state, offers an array of programs and services to adults with serious mental illness and provides access to some state-of-the-art evidence-based practices (EBPs). The Community Mental Health Centers (CMHCs) have fully embraced the concept of ***a life in the community for everyone***, championing case management and functional support services, advocating for vocational rehabilitation and supported employment, and creating a variety of approaches to supported housing and residential services.

As a group the CMHCs have recognized the need to:

- Embrace the philosophy of a consumer directed system of care including shared decision making of consumer and provider;
- Implement several national evidenced-based practices;
- Raise the awareness of the importance of family education and support;
- Develop peer and consumer run programs;
- Experiment with continuous treatment teams to better treat their clients with co-occurring substance use disorders;
- Build partnerships with area agencies serving the developmentally disabled;
- Extend their expertise to adults who carried dual diagnoses of cognitive impairment and major mental illnesses; and
- Recognize the importance of treating the whole person in an integrated model.

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Often when individuals attempt to access services from either their Community Mental Health Center (CMHC) or New Hampshire Hospital (NHH), they and their families are surprised when they are told about the financial obligation to pay for services. The services offered by the CMHCs and NHH come with a cost and the resources available to the community mental health system are not limitless.

All the CMHCs are private, not-for-profit organizations and each has different financial policies and procedures. CMHCs accept Medicare and NH Medicaid. They all do not accept the same third party private insurances. Uninsured individuals are expected to apply for all public health insurance benefits for which they may be eligible or entitled. If an individual does not have insurance (public or private) **most CMHCs offer either a sliding fee scale or a reduced fee based upon the individual's ability to pay for services.** CMHCs are required by federal and state law to bill for services they provide. It is important to understand these financial policies and discuss financial responsibilities at the intake appointment.

NHH is a state operated publicly funded hospital. During the first days of a hospitalization, a staff member will meet with the patient to review what financial resources he or she has to pay for the hospitalization. The patient will be provided a full explanation of the financial obligation along with information about Medicare and Medicaid benefit programs. If the patient has private insurance, he or she will be asked to sign the release of information form necessary for NHH to bill the patient's insurance company. The patient will be asked to complete a financial statement about his or her ability to pay. This financial statement is required by law. **When an individual has no insurance or personal resources, NHH will NOT deny necessary care.**

To manage the challenge of balancing the needs of those with serious mental illness and resource limits, the state mental health authority and public policy makers have the power to define "serious mental illness" and control the size of the population for which they will be responsible. **In other words, not everyone in New Hampshire with a mental health challenge is eligible to access those "state-supported community mental health services" which have been specifically designed to treat and support adults with serious mental illness.** Thus, the state mental health authority has developed a tool and process to ensure only those identified with a serious mental illness will have access to "state-supported community mental health services."

### ***New Hampshire's Eligibility Criteria: He-M 401***

In New Hampshire every adult citizen has the right to apply, through their local CMHC, for state-supported community mental health services. When requested, a qualified CMHC staff member will assess and evaluate the applicant to determine whether he or she meets the eligibility criteria established by the state rules He-M 401 as having:

- Severe and Persistent Mental Illness (SPMI), or
- Severe Mental Illness (SMI), or
- Severe and Persistent Mental Illness with Low Service Utilization (SPMI-LU), or
- Severe Mental Illness with Low Service Utilization (SMI-LU).

At the time of the printing of this guidebook, the following is the criteria to determine eligibility for the adult state-supported community mental health services. However, there is a plan to utilize a new eligibility tool identified as the Adult Needs and Strengths

## Chapter 8. Paying for Services

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Assessment (ANS) beginning in 2013. When this plan is finalized and implementation strategies are confirmed, NAMI NH will post it on our website, you may also discuss this with the CMHC staff.

There are three criteria used in making an eligibility determination: Diagnosis, Disability, and Duration.

### ***Criteria #1: Diagnosis***

The individual has one or more of the following primary mental illness diagnosis:

- Schizophrenia and other psychotic disorders,
- Mood disorders,
- Borderline Personality Disorder,
- Post-traumatic Stress Disorder,
- Obsessive Compulsive Disorder,
- Eating disorders,
- Panic Disorder, and
- Dementia, where the psychiatric symptoms cause the functional impairments and one or more of the following co-morbid symptoms exist:
  - Anxiety,
  - Depression,
  - Delusions,
  - Hallucinations, or
  - Paranoia.

See *Chapter 3. Serious Mental Illness: A Closer Look, page 23* for more information on these psychiatric disorders.

**In extraordinary situations, a CMHC can ask the NH DHHS Bureau of Behavioral Health for a waiver to this criteria to allow other serious mental illnesses to qualify, as long as all of Criteria #2 and #3 are met.**

### ***Criteria #2: Degree of Functional Impairment or Disability***

In addition to Criteria #1, the individual must also have as a result of his or her mental illness, a moderate to extreme functional impairment as determined through an assessment of the person's ability to function in the following four domains:

1. ***Activities of Daily Living*** –assesses the person's ability to perform such tasks as personal hygiene, nutrition, housework, taking medication, shopping for groceries, using the telephone, managing money, personal safety, etc.
2. ***Interpersonal Functioning*** –assesses the person's ability to relate to and communicate with others, to sense, understand and react to other people's emotions, to resolve conflict with others, and to control emotional intensity and impulsivity.
3. ***Adaptation to Change*** – assesses the person's ability to experience and adapt to such changes as the loss of a friendship, the obtainment of a job, the birth of a child, the death of a parent, the diagnosis of a major illness, etc.



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4. ***Concentration, Task Completion or Pace*** – assesses the person’s ability to follow simple and sequential directions, to focus one’s attention, to manage distractions, to begin and finish a job, and to work in a steady and timely manner.

In determining the degree or level of functional impairment, the clinician performing the assessment must find evidence the adult individual demonstrates:

- ***Moderate impairment*** causing chronic or durable problems *in each of the four functional domains* such that the person requires regular support and a variety of services; or
- ***Marked impairment*** causing ongoing symptoms *in two or more of the functional domains* such that the person requires intensive and frequent supportive interventions; or
- ***Extreme impairment*** causing risk of death *in at least one functional domain* such that the person requires a constant level of services.

### ***Criteria #3: Duration of Functional Impairment or Disability***

In addition to Criteria #1 and #2 above, the individual must have lived with the functional impairment caused by their illness for a prescribed length of time as described in the following eligibility categories:

#### ***Severe and Persistent Mental Illness (SPMI)***

The individual shall be eligible for community mental health services if he or she is determined to have a Severe and Persistent Mental Illness (SPMI) – that is, has one or more of the identified mental illnesses, meets one of the three levels of disability, and has experienced the functional impairment for one or more years.

#### ***Severe Mental Illness (SMI)***

The individual shall be eligible for community mental health services if he or she is determined to have Severe Mental Illness (SMI) – that is, has one or more of the identified mental illnesses, meets one of the three levels of disability, and has experienced the functional impairment for less than one year.

#### ***Severe and Persistent Mental Illness with Low Service Utilization (SPMI-LU) and Severe Mental Illness with Low Service Utilization (SMI-LU)***

The individual shall be eligible for community mental health services if he or she is determined to have either SPMI or SMI with Low Service Utilization:

1. If the individual has one or more of the identified mental illnesses, but no longer meets the functional impairment or level of disability criteria and is receiving ongoing services designed specifically to prevent relapse; or
2. If the individual has one or more of the identified mental illnesses, meets one of the three levels of disability but has refused recommended services and for whom the CMHC is providing outreach; or
3. If the individual has functional impairments that are due to a developmental disability or receives services primarily through another agency such as a provider for persons with developmental disabilities.

### Public Cash and Medical Benefit Programs: A Snapshot

SSI. SSDI. Medicaid. Medicare. APTD. Acronyms abound in any field, and the disability field has its share. When a parent hears these acronyms, however, the reaction can range from hope to frustration.

Each of these acronyms represents a benefits program available to people with disabilities (some are available to others as well). The programs vary in benefits available and eligibility and can cause otherwise sane and intelligent people to collapse in a heap of frustration. It is not impossible to apply for and receive benefits on one's own, but it is always wise to enlist the assistance of someone who "knows the system..."

**Janet M. Krumm & Jan Larsen<sup>1</sup>**

There are programs through the Social Security Administration (SSA) and the NH Department of Health and Human Services (DHHS) that can provide financial and medical assistance to individuals and families who qualify. When applying for these benefits, the individual seeking them will be required to file a written application and provide proof of their identity, social security number and citizenship. Unless you are already your loved one's legal guardian; if they are over the age of eighteen, they will be required to complete all applications and interviews. You can accompany them and assist them. Your loved one will also be asked to verify their residency, income and resources. If applying for disability programs, they and their medical providers will be required to provide medical information. *Eligibility decisions must be provided in writing to the applicant and include the information about how to file an appeal of the decision.* If your loved one is denied benefits, **the eligibility decision must clearly explain the reason for denial** and provide information on how to appeal the decision. The appeal must be requested by the applicant within a specific period. **ALWAYS GET A RECEIPT FOR ANY APPLICATION FILED AND KEEP A PHOTOCOPY OF ANY DOCUMENTS SUBMITTED.**

Every CMHC in New Hampshire has on staff at least one Benefits Specialist who is trained in how to help individuals with mental illness access both cash and medical benefits. The Benefits Specialist at your local CMHC can be an important resource and ally for your loved one.

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## Cash Benefits

### Social Security Disability Insurance (SSDI)

SSDI is a program for individuals who have worked, paid FICA taxes and then become disabled. The benefit eligibility is based on the number of working “quarters” that the individual has paid into Social Security which then determines what will be the monthly cash benefit. Once the disabled individual becomes eligible for SSDI benefits, he or she is called a “beneficiary.” It is important to note that his or her family members may also be eligible to receive assistance, based on the records of their wage-earnings. There are informational booklets available from the SSA that can provide more details about this program. To receive SSA informational booklets or to talk with a SSA representative, see *Appendix C. Local, State and National Resources, page 142* for contact information.

To apply for SSDI, a written application must be filed and requires an interview and the applicant /representative must provide requested documentation and verifications within a specific timeframe. Your loved one or their representative can do this in person by going to the local SSA district office or by calling the office and arranging to do it via telephone and mail. See *Appendix C. Local, State and National Resources, beginning on page 142* for a list of the local SSA district offices in New Hampshire. The Benefits Specialist at your local CMHC can also provide information on this and other benefits programs.

- **Representative Payee:** If an individual has difficulty managing their finances, they can apply to have a “representative payee” appointed by SSA. The SSA can provide the form and a booklet that explains the responsibilities of the representative payee (often referred to as a “rep payee”).
- **Work Incentive Programs:** If an individual is on SSDI and wants to return to work, there are work incentive programs to help with this transition. These work incentives provide a “safety net” for their benefits as they return to the workforce. It is important to know the individual DOES NOT automatically lose their benefits if they return to work. Before returning to work, individuals should talk about the work incentive programs with a Benefits Specialist or Employment Specialist at the CMHC or contact the SSA directly. There are informational booklets available through the SSA about work incentive programs.

**If an individual receives SSDI, they will be eligible for Medicare 25 months after they are determined eligible for SSDI.** See the *Medical Benefits* section in this chapter for more information about Medicare.

### Supplemental Security Income (SSI)

SSI is another federal program which is an (poverty-based) income based program that provides monthly cash payments. **There are no medical benefits attached to SSI.** This program was established to provide cash assistance to low income children and adults with disabilities. Unlike SSDI, this benefit is not based on the person paying into the system but is an entitlement program. The amount of a person's monthly check is based on his or her current income including SSDI, wages, and Veteran's Administration benefits. If an individual is determined eligible for SSI, they are referred to as a "recipient." The income level of an adult (18 years of age or older) is determined on the basis of the adult's income even if he or she is still living with their family.

To apply for SSI, a written application must be submitted and requires an interview and the applicant/representative must provide requested documentation and verifications within a specific timeframe. Your loved one or their representative can do this in person by going to the local SSA district office or by calling the office and arranging to do it via telephone and mail. See *Appendix C. Local, State and National Resources, page 142* for a list of the local SSA district offices in New Hampshire. The Benefits Specialist at your local CMHC can also provide information on this and other benefits programs.

- **Representative Payee:** If an individual has difficulty managing their finances, they can apply to have a "representative payee" appointed by SSA. The SSA can provide the form and a booklet that explains the responsibilities of the representative payee.
- If you are the parent of a child with a disability, we encourage you to contact SSA and file an application on or just after your child's 18th birthday. **If your family member is determined to be eligible for SSI, the monthly payments will be retroactive to the date of this contact.**
- In some states a person who is determined eligible for SSI is automatically eligible for Medicaid. **This is not the case in New Hampshire.** The person must apply for NH state public assistance programs: Aid for the Permanently Disabled Program (for individuals ages 18 through 64) or Old Age Assistance Program (for individuals ages 65+) and indicate on the application they wish to apply for Medicaid. See the **Medical Benefits** section in this chapter for more information about Medicaid.

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### **Aid to the Permanently and Totally Disabled (APTD)**

This is a public assistance program administered through the State of New Hampshire. To be eligible, a person (between the ages of 18 and 64) must be disabled (according to the State's definition of disability), meet the income and resource limits set by the State, and must provide verification that they have applied for SSI. There are significant advantages associated with applying for this program. Eligibility for APTD automatically makes one eligible for Medicaid and potentially eligible for Food Stamps. An individual can refuse cash benefits and accept only the Medicaid under the APTD program. An adolescent who will be turning 18, should file an application before their 18th birthday.

To apply for APTD, a written application must be submitted. Your loved one or their representative can do this in person by going to the local DHHS district office and scheduling an appointment or can file an application online by going to the NH EASY web page: <https://nheasy.nh.gov>. The application process requires an interview and requested documentation and verification must be submitted within a specific timeframe. One of the requirements for receiving APTD is signing a paper stating the recipient agrees that if he or she comes into money in the future that they may be required to pay the state back for the services received. See *Appendix C. Local, State and National Resources, page 142* for a list of the local DHHS district offices. The Benefits Specialist at your local CMHC can also provide information on this and other benefits programs.

- **Authorized Representative:** If an individual has difficulty managing their finances, they can apply to have an “authorized representative” appointed by DHHS.
- **A person who had been receiving both SSI and APTD and who loses his or her SSI eligibility for medical reasons automatically loses his or her APTD eligibility as well.**

### **Medical Benefits**

#### **Medicare**

Medicare is a federal health insurance program administered by the Social Security Administration. A person becomes eligible for Medicare at age 65, or by receiving SSDI benefits. SSDI recipients must wait two years after SSDI cash payments begin before Medicare coverage begins. See the section above on SSDI for details about filing an application.

When determined eligible for Medicare, it is important before receiving any medical care that your loved one makes sure their medical providers accept Medicare and be clear what coverage they have through Medicare. Medicare has three coverage programs: Part A, Part B and Part D.

- **Medicare Part A** coverage does not have a monthly premium and covers hospitalization and related costs.
- **Medicare Part B** coverage requires a monthly premium (which is deducted from your SSDI monthly check) and covers physician's charges, therapies, outpatient visits and some medical equipment. Medicare does not cover routine physical exams, preventative dental care, eyeglasses, and hearing aids.
- **Medicare Part D** coverage requires a monthly fee and covers prescriptions; however, you must choose a Part D prescription coverage provider or Medicare will automatically enroll you with a prescription coverage provider. **If you receive Medicaid there will not be a monthly premium for Medicare Part D coverage but there will be co-pay for most prescriptions.**

Note: If you have Medicaid and are eligible for Medicare, the Medicare premium may be covered under the NH State APTD or Old Age Assistance (OAA) programs.

Questions about Medicare can be answered by calling the local SSA district office, visiting SSA website or calling the toll free number on the back of the Medicare card. See *Appendix C. Local, State and National Resources, page 142*, for a list of local SSA district offices in New Hampshire. The Benefits Specialist at your local CMHC can also provide information on this and other benefits programs.

### New Hampshire Medicaid

Medicaid is administered through the NH Department of Health and Human Services. Created by federal legislation in the 1960s, Medicaid was originally designed to provide basic healthcare for the poor. Since then eligibility has been expanded to include long-term care for the elderly and people with disabilities. Medicaid continues to be a (poverty-based) income-based program.

At the time this guidebook is going to press, the New Hampshire Medicaid Program will be undergoing some changes. NH will be moving into a Care Management Program. The State believes this will provide Medicaid recipients with more effective medical care and improve health outcomes through coordination of their healthcare especially individuals with chronic health conditions. The program also will offer wellness and prevention programs. Current Medicaid benefits will not change. It is important to know that not all Medicaid recipients will immediately become enrolled in the Care Management Program. To be enrolled means that a Medicaid recipient will choose a health plan from a list of three insurance carriers and a primary care provider from the health plan's list of providers. Medicaid recipients will be receiving letters explaining the changes and the steps they need to take over the fall of 2013. If you have questions about the NH Medicaid Care Management Program, you can contact Medicaid Client Services by phone at 1-(800) 852-3345, Ext. 4344 or (603) 271-4344 or visit the NH DHHS website:

**<http://www.dhhs.nh.gov/ombp/caremgmt/>.**

If an individual is between the ages of 18 and 65 and has a disability, he or she can apply for Medicaid under the APTD program. Your loved one can apply at the local DHHS district office or can file an application online by going to the NH EASY web page: <https://nheasy.nh.gov>. Since this is an income-based program an applicant must verify his or her income and resources. An individual must be determined medically eligible as well as financially eligible by DHHS-Medical Determination Unit to receive Medicaid coverage under the APTD program. An individual can refuse cash benefits and accept only the Medicaid under the APTD program.

**Before your loved one schedules any appointments for medical care or procedures, be sure their medical providers accept Medicaid.** Medicaid pays for services not often covered under private insurance; for example, targeted case management services and functional supports through the CMHC.

**If an individual with mental illness meets the eligibility criteria for state-supported mental health services and has Medicaid under the current system they will have a higher coverage limit at the CMHC** than if they went to a private mental health professional who accepts Medicaid.

Questions about Medicaid can be answered by calling Medicaid Client Services at 1-(800) 852-3345, Ext. 4344.

### Medicaid In and Out

When an adult with a disability applies for Medicaid and has an income that is over the income limits set by Medicaid but still meets the disability criteria, he or she can still be eligible under the “Medicaid In and Out” program. This is often the case for individuals who receive SSDI benefits. The individual will receive an eligibility determination notice from DHHS explaining they have to meet a “spend down” to be eligible for the Medicaid program.

Medicaid calculates a “spend down” by comparing an individual’s income with the state’s determined “standard of need.” The difference between the person’s income and the “standard of need” is called the “spend down”. The “spend down” can be determined for a month or 3 month period. An individual is “not eligible for Medicaid coverage “until they have **incurred medical expenses equal to or exceeding the “spend down” amount.** Once they have met their “spend down,” they have Medicaid coverage and their medical expenses are covered, usually until the beginning of the next month when they again have to meet a “spend down.”

The individual must submit all the medical bills he or she has incurred during the period identified in the eligibility determination notice or any outstanding medical bills from a previous period. The individual is eligible for Medicaid coverage when they can document they have incurred medical expenses that equal or exceed the “spend down” amount.



Note: Always keep copies of any medical bills you submit to be applied toward the spend down. It is recommended you also submit a copy of the notice of decision that shows the “spend down” amount.

Questions about the *Medicaid In and Out* program can be answered by calling Medicaid Client Services at 1-(800) 852-3345 Ext. 4344. The Benefits Specialist at your local CMHC can also provide information on this and other benefits programs.

### Medicaid for Employed Adults with Disabilities (MEAD)

Another Medicaid program is MEAD. Many people with disabilities work part-time and are not eligible for health insurance coverage from their employer. In the past, income from work made some individuals ineligible for Medicaid. This is no longer necessarily true. **Now individuals with disabilities can work and even receive medical benefits from their employer and still buy into Medicaid by paying a monthly premium based on their net income (which is approximately half of their gross earned income).**

To be eligible, a person must be between the ages of 18 and 64, have a disability (as defined by the state), be working (which is based on a person paying FICA), and meet the income and resource requirements (which are larger than those otherwise used to determine Medicaid eligibility). Monthly premiums range from \$0 to \$210 until the person’s annual gross income exceeds \$75,000.

There are significant benefits to participating in the MEAD program: the individual can work just a few hours a month to be eligible; they are able to keep their Medicaid coverage, if they have a “spend down” it is in essence waived, and they can save up to \$20,000 without losing their Medicaid benefits.

Questions about the MEAD program can be answered by calling the local DHHS district office or visiting their website. See *Appendix C. Local, State and National Resources, page 128*, for the list of local DHHS district offices. The Benefits Specialist at your local CMHC can also provide information on this and other benefits programs.

## Town/City Welfare Assistance

If your loved one has applied for assistance or benefits through the SSA or DHHS, there will be a period of time that passes before they receive a notice of eligibility determination. It is important to know that your loved one has the right to apply for financial assistance through their town or city of residence to help meet their basic needs for housing, food, clothing, medication and medical care.

Application to apply for city or town assistance can be made by going to the town or city hall where they live and speaking with someone in the Welfare Department. The contact information is listed in the front of the local telephone directory. It is best to call and schedule an appointment because many Welfare Departments are open limited hours, especially in smaller towns.

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The application process is similar to that for the DHHS and SSA programs. Applicants will be asked to complete an application and prove who they are, and verify where they live, who lives with them, rent/mortgage costs, utilities, medical expenses, income and resources. They will be asked to sign an agreement to repay any financial assistance they receive from the town or city, participate in a work program and/or acknowledge that the town or city can place a lien on any property they own.

They will be asked to provide documentation that they have applied to the DHHS and SSA for assistance or benefits. If they have not applied to the DHHS and SSA, the city or town Welfare Department will require that they do so and provide verification that the application was filed.

The city or town Welfare Department is required to provide applicants with a written eligibility determination, and if denied the reason for denial and information on the appeal process.

## Filing an Appeal

When an individual applies for any town, city, state or federal benefits or assistance programs, the agency is required to provide a written eligibility determination notice. If the individual is denied benefits, the notice must explain the reason why and provide information on how to file an appeal if the applicant disagrees with their decision.

1. An appeal should be filed if the agency has made a factual error or a mistake in applying or interpreting a law. **IT IS IMPORTANT TO FILE THE APPEAL AS SOON AS POSSIBLE AFTER RECEIVING THE DETERMINATION NOTICE.** Most appeals must be filed within 30 or 60 days of the date of the eligibility determination notice.

The appeal process is a regulatory procedure that requires knowledge of the rules and regulations of the specific programs and experience in gathering and presenting information. We encourage individuals and families to seek out someone who “knows the system” to guide them or represent them in the Appeal Process. The CMHC staff can provide referrals to individuals who can help with this process or contact NAMI NH's Information and Resource (I&R) Line 1-(800) 242-6264, Ext. 4.

## Who Can Help When Questions Arise?

As indicated in this chapter's overview, we encourage individuals to seek out someone who “knows the system” to assist them when seeking funding for services or answers to questions about benefit programs. The system is fragmented and is confusing to most people. The good news is that there are resources available to individuals with mental illness and their families that can provide information, support and legal guidance. **The Benefits Specialist at each CMHC can be an invaluable resource to your loved one and you as you navigate the benefits system.**

Many questions can be answered by going directly to the agency or organization and speaking with your loved one's assigned worker or an agency representative. You can request they send you informational booklets or go to their website for details about

## Chapter 8. Paying for Services

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eligibility, how to file an application, the appeal process and answers to Frequently Asked Questions. For a listing contact information for the DHHS and SSA, see *Appendix C. Local, State and National Resources*, page 142.

However, sometimes, you may need additional technical support or expertise.

### **NAMI NH**

NAMI NH's Information & Resource (I&R) Line 1-(800) 242-6264, Ext. 4, is staffed by individuals who are knowledgeable about the systems, the resources available, and how to make referrals. If a caller needs more one-to-one assistance, the I&R Specialist will refer them to the Family Support Specialist. NAMI NH offers education programs and support groups which address, among other mental health topics, benefits and entitlements. Staff can connect you to other family members who can provide invaluable information to you and share their firsthand knowledge of how they have successfully negotiated the assistance and benefit programs with their loved ones.

### **Community Mental Health Centers**

If your loved one is in treatment at the CMHC, then you can ask to speak with the Benefits Specialist or their case managers who can assist you with the application process, appeal process, and/or other funding questions. If there are questions about how benefits may be impacted if your loved one goes to work, then he or she can speak with an Employment Specialist or the Benefits Specialist at the CMHC.

### **Legal Resources**

In some cases, legal counsel maybe needed. You may want to contact the Disability Rights Center (DRC) which is the federally designated protection and advocacy agency in New Hampshire and authorized by federal statute to act on behalf of individuals with disability-related problems. Besides the DRC, there are other resources such as the Legal Advice and Referral Center (LARC) that can assist in finding an attorney and NH Legal Assistance. There are also attorneys who can be retained and who specialize in disability law. These can be located by contacting the NH Bar Association. For contact information, see *Appendix C. Local, State and National Resources*, page 147.

### **Other Resources**

There are other agencies and organizations that can provide information such as Granite State Independent Living, NH 2-1-1, and the Bureau of Vocational Rehabilitation. For a listing and contact information for these and other resources, see *Appendix C. Local, State and National Resources*, beginning on page 127.

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Our son has been on disability nearly his entire adult life because of the severity of his mental illness. Because he never really worked, he always received the minimum cash benefit available – less than \$700 a month. Luckily, he also got a rent subsidy, food stamps and Medicaid. Even then, he never had enough money to get through the month.

When I turned 65 and applied for Social Security, I was excited to learn that, since my son had become disabled before turning 21, he could now receive SSDI, based on my earnings. His monthly benefit nearly doubled! However, now that he had more income both his food stamps and rent subsidy were reduced, but he was still better off financially than he had been before – or so we thought. Then the state changed his Medicaid benefits, so now he had a “spend down” which meant that, essentially, he had to spend his cash benefits for medical expenses until he got down to the minimum benefit level again – less than \$700 a month.

Thank goodness we went and spoke with the Benefits Specialist at the mental health center. She was able to get his outstanding bills from NH Hospital and because of these bills he was able to meet the “spend down” and still has full Medicaid benefits and sufficient income to get through the month.

***Parent of Adult Medicaid Recipient***

## **Chapter 8 Notes**

1. Krumm, Janet M. and Larsen, Jan. *Benefits 101: An easy to understand explanation of Federal and State cash and medical benefits*. The New Hampshire Challenge. 2003, Vol. 15, 4.



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# Chapter 9. Relapse Prevention and Crisis Management

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## Chapter Overview

*As a family member, significant other or close friend you are most likely to have noticed an early change in your loved one's behavior or thinking that in looking back it was a quiet signal that things were about to go in the wrong direction. You are often the first to see when your loved one is experiencing increased symptoms and may be in need of help; you are just as likely to be one of the first to recognize that a relapse has passed and he or she has returned to his or her previous level of functioning and back on the path of recovery.*

*This chapter is about planning during periods of stability for those times when things are not going well. You will learn about the episodic nature of*

*mental illness, warning signs of relapse, and two major strategies used to help individuals with a serious mental illness resume their journey on the road to recovery.*

*The intent of this chapter is to provide you with information you can use to support your loved one and work with their treatment team to develop a Relapse Prevention Plan and a Crisis Management Plan. Even if at the present time your loved one is not allowing you to have an active role in their ongoing treatment, understanding these processes will be helpful for you. Keep in mind that in times of crisis, it is important to take care of yourself so you can continue to be a support to your loved one.*

### Chapter Content

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### The Episodic Nature of Mental Illness

While some people who experience mental illness may fully recover and never have an episode again, other individuals will experience another episode, or a number of episodes, during their lifetime. These painful interruptions, the worsening or return of specific symptoms of the illness, are commonly referred to as “acute episodes” or “relapses.” How individuals experience the course of their mental illness is as different as individuals are unique. Some people have milder forms of the illness and only experience an episode once or twice in their lives. Others have more intense forms of illness and have several episodes which may or may not require hospitalization. Individuals with the same diagnoses may have very different courses of the illness. **Diagnosis alone is not a predictor of the course of an illness or its outcome.**

Scientists and medical research have not been able to identify all the reasons people have relapses. The research has shown, however, that relapses are more likely to occur when people are under more stress, or stop taking their medications, or use alcohol or drugs. The research has also indicated that somewhere between 50% and 70% of individuals with serious mental illness experience changes in their feelings, thoughts and behaviors that signal an increase in symptoms. These changes are commonly referred to as “early warning signs,” and while similarities do exist, they are often specific and unique to the individual.

“**Relapse Signature**” is a term sometimes used to describe those early warning signs that are unique to the individual and can be used to predict if he or she is experiencing a relapse. Examples of someone’s relapse signature can be a common everyday behavior for others, but a behavior that is totally out of character for the individual such as whistling in the morning, wearing lipstick, fingernail biting, or wearing sunglasses.

Identifying early warning signs as quickly as possible means an individual can take positive steps to seek help early to minimize or possibly prevent the impact of a relapse on their life.

**Early intervention has been shown to reduce the severity of symptoms, shorten the duration of relapse and reduce the likelihood of further episodes.**

### Relapse Prevention and Planning

Relapse prevention is one of the major “illness self-management skills” or “wellness promotion” taught in programs such as Illness Management & Recovery (see *Chapter 7, page 65*) and will be learned by your loved one when he or she engages in this evidenced-based practice. Because of its usefulness, this skill is sometimes lifted out of the IMR curriculum and taught by itself. In either case, a relapse prevention plan includes identifying the following:

- Triggers,
- Early warning signs,
- Strategies that have helped, and
- Supports.

By completing this four step planning process, your family member will have all of the ingredients necessary to write a **Relapse Prevention Plan**. In putting the plan together, it may be helpful for your loved one to consult with supportive people in his or her life. Peers, family members, and practitioners can be of assistance in remembering other details about



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what helped in past situations and can make suggestions about other possible steps your loved one can take if early warning signs appear.

The following is a description of the four steps used to guide an individual through the relapse prevention planning process:

### **Step One: Triggers**

They are encouraged to identify those external situations and events that he or she believes may have contributed to past relapses. These situations and events can be thought of as having triggered the relapse. Common examples may include such things as:

- interpersonal arguments;
- feeling overwhelmed by external demands such as work deadlines;
- isolation or avoidance of friends;
- the ending of a relationship;
- feeling well and stopping medication or missing appointments;
- spending money frivolously;
- either positive or negative life changes; and/or
- drinking beer or smoking marijuana with friends.

### **Step Two: Early Warning Signs**

Next they are asked to identify those internal feelings, thoughts, and behaviors which he or she experienced in the days leading up to past relapses. For some people, the changes might have been so subtle at first that they did not seem worth noticing. For others, the changes were more obvious and distressing. When people look back after a relapse, they often realize these early changes, even the slight ones, were signs they were starting to experience a relapse. Common examples may include such things as:

- feeling tense or nervous;
- eating less or more;
- sleeping too much or too little;
- feeling depressed or unhappy,
- not wanting to be around people;
- feeling irritable;
- difficulty concentrating; and/or
- thinking that people are out to get you;
- hearing voices;
- drug or alcohol use or abuse;
- being overconfident about your abilities;
- feeling unsafe or threatened; and/or
- dwelling on past events.

### Step Three: Strategies That Have Helped

Here they are asked to list those steps that were taken in the past that helped him or her when they were experiencing early warning signs. These are the strategies that your family member believes were (or will be) helpful in avoiding a worsening of his or her symptoms. Common examples of steps frequently reported by others include:

- review skills and strategies learned in IMR such as ways to cope with stress;
- talk with friends at the Peer Support Agency;
- make a special appointment with your counselor;
- use relaxation techniques;
- call your psychiatrist to consider a temporary medication adjustment; and/or
- ask for more support from friends and family.

### Step Four: Supports

As the final step, they are asked to identify those people who can help notice early warning signs and who can be supportive in avoiding a relapse. Thinking back on past relapses, your loved one may, with your help and the help of other family members, friends, co-workers, and mental health practitioners, be able to identify warning signs he or she did not recognize at the time. **Remember, the earlier warning signs are detected, the greater the likelihood a relapse can be prevented or its severity lessened.**

There are several factors that may be important to your family member in selecting suitable “helpers” to assist in identifying early warning signs and in providing pre-planned ways of help and support. These factors include:

- is the person supportive and interested;
- is he or she trustworthy;
- do they know something about your loved one’s illness;
- has he or she noticed warning signs in the past;
- have they been helpful before during episodes of illness;
- can they be available; and/or
- would he or she be willing to help in this way?

After this planning process is completed, then a Relapse Prevention Plan is written. This plan can be useful to both your loved one and their support system. Hopefully, they will share this written plan with you and others who support them. For a sample Relapse Prevention Plan, see *Appendix D. Forms You Might Find Useful*, page 158.

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When my sister's therapist suggested she develop a Relapse Prevention and Crisis Management Plan, I admit I was skeptical. I had seen my sister go through the ups and downs with her illness for over ten years. Yes, I often could see early on when she was starting to get worse, but she never listened to me when I would tell her my concerns.

Just going through the process of developing the plan was incredibly helpful. She was doing fairly well at that point and seemed surprised when I shared the red flags that I would see before anyone else, even she, picked up on them. When the time came and she started to get worse, I had the support of her therapist when I told her what I was seeing. My sister was angry and annoyed with me and her therapist, but, after telling us how crazy we were, she calmed down and agreed to a small increase in medication that seemed to help.

Having the plan didn't make the process any more pleasant, for sure. (She was really angry.) But it made it easier for me because I was following the plan we'd agreed upon together with her therapist. I didn't feel like I was begging or forcing her to do something she didn't want to do.

*Family Member of an Adult with Mental Illness*

## Crisis Management Planning

Even with your loved one's best relapse prevention efforts, his or her symptoms may progress to the point where they are very uncomfortable, serious, and even dangerous. For this reason, it is important for families and their loved ones to plan for the possibility of a future crisis when things are stable.

Individuals with mental illness should take as much time as necessary to develop a plan that feels right and has the best chance of working for her or him. Developing a **Crisis Management Plan** that is clear and easy to understand can be done when your family member is well. A crisis management plan differs from a relapse prevention plan as it can be used by others to help the individual with mental illness when they are in crisis. The plan helps the individual maintain responsibility for his or her own care by allowing him or her to instruct others in what they could and should do to be most helpful and supportive during a crisis. This plan prevents family members and friends from wasting time trying to figure out what to do and relieves the guilt they may feel when making decisions.

Preparing a Crisis Management Plan involves decisions that take time, thought, and collaboration with healthcare providers, family members and friends. Once completed, copies of the plan should be given to those people who are named and asked to be important players in the plan. Keep in mind these plans can be changed. They belong to the individual and it is important for him or her to feel as comfortable as possible with their plan so that its likelihood of being used is maximized. The following information has been adapted from *Action Planning for Prevention and Recovery: A Self-Help Guide* published through SAMHSA'S National Mental Health Information Center; see *Appendix E. Suggested Reading, beginning on page 161*.

### Step One: Feeling Well

The individual should describe what he or she is like when they are feeling well. What does a typical day look like, what responsibilities do they fulfill, how do they occupy their time, and who do they spend their time with? In other words, where on the road to recovery was your loved one before the crisis occurred?

In order for those responsible for the management of the crisis to know when they have been successful and when the person can safely return to their normal everyday routines, it is important for them to know what the individual's baseline or pre-crisis level of functioning was like.

### Step Two: Crisis Symptoms

This is perhaps the most difficult of all the steps in the Crisis Management Plan. Here the individual describes those symptoms that would indicate to others they need to take control of their care and make decisions on his or her behalf.

No one likes to think someone else will have to take over this responsibility. Yet, through a careful, well-developed description of the symptoms the individual would indicate when he or she cannot make smart or good decisions anymore; they can stay in control even when things are out of control.

This step should not be hurried. Even though the final decision about what symptoms are listed belongs to the individual, it would be highly useful for him or her to seek the input of family members, friends and others who have personally observed them when experiencing a crisis. Such a list might include:

- being unable to recognize or correctly identify family members and friends;
- inability to sleep;
- uncontrollable pacing or inability to stay still;
- displaying abusive, destructive, or violent behavior, toward self, others, or property;
- refusal to eat or drink;
- neglect of, or no concern for, personal hygiene;
- inability to understand what people are saying;
- believing to have abilities that clearly don't exist or being controlled by voices from within; and/or
- uncontrollable use or abuse of alcohol or drugs.

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### Step Three: Supporters

This step names the people who have agreed to take control when the symptoms described in Step Two arise. Before placing anyone's name on this list, however, the individual should talk with the person to be sure they understand and agree with the plan and know what part in the plan they are being asked to fulfill. Typically, the people who are willing to take on such responsibility are family members, close friends and mental health providers. To assure availability and avoid such issues as vacations and sickness, it is best to identify at least five people on the list of supporters.

If your loved one is in crisis, this plan can help him or her realize they are in crisis and it is time to let their supporters know they should take control. However, in certain situations, your loved one may not be aware, or willing to admit, that a crisis exists. This is why having a strong team of supporters is so important. The team will observe the symptoms your loved one has identified and take over responsibility for their care, whether or not they are willing to admit they are in crisis.

### Step Four: Healthcare Providers and Medications

The individual's Crisis Management Plan should include the names and phone numbers of those healthcare practitioners involved in his or her care. The providers can be an important source of information for those who will be responsible for stabilizing the crisis. It is also very important for the individual to list all the medications he or she is currently taking including the dosage, as well as the reason why they were prescribed.

A more comprehensive Crisis Management Plan could also include a list of those medications the individual would prefer to take if medications need to be changed or additional medications need to be tried. **It is important to list those medications that must be avoided because of past allergic reactions, conflict with other medications, or undesirable side effects.**

**Also, suggest that if they are a parent of minor children, the individual should identify who can take care of their children during their illness. They should identify one or two close family members or friends who know the children well and agree to take on this responsibility.**

### Step Five: Current and Past Treatments

It is useful for a Crisis Management Plan to include a list of those treatments and interventions the individual has identified as being helpful in past crises and those that he or she remembers as having been unhelpful. It can also be useful to those who will be responsible for stabilizing the crisis to know what types of treatments were being provided before the crisis and those that have been, or have not been, most effective.

### Step Six: Planning for Crisis Care

The individual should consider whether or not he or she possesses the supports and resources that would enable him or her to try to stabilize the crisis at home:

- Are there friends and family who could provide almost around the clock support?
- Could transportation be arranged to healthcare appointments?
- Are there mental health programs in your community that could provide him or her with safe and structured care part of the time, with family members and friends filling in the rest of the time?

The goal is to ensure the individual is provided support and treatment in the least restrictive environment.

### Step Seven: Preferred Treatment Facilities

If it is decided the crisis cannot be safely managed at home, this step of the plan must identify which hospital or hospitals your loved one would prefer to enter. This is a good time to figure out such things as admission and discharge procedures, insurance coverage questions, relationships with your loved one's community treatment providers, transportation, visitation policies, etc. Because options may be limited by the facilities available in your area and/or by insurance coverage, it is best to make these determinations before there is a crisis.

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### **Step Eight: Recognizing Recovery**

In this final step, the individual should identify those indications that signal to him or her and, just as importantly, to others that he or she has recovered from the crisis enough to once again take responsibility for herself or himself. Improved sleep patterns, eating habits, and physical activity as well as increased interpersonal communication, emotional regulation, concentration, and ability to complete tasks are some of the common indicators.

Like the Relapse Prevention Plan, the Crisis Management Plan needs to be clear and easy to understand. It is important the individual shares copies of the Crisis Management Plan with the supporters listed in it and make sure they understand it. It is also a good idea to review and update the plan as often as necessary. Things change; so too, should this plan. For a sample Crisis Management Plan, see *Appendix D. Forms You Might Find Useful, page 159*.

To learn more about relapse prevention and crisis management, see *Appendix E. Suggested Reading, beginning on page 161*.





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## Chapter 10. Suicide Awareness & Prevention

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### Chapter Overview

*Many of the warning signs discussed in this chapter echo those described in the preceding chapter on relapse prevention and crisis management. Despite the similarity, however, the risk of dangerousness or self-destructive behavior needs to be looked at separately.*

*In this chapter we will learn about suicide, suicide risk, and the relationship between mental illness and suicide. We*

*will look at steps that can be taken to help recognize someone at-risk and connect that person to services to prevent suicide, as well as risk factors and warning signs. Within the chapter are suggestions about what we can do when we are concerned that someone we love may be suicidal and how to work with our loved one and their treatment team in designing a Safety Plan.*

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### Suicide and Suicide Risk in Adults

In New Hampshire, suicide is the second leading cause of death (after unintentional injuries) for individuals between the ages of 10 and 34; and the fourth leading cause for individuals between the ages of 35 and 54. Although illnesses such as heart disease and cancer are the primary causes of death in middle-aged and older adults; suicide remains in the top ten causes of death across the lifespan. In men, suicide rates increase as they get older. Men are four times more likely to die by suicide; women are 2 to 3 times more likely to attempt suicide and survive. Suicide deaths, however, are just the tip of the iceberg with the number of attempts far outnumbering suicide deaths. For example, in New Hampshire in 2005, there were a reported 162 suicide deaths and 721 hospitalizations due to suicide attempts.

#### Definitions

(Institute of Medicine, 2002)

<b>Suicidal Ideation:</b>	Thoughts of harming or killing oneself.
<b>Suicide Attempt:</b>	A non-fatal, self-inflicted destructive act with explicit or inferred intent to die.
<b>Suicide:</b>	Fatal self-inflicted destructive act with explicit or inferred intent to die.

### Mental Illness and Suicide Risk

The Centers for Disease Control and Prevention (CDC) estimate that 90% of people who kill themselves suffer from depression or another diagnosable mental illness or substance use disorder (many of which went undiagnosed and/or untreated). While our information regarding diagnosis and suicide is not yet the product of an exact science, the work of the American Foundation for Suicide Prevention (AFSP)<sup>1</sup> has produced some thought-provoking observations. While some of the following statistics may be alarming, it is important to note suicide risk is highest in individuals with **untreated** mental illness. The good news is that there are very effective medications and treatments for mental illness that will reduce both symptoms and the risk of suicide.

I knew my daughter had a tendency to feel depressed and anxious. She had had a rough year in high school, but then, after seeing a counselor, rebounded and graduated at the top of her class. Off she went to the college of her choice; she said she loved it there and seemed to be truly blossoming.

Late in her freshman year she called to tell me she was in a Crisis Stabilization Unit because she was suicidal. I knew it was serious then and responded immediately; driving the three hours to get there; talking to the clinicians, the school, her counselor and primary care provider. What I didn't know then was that the shift in my world that had occurred that day was to be permanent.

My daughter has done all the things she's supposed to in terms of treatment and she is living on her own. But I am never without my phone – and the rare times it rings late at night or early in the morning, I never pick it up without thinking it could be the worst news.

*Family Member of an Adult with Mental Illness*

### Depression and Suicide Prevention

- **Although most depressed people are not suicidal**, over 60% of all people who die by suicide suffer from major depression. If one includes alcoholics who are depressed, this figure rises to over 75%.
- Thirty percent of all clinically depressed patients will attempt suicide.
- Depression is among the most treatable of psychiatric illnesses. Between 80% and 90% of people with depression respond positively to treatment; nearly all of those with depression and who are treated gain some relief from their symptoms.

**Early recognition of and treatment for depression significantly helps prevent the risk of suicide.**

### Schizophrenia and Suicide Prevention

- Co-occurring depression is probably the most important risk factor for suicide in schizophrenia. Researchers have found that only 4% of those with schizophrenia who exhibit suicidal behavior do so in response to voices telling them to kill themselves.
- The risk for suicide is high among individuals with schizophrenia. It is estimated that 20% to 40% make suicide attempts and over 10% of individuals with schizophrenia eventually complete suicide.
- While there is no cure for schizophrenia, it is a highly treatable disorder. In fact, the treatment success rate for schizophrenia is 60%.

**Key to the prevention of suicide among this group of individuals is early recognition and treatment of their disorder.**

### Bipolar Disorder and Suicide Prevention

- Between 25% and 50% of persons with bipolar disorder make at least one suicide attempt.
- Studies indicate that most bipolar patients who die by suicide communicate their suicidal state to others – most often through direct and specific statements of suicidal intent.

- Hopelessness, a family history of suicide and previous attempts are all factors which indicate an increased risk of suicide for individuals with bipolar disorder.
- Maintaining treatment for bipolar illness is critical: the suicide rate in the first year off lithium treatment is 20 times that during treatment.

**Early and accurate diagnosis of bipolar disorder and aggressive treatment of symptoms by professionals are essential in preventing suicide.**

### Suicide Prevention: The Actions We Can Take

Despite a growing body of research and increasing public attention on suicide prevention, there is no single foolproof strategy for its prevention. Occasionally, even when all the “right” treatments and supports are in place, an individual may still die by suicide. However, by learning about mental illness and the risk factors and warning signs of suicide, families can play an important role in reducing the risk and helping to prevent suicide. There are three important steps that families can take to help prevent their loved one’s suicide:

1. Families are often the first to **RECOGNIZE** that their loved one is having difficulty and may be at-risk for harming him or herself.
2. Families can **CONNECT** with their relative, first by listening and then by asking direct questions about their loved one’s safety, e.g. “Are you thinking about killing yourself?”
3. **CONNECTING** their family member with a professional who can assess the level of risk and get him or her the help they need.

Like any medical illness, early recognition and treatment is a major key to suicide prevention. An individual who is thinking of harming or killing him or herself almost always exhibits some advance warning signs. *In fact, research has shown that most people who are suicidal are ambivalent about dying and they often give signals or make statements that they are contemplating taking their life before making a suicide attempt.*

### Risk Factors and Warning Signs

#### ***Risk Factors for Suicide***

Risk factors are characteristics that are statistically associated with suicide. Risk factors do not predict imminent danger for a particular person. Rather, they are an indication that an individual may be at a higher than normal risk.

Although risk factors often include observable behaviors, they can also include other factors (like having known someone who died by suicide) that might not be readily observable to someone who only casually knows the individual. Many risk factors are uncovered during the process of having an assessment done by a qualified physician or mental health provider. While mental illness and substance use are high among the risk factors for suicide, there are others as well to which to be attentive. Other risk factors, especially when combined with mental health problems, can increase the risk for suicide.

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The following list of risk factors is a composite of those identified by the Centers for Disease Control, the National Center for Suicide Prevention, the Suicide Prevention Resource Center, and NAMI NH.

#### **Personal Risk Factors**

- History of depression or other mental illnesses (particularly schizophrenia, anxiety disorder, and personality disorders)
- History of alcohol and other substance use disorders
- History of trauma or abuse
- Stressful loss (relationship, job, freedom, security, identity, status)
- Feelings of hopelessness, helplessness, or powerlessness
- Impulsivity and/or aggressiveness
- Isolation or a feeling of being cut off from other people
- Life changing or threatening physical illness
- Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma)

#### **Behavioral Risk Factors**

- History of previous suicide attempt(s)
- Aggression, rage, defiance
- Fascination with death and violence
- High risk or reckless activities and behaviors

#### **Environmental Risk Factors**

- Family history of suicide (particularly around the anniversary of a family member's death)
- Easy access to lethal means (e.g. firearms)
- Local clusters of suicide that have a contagious influence
- Stigma associated with help-seeking behavior
- Lack of social support system
- Lack of access to mental health or substance use disorder treatment

## Chapter 10. Suicide Awareness & Prevention

Most people will experience some risk factors; however, what is important is to look for changes in behavior. **When you are aware of such risk factors or changes, keep communication open with your family member and involve others who can help provide support or supervision as needed, and let your loved one know where they can find help.**

### ***Suicide Warning Signs***

Many people give “**warning signs**” when they are thinking of attempting suicide. Family members should pay close attention if they see, hear or sense any of the warning signs described below. Because of the strong correlation between suicide and mental illness (90% of those individuals who kill themselves have depression or another diagnosable mental illness), many of the warning signs associated with suicidal thought and behaviors are very similar or even identical to those early warning signs identified in *Chapter 9. Relapse Prevention and Crisis Management*, page 92.

While depression is a major theme in individuals with suicidal ideation, it is important to remember that most people who are depressed are not suicidal. It should also be noted that a person can appear to be stable, or have a sudden rush of improvement in mood, and still be suicidal. Therefore, any unusual or sudden change in behavior should be cause for caution and all warning signs for suicide should be taken seriously. Family members should not hesitate to discuss any of the following warning signs with their family member and their treatment provider. **Remember, even if your loved one has not signed a release allowing their provider to talk to you, you can talk to the provider and share your concerns for your family member’s safety.**

Suicide Warning Signs: Cause for Concern
<ul style="list-style-type: none"><li>▪ Feeling hopeless</li><li>▪ Feeling rage or uncontrolled anger or seeking revenge</li><li>▪ Acting reckless and engaging in risky behaviors</li></ul>
<ul style="list-style-type: none"><li>▪ Feeling trapped or believing that there is no way out</li><li>▪ Increasing alcohol or drug use</li><li>▪ Withdrawing from friends, family, and society</li><li>▪ Feeling anxious or agitated, being unable to sleep, or sleeping all the time</li><li>▪ Experiencing dramatic mood changes, or sudden improvement in mood</li><li>▪ Seeing no reason for living, or having no sense of purpose in life</li></ul>



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### **Suicide Warning Signs: Cause for Immediate Action!**

- Threatening to hurt or kill oneself, or talking about wanting to hurt or kill oneself
- Looking for ways to kill oneself by seeking access to firearms, drugs, or other means
- Talking or writing about death, dying, or suicide when these actions are out of the ordinary

**Seek help as soon as possible by contacting a mental health professional or by calling the National Suicide Prevention Lifeline at 1-(800) 273-TALK (8255), if your loved one exhibits any of the above signs.**

**If the person is in imminent danger of hurting themselves and/or others, call 911.**

**Do not leave the person alone; wait for help to arrive.**

The majority of suicide attempts are expressions of extreme distress and/or symptoms of depression or another mental illness, not just harmless bids for attention. **All warning signs and attempts should be taken seriously.**

## **Things You Can Do When You Are Concerned**

### **1. Talk to your loved one about your concerns.**

If your loved one says, “I want to kill myself,” or “I wish I were dead,” or makes a similar, less direct statement, always take the statement seriously. Seek evaluation from their treatment provider or a psychiatrist, physician, or other qualified mental health professional.

Families often feel uncomfortable talking about death. However, asking your loved one whether he or she is depressed or thinking about suicide can be helpful. Rather than “putting thoughts in the person’s head,” such a question from you will provide assurance that somebody cares, and it will give the person at-risk a chance to talk about their problems and access help.

### **2. Make sure your loved one does not have easy access to lethal means.**

Remove from the vicinity any firearms, poisons, sharp objects, or medications that could be used in a suicide attempt. Death by firearms is the fastest growing method of suicide accounting for 52% of all suicides. (CDC statistics show that firearms are the most commonly used method of suicide among males and poisoning is the most

common method of suicide for females.) Depending on the situation, car keys should also be taken and held until the crisis has past.

Medications can be lethal in high doses. Dispose of old medication. If you are concerned about the amount of medication available to your loved one, ask their doctor to write prescriptions for shorter periods of time, e.g. two weeks instead of one month.

- 3. Educate yourself about your loved ones illness, symptoms, risk factors and know the warning signs for suicide. If you are seeing warning signs or are concerned, ask them directly if they are thinking about killing themselves.**

**Don't worry alone!** Seek professional help and describe your concerns to a qualified professional to see if your relative should be assessed. Contact your family member's psychiatrist or mental health provider. If they are unavailable, contact your Community Mental Health Center's Emergency Services or call the National Suicide Prevention Lifeline at 1-(800) 273-TALK (8255). **If it is a medical emergency, call 911.**

- 4. Provide supervision until there is substantial reason to believe the person is not at-risk of attempting suicide.**

If you have concerns about your loved one's safety or mental health condition, involve other key people such as trusted family, friends, neighbors, or others in the community who can maintain contact with your family member, watch for warning signs, and help him or her feel connected to supportive people who care.

### ***To Hospitalize or Not***

It is a common misconception that a successful suicide prevention effort results in hospitalization. In fact, situations requiring inpatient hospitalization are rare. Most people who are contemplating suicide can be treated effectively in the community and few require hospitalization. With communication, treatment, and support from family and friends, persons who are suicidal can return to a healthier pathway to recovery.

Today, Community Mental Health Centers (CMHCs) and private practitioners are able to manage suicidal individuals in community settings using better risk assessment tools, improved safety planning, more effective therapies and medications. Friends and family can play an important role in recognizing warning signs and communicating their concerns to the individual and the professional who is assessing or providing treatment to the individual.

## **Safety Planning**

Individuals who have made a suicide attempt; or who have been thinking about suicide; or have been identified as being at-risk for suicide; should develop a **Safety Plan**. It is essential for the Safety Plan to include family and/or other key members of the individual's support system. The plan will include working with the person and their support system to recognize symptoms which would indicate the person may be having a relapse or be in need of additional supports. It should also identify individual strategies for symptom management and relaxation, as well as information on medications prescribed, side effects to watch for, and dates of any follow up appointments. Lastly, it should clearly lay out who to contact (including phone numbers) and what to do in the case of an emergency regardless of the time of day or day of the week. In essence, a Safety Plan will look much like the Crisis

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Management Plan discussed in Chapter 9. In fact, for individuals who experience suicidal thoughts or have made suicide attempts, the plans are essentially the same.

It is important to recognize that suicide risk can change over time. Risk can either increase or decrease as a result of psychosocial stressors and can also be impacted by symptoms of a mental illness. This may mean an individual's risk level will need to be reassessed if there are indicators they or their family members have concerns, or there are changes in their mental status. The Safety Plan should take these variables into account.

## Healing After a Suicide

As one of the ten leading causes of death for all ages in New Hampshire, many families have experienced a loss due to a suicide. This loss can be devastating for family members and friends and even further compounded by the stigma associated with mental illness and suicide.

Those who lose someone to suicide are referred to as “survivors of suicide loss” and most struggle with intense, complicated grief which may include shame, guilt, self-blame, anger, relief, and other emotions. All are left to wrestle with the question of “why?”

**If you have, or someone you know has, experienced a loss from suicide, you do not need to be alone.** There are a variety of supports that are available to people, from books to internet resources to support groups and outreach programs. There are **Survivors of Suicide Loss Support Groups** available across New Hampshire for those who have lost a family member, friend or relative to suicide. Each November NH survivors gather at locations around NH to share a day of healing by taking part in the annual survivor teleconference produced by the American Foundation for Suicide Prevention.

Through the display of the NH Lifekeeper Quilt created by NH survivors in July of 2007 exhibited around NH and elsewhere the general public is educated about suicide resources and lets survivors know they are not alone. There is the **Survivors of Suicide (SOS) Loss Speakers Bureau** which is a NAMI NH program comprised of individuals who have lost a loved one to suicide and who have been trained to speak safely and effectively about their loss to the public. These families speak about the loss of their loved one, how they coped and continue to cope with the loss, and what has and has not helped along the way. Trainings are offered twice a year for survivors interested in joining the Speakers Bureau.

Supporting survivors of suicide loss not only helps survivors heal and not feel so alone in their grief, but because survivors are at an increased risk of suicide themselves survivor support is important in the prevention of further suicides. A variety of resources are available to survivors of suicide in NH. NAMI NH maintains information on these resources through its Connect Suicide Prevention Project, **[www.theconnectproject.org](http://www.theconnectproject.org)**. See *Appendix C. Local, State, and National Resources, page 154 and Appendix E. Suggested Reading, page 164.*

***After An Attempt: A Guide for Taking Care of Your Family Member  
After Treatment in the Emergency Department***

is a brochure available through NAMI National; or it can be downloaded through the following link:

***<http://download.ncadi.samhsa.gov/ken/pdf/SVP-0159/SVP-0159.pdf>*** or  
by contacting the NAMI NH Information & Resource Line  
1-(800) 242-6264, Ext. 4

### Chapter 10 Notes

1. *American Foundation for Suicide Prevention. [Online] [www.afsp.org](http://www.afsp.org)*

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# Chapter 11. Legal Terms, Considerations and Procedures

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## Chapter Overview

*In a previous chapter we addressed the rights of consumers in the mental health system. In this chapter we will provide an overview of a number of legal issues that may arise as a result of having a loved one with a serious mental illness. For example, there may come a time when you are concerned about your loved one's ability to make informed decisions about how they live, spend their money and take care of themselves. You may find yourself fearful for their safety or the safety of others. You may get a call that your loved one has been arrested and is in jail. **The information***

***in this chapter is intended to provide basic knowledge and is not meant to provide legal advice.***

*You and your loved one should always seek the advice of legal counsel. If you or your loved one cannot afford an attorney, there are a number of situations where he or she may have one appointed by the court. There are also free or low-cost legal resources available in the state. For contact information, see Appendix C. Local, State and National Resources, page 147.*

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# Chapter 11. Legal Terms, Considerations and Procedures

## Guardianship and Alternatives

It is important to remember that everyone, regardless of their mental health status, makes good and bad choices or decisions at times. When your loved one has a serious mental illness you will be concerned about the choices your loved one makes, but it is his or her ability to make “**informed decisions**” that should be examined closely. For example, if your loved one spends his or her lunch money one day on a pack of cigarettes, that may have been a poor choice. If he or she consistently spends his food money each month on things other than food, even after receiving assistance with budgeting, he or she may not be able to manage his or her own finances without help.

There are several alternatives available to someone who needs help with financial and/or medical decisions. These alternatives described below range from the most to least restrictive. It is in the best interest of the person with mental illness to ensure that he or she maintains as much autonomy as feasible, so the least restrictive alternative should be chosen.

### **Guardianship**

Guardianship is the **most restrictive** alternative available to someone who needs help with making decisions. As a family member, if you are going to seek guardianship it is important to obtain legal counsel and also speak with the mental health professionals who may be asked to testify at the court proceedings.

In order to be appointed guardian, you need to prove to the satisfaction of the probate judge that your loved one is incapacitated. Under New Hampshire law, incapacity “shall be measured by functional limitations. It shall be construed to mean or refer to any person who has suffered, is suffering or is likely to suffer substantial harm due to an inability to provide for his personal needs for food, clothing, shelter, healthcare or safety or an inability to manage his or her property or financial affairs.” NH RSA 464-A:2, XI.

If your loved one’s incapacity deals with money and property, then the court will appoint you as “**guardian over the estate.**” If his or her incapacity deals with personal care issues, then the court will appoint you as “**guardian over the person.**” In many instances, the court will appoint a guardian over both the person and estate. Nevertheless, when appointing a guardian, the court always looks for the least restrictive alternative. The person appointed as guardian over the estate will be required to post a bond (purchased through an insurance company) and must report to the court annually about the incapacitated person’s finances and health condition.

Note: Your loved one has an absolute right to legal counsel, which he or she will be financially responsible for the fees. The attorney will argue for the wishes of your loved one, even if doing so is not in his or her best interests. If your loved one is indigent, then the state will pay his or her legal fees. It is important to understand that having been diagnosed with a mental illness such as bipolar disorder or schizophrenia does **not** necessarily mean guardianship is needed.

The Probate Court will hold a hearing. The Court must notify the person over whom the petition has been filed of all hearings and proceedings. The person has the right to be at the hearing, and to present evidence and testimony. At the hearing, the person

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seeking guardianship will have to testify and provide evidence and/or witnesses as to why guardianship is necessary. He or she may be subject to cross-examination.

Although the guardian will have the authority to make decisions, he or she must always take into account the goals, values and desires of the individual over whom they have guardianship. The long term goal is for the individual to receive the supports and services needed to help him or her to be able to have the right to make his or her own decisions returned. The guardian should be sure to have copies of the guardianship papers available at all times. Situations will arise in which they will have to provide copies of these papers.

NAMI NH encourages family members to seriously consider whether it is in their best interest and that of their loved one to take on the role of guardian. In many cases, being in this role increases tensions in their relationship with their loved one.

### ***Public Guardian Services***

The services of public guardianship agencies are available for individuals who have no family or friends who are willing or able to serve as guardian. These agencies are under contract with the Department of Health and Human Services and may serve as sole guardian or may serve jointly with a family member or friend as co-guardians. Community Mental Health Centers and Area Agencies have procedures for seeking approval to use public guardians when necessary. See *Appendix C. Local, State and National Resources, page 142*, for a list of agencies.

### ***Alternatives to Guardianship***

You may be concerned about your loved one's ability to make informed decisions about where they live, how they spend their money and their medical care. Guardianship is the most restrictive option and many family members are unaware that there are less restrictive alternatives that can safeguard the rights of the individual with mental illness as well ensure his or her safety and well-being. These **less restrictive** alternatives allow the individual to have a voice in when and who is involved in their decision making, and, in some cases, under what circumstances. When put into place, they can be effective and make more restrictive action unnecessary.

The following is a simplified description of these less restrictive alternatives:

### ***Consent to Release Information***

A consent to release information signed by your adult family member allows their mental health or medical provider to share information with you. This consent to release information can be very broad or limited. **This is the least restrictive form of maintaining involvement in your family member's care, but does not allow you any decision making authority.**



# Chapter 11. Legal Terms, Considerations and Procedures

## *Authorized Representative*

An authorized representative is assigned for individuals who are not able to manage their own benefits through the New Hampshire Department of Health and Human Services (DHHS). See *Chapter 8. Paying for Services, beginning on page 73*, for more information on DHHS benefits.

## *Representative Payee*

A representative payee (often called “**rep payee**”) is assigned for individuals who are not able to manage their own Social Security Administration (SSA) benefits. This can be at the request of the applicant or another party who is concerned about the individual’s ability to manage their benefits. The attending physician provides a recommendation to SSA regarding the applicant’s ability to manage his or her funds. The representative payee is required to file an annual report with SSA accounting for the funds with which he or she has been entrusted. See *Appendix C. Local, State and National Resources, page 142*, in order to access the free SSA booklet, Rights and Responsibilities of the Representative Payee. For more information on SSA benefits, see *Chapter 8. Paying for Services, page 84*.

## *Durable Power of Attorney*

A durable power of attorney is a voluntary agreement in which an individual asks someone (an “**agent**”) he or she trusts to make financial or medical decisions. The document is usually prepared by an attorney, but individuals can prepare their own. The power of attorney document can be very specific as to what authority the individual is giving the agent. **This is a voluntary agreement, so it is important to note that it can be revoked at any time by the individual.** The agent is not subject to supervision of the court; however, if he or she abuses the power of the attorney, the court can, upon review of the case, remove him or her from that role. New Hampshire law has very specific requirements about the format of the power of attorney, and a power of attorney that does not comply is void. Therefore, it is recommended that a competent attorney prepare this document. There are two types of powers of attorney. A “**durable power of attorney**” deals with financial and business issues, and an “**advance directive**” deals with medical and end-of-life issues.

## *Conservatorship*

A conservatorship can be considered a midpoint between “power of attorney” and “guardianship.” With conservatorship, if an individual needs help in making decisions (often used to manage income or property), he or she can ask for a “**conservator**” to be appointed by the probate court. The conservator does the same things that an agent does under a durable power of attorney, but the conservator is appointed by the court and operates under supervision of the court.

## Estate Planning

Because state and federal benefit programs have limits on how many assets an adult with disabilities can hold before losing benefits, you may want to consult an attorney when doing

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your own estate planning. It is possible, usually through a Special Needs Trust, to leave assets for your loved one without jeopardizing their cash and, perhaps more importantly, medical benefits. Establishing a trust is usually the safest way of ensuring your estate will be used as you intend for the benefit of your loved one with mental illness. If you simply leave the assets to another family member with instructions they should “take care of” your loved one, the assets could be jeopardized if, for example, there is a divorce or other legal financial judgment against that family member.

There are many attorneys in New Hampshire who are qualified to advise you and set up a trust for your loved one’s future. Make sure the attorney you select is familiar with disability law in order to ensure future public benefits to your loved one will not be adversely affected by the plans you are making. To find an attorney who specializes in disability law and estate planning, contact the National Academy of Elder Law Attorneys ([www.naela.org](http://www.naela.org)) or The New Hampshire Bar Association. See *Appendix C. Local, State and National Resources*, page 147.

## Involuntary Hospitalization and Treatment

### ***Involuntary Emergency Admission (IEA)***

An IEA is a legal process that can be very difficult for both the individual and their family. It is a process that takes away an individual’s rights. The goal of an IEA is to provide treatment to stabilize the individual so he or she can return to the community. An IEA should always be used as an intervention of last resort. Every effort should be made to provide the necessary services and supports to maintain the individual in the community. An IEA can be only made to facilities identified by the State of New Hampshire as a Designated Receiving Facility (DRF). New Hampshire Hospital (NHH) is the primary facility in the state. The CMHC emergency staff will be aware of other DRFs available.

The IEA process begins with a mental health evaluation at the local community mental Health Center (CMHC) or in a local emergency room by a member of the CMHC’s Emergency Services staff. If it is determined that the individual meets the defined criteria, an IEA petition is completed. The petition is submitted by the “petitioner” who must provide, in writing, examples of the symptoms and/or behaviors that support the reason for the petition.

**Due to the adversarial nature of the process, NAMI NH does not recommended a family member act as a petitioner.**

Witnesses can provide written statements. A psychiatrist or medical doctor who has privileges to admit to NHH must also complete the section of the petition that certifies he or she feels the IEA is necessary. The individual is then transported to NHH either by the county sheriff’s department or by ambulance. Note: there are situations where transport by ambulance is not an option and other times, it is the best option. This should be discussed with the CMHC Emergency Services staff.

Upon admission, the individual will receive a physical examination and meet with a psychiatrist. The person’s rights and responsibilities are provided to them in writing

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and reviewed. The individual will then be assigned to a treatment team consisting of a psychiatrist, social worker, nurse, psychologist and case manager. Families can contact the hospital and ask for the name of the social worker to whom their loved one has been assigned. This person can be a contact for the family if the hospitalized individual signs a release of information. The individual will meet with his or her treatment team on the next business day following admission. Discharge planning begins at admission. Family members, community mental health providers and anyone who the individual identifies can be invited to these meetings with their consent.

Within three business days of admission, a probable cause hearing is held at NHH. At this hearing a judge hears the evidence regarding the IEA and makes a determination whether there was probable cause for the involuntary admission. The individual may choose to be represented by a private legal counsel, or can be assigned a court-appointed attorney who will represent him or her at the hearing.

The individual may choose not to attend the probable cause hearing. **Only the petitioner is required to attend.** The petitioner explains to the court their reasons for petitioning for this admission and must provide recent examples of why they felt this was necessary. The petitioner may ask questions of the individual who has been involuntarily admitted. The individual's attorney may cross examine the petitioner. The court then makes a decision on whether the IEA is **"founded"** – meaning that the individual's rights were not violated and he or she can be held at the hospital for up to (10) ten calendar days. The judge can either make a decision and share it at the hearing, or decide to "take it under advisement" and issue a decision within 24 hours.

***Note: Family members can contact the legal department at the hospital to have the process explained to them or they can contact NAMI NH 1-(800) 242-6264 and ask for assistance through the Information & Resource line, Ext 4.***

If the IEA is upheld, the individual will receive treatment at the hospital, such as medications, rehabilitation treatments, and individual or group therapy. If the IEA petition is not upheld, the individual can be released as soon as the hearing ends or within a few hours. If the treating psychiatrist, in consultation with the treatment team, believes there is a need for a longer stay at the hospital, he or she can offer the individual a "voluntary" admission. This means the individual can sign him or herself into the hospital; however, it also means he or she can choose to leave when he or she wants. This requires they sign a form giving 24 hours notice that they are requesting release. The psychiatrist, again in consultation with the treatment team, can also decide the need for a probate commitment.

### ***Probate Commitment to New Hampshire Hospital (NHH)***

If at the end of the ten-day period the treating psychiatrist believes the individual is in need of a longer hospitalization because of his inability to care for himself or because he presents as a danger to himself or others, a petition for a **probate commitment** to NHH is initiated. This petition is filed with the county Probate Court. In this instance, the burden of proof is on the State of New Hampshire to show by clear and convincing evidence the individual needs to remain hospitalized for a longer period of time. The original petitioner of the IEA may be subpoenaed to testify. The individual will receive a psychiatric evaluation by a court-appointed, independent psychiatrist who will submit a report to the court as to whether or not the individual should be held at NHH under the criteria of the law for involuntary commitment.

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The length of commitment to NHH requested by the state varies from three months to five years. NHH must include in its petition the length of the commitment being requested; however, the length of the commitment is at the discretion of the court. If, after the court hearing, the petition for commitment is granted, the individual can be held at NHH for the length of commitment or can be released on a “**Conditional Discharge.**”

This longer admission allows for the individual to receive treatment for his or her symptoms, and, once stabilized, to be discharged to the community on an absolute discharge (i.e. a discharge with no conditions needing to be followed). Individuals who are committed for longer periods (6 months to 5 years), typically take longer to stabilize, and when discharged are released on a conditional discharge.

### ***Conditional Discharge (CD)***

The Conditional Discharge was one of the best things that ever happened to my brother. He doesn't think he has schizophrenia, but he knows he doesn't want to go back to the hospital, so he does everything his treatment plan says he should. He takes his medication every day; he goes to AA meetings every day; he was able to get his driver's license back; he worked with the Employment Specialist at the mental health center and got a job. Most of all, he's happier and things are better for us as a family.

***Brother of a Adult with Mental Illness.***

A CD is a legal contract which allows the individual who is on a Probate Commitment to leave the hospital before the commitment expires and return to their community to receive services and supports from their CMHC. However, they must comply with the conditions outlined in the CD. This CD is a three-way binding agreement between the individual, NHH, and the local CMHC. Each CMHC has a liaison to NHH and they represent the CMHC in this process.

The CMHC has a legal obligation to provide treatment to individuals who are conditionally discharged from NHH. Conditions for treatment in the community are developed by the CMHC and reviewed by the individual and the NHH treating psychiatrist. If all parties agree to the conditions for treatment and sign the Conditional Discharge document, the individual is conditionally discharged to the community for CMHC outpatient treatment. The individual has a right to have his attorney review the document before entering into this agreement.

Conditions typically state the individual will follow their Individualized Service Plan (ISP) which may include taking their medications as prescribed; meeting with their psychiatrist or nurse practitioner on a regular basis; and participating in therapy or other treatment services; and keeping appointments for case management. Other conditions are added as necessary to allow the individual to function effectively in the community and minimize his or her potential for re-hospitalization.

Individuals who have been conditionally discharged have agreed to follow specific, individualized conditions while receiving treatment from their local CMHC team during their commitment period. If they follow all of the agreed conditions, at the end of the

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commitment period, the discharge becomes “**absolute**”, which means NHH releases them from the hospital. This decision is made in consultation with all parties.

Watching your child growing up – learning to walk, to run, to ride a bike, going off to school, playing soccer, learning to drive – you can never even imagine that one day you may watch the County Sheriff take your child away in shackles.

That’s the worst part when they revoke his conditional discharge. I mean, he needs to be hospitalized – usually he’s become so ill that I feel a sense of relief he is going back to NH Hospital – but the sight of him in those shackles, being led to the Sheriff’s van for the trip to Concord – it just breaks my heart.

*Parent of an Adult with Mental Illness*

Individuals who do not follow the agreed upon conditions (an example would be not taking their medications as prescribed) while being treated in their community can have their CD revoked and be sent back to NHH. A **Revocation of Conditional Discharge** is a legal process which requires the CMHC clinical staff, in consultation with an outpatient treating psychiatrist, to file a petition that identifies the specific conditions the individual did not follow and requires that he or she be sent back to NHH. The CMHC must consult with the psychiatrist at NHH during this process. There is no court hearing held when the individual returns to the hospital on a CD revocation. Individuals can contest being sent back to NHH, and can contact the attorney who handled the Probate Commitment to assist them in filing this appeal. The appeal is held in front of and overseen by a Department of Health and Human Services Hearings Officer.

*Note: If the individual is under the age of 21 and has Medicaid coverage, they are eligible for a Conditional Discharge; however, Medicaid will not cover any services in the community. In these cases an “outpatient treatment court order” is utilized. Contact NHH Legal Department for information about outpatient treatment court order.*

### **Legal Representation**

At every step of the way the individual has the right to legal counsel. Individuals always have the option of hiring their own lawyer, if they have the means to pay for one. If they are not able to afford legal counsel, the State of New Hampshire is responsible to pay for court-appointed legal representation. This legal representation may be funded or provided from different sources. For example, during the IEA process, individuals who cannot pay for legal representation are provided attorneys who are contracted by Client and Legal Services of the Department of Health and Human Services. During the probate process, the county Probate Court assigns a lawyer to the individual who cannot afford legal representation. Legal counsel is also provided to individuals who wish to contest the revocation of their conditional discharge.

It is important to remember that the legal counsel provided to your loved one is required to represent your loved one’s wishes, even if those wishes would seem to be in conflict with their best interests.

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## Justice System Involvement

We knew she was in trouble and acting bizarre. When she became violent, we had no choice to call the police. No one in our family has ever been arrested. This was a horrible situation and we felt so powerless.

*Family member*

Unfortunately, untreated serious mental illness often causes people to become involved with the criminal justice system. In New Hampshire's jails and prisons, anywhere between 15% and 30% of inmates may have a *serious* mental illness at any given time. These inmates typically remain incarcerated longer than individuals without a serious mental illness who have committed similar offenses. Most individuals in this situation require treatment rather than incarceration. The jails and prisons must offer basic medical care, including treatment for mental illness. They are not mental health treatment facilities; however, it is believed that our county jails are becoming the largest mental health providers in the state.

### ***If Your Loved One is Arrested***

The procedures and time frames for moving through the criminal process vary considerably based on the jurisdiction, as well as day of the week and time of the day of the arrest. Most local police departments do not have the capacity to detain anyone for more than a few hours, so your loved one might be moved to the county's House of Correction (jail) relatively quickly. If the arrest has been made on a weekend, they may have to remain in jail until court convenes on the next business day.

However, as soon as you become aware that your loved one has been arrested, you can take action. Even if your loved one has not signed a release of information for their mental health providers to speak with you, you should still inform them of the arrest as soon as possible. Most community mental health centers have a liaison to the county jail that may be able to work with the correctional staff to arrange transfer to a mental health inpatient unit.

The county jail has its own medical services. They will not be able to administer medication until they have confirmation of the medication regimen that has been prescribed by community providers. The medical staff at the county jail will not be able to tell you anything about your loved one's medical condition without a release of information, but you can tell them your loved one's diagnosis and name of their doctor and how to reach the doctor.

If your family member has a history of suicidal ideation/threats, addiction or trauma, it is important to inform the staff of the correctional facility.

If it is after office hours and your loved one is a patient at the local CMHC, the Emergency Services staff has the ability to provide the correctional facility with the information related to treatment and medication regimen.



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If you are guardian over the person of your loved one, the county jail will ask you to provide a copy of the court order establishing the guardianship before they share any medical information with you. Be prepared to give them a copy of the order when you contact county jail personnel.

### ***Legal Representation***

Your loved one will have the right to legal counsel and if they cannot afford an attorney, the court can appoint a Public Defender to represent them. While your loved one's communication with their attorney is privileged – held in confidence between he or she and the attorney, you can certainly speak to the attorney and tell them about your loved one's mental illness. NAMI NH suggests you approach the attorney as being available to assist in whatever capacity will support your loved one. Being available to share information is critical and can assist the attorney in preparing a defense and exploring sentencing alternatives. The attorney will most likely need to speak with your loved one's mental health provider. Your loved one will have to sign a release of information for this communication to occur. If you are guardian over the person of your loved one, you may be able to sign the release for open communication with the attorney.

### ***Mental Health Courts***

In New Hampshire, several counties have established Mental Health Courts. Each Mental Health Court has slightly different procedures; however, in essence, their purpose is to provide sentencing alternatives for individuals with serious mental illness. Usually, the offenses have to be misdemeanors, or less severe felonies that can be reduced to a misdemeanor as part of the sentencing agreement.

Typically, the offender enters into a one-year contract in which he or she agrees to receive treatment in the community, comply with the treatment plan, report back to the court on a regular basis and not commit another offense during the contract period. Depending upon the person's criminal history and the nature of the offense committed, some contracts allow for the charges to be dismissed upon successful completion; others require that a conviction appears on the person's record, but that the sentencing is suspended or deferred pending successful completion of the contract. All contracts must be approved by a judge and entered as a court order.

Currently, there are Mental Health Courts available in the following counties: Belknap, Cheshire, Grafton, Hillsborough, Merrimack, Rockingham and Strafford Counties. If your loved one becomes involved with the justice system you can ask your local CMHC if there is a Mental Health Court in your area. There have been situations when a case has been moved to a jurisdiction that has a Mental Health Court. For example, your loved one lives in a county with a Mental Health Court, but commits a crime in another jurisdiction. The CMHC liaison to the Mental Health Court can work with your loved one and their attorney to file a request. It is up to the presiding judge to determine if a case will be moved.

### ***County Jails and State Prisons***

All ten New Hampshire counties have their own House of Corrections (often referred to as county jail). The State of New Hampshire's Department of Corrections operates three



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facilities – two State Prisons for men and one for women. The state also has one Secure Psychiatric Unit (SPU) for inmates with very severe mental illnesses.

Sentences of two years or less are served in the county jail, and longer sentences are served in a state prison. Both the county jails and state prisons provide mental health services. If your loved one signs a release of information, the medical staff at either the jail or prison can communicate with you and you can remain involved in your loved one's mental health treatment.

### ***Planning for Release***

When your loved one is going to be released from jail or prison, it is important for him or her to work with the corrections personnel to help plan for his or her return to the community. If he or she is being paroled (from prison), they will be assigned a correctional case manager who will assist them in developing a re-entry plan.

The plan should provide for medical care, mental health services, medication, housing, food, and assistance to apply for or re-establish public assistance benefits prior to release. Note: Public assistance benefits may have been suspended or terminated while he or she was incarcerated.

As family members, remember, as much as you want to help, make sure you are making realistic commitments for yourself. Try not to overextend yourself. Make sure your loved one is accessing all the available community supports. Your mental and physical well-being are essential to your ability to continue to support your loved one's recovery journey.

#### **Key Points to Remember**

- Even if your loved one has not signed a release of information, you can share information with his or her mental health providers, attorney, and the corrections medical staff.
- Make sure that your loved one's mental health providers know of his or her arrest as soon as possible is very important.
- Make sure your loved one's attorney knows he or she has a serious mental illness that may have contributed to their committing the offense. Also provide names and contact information for providers.
- Helping to ensure that corrections medical staff have access to your loved one's medical history, treatment and providers is essential to ensuring continuity of care and no interruption in medications.
- You are not alone. Other families are going through and have gone through such difficulties as well. Contact NAMI NH to access support for yourself and your family.

## Chapter 11. Legal Terms, Considerations and Procedures

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## Appendix A. Acronyms

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<b>ACT</b> Assertive Community Treatment	<b>HIPPA</b> Health Information Portability and Accountability Act
<b>ADL</b> Activities of Daily Living	<b>HMO</b> Health Management Organization
<b>APS</b> Acute Psychiatric Services	<b>IDDT</b> Integrated Dual Disorders Treatment
<b>APTD</b> Aid to Permanently and Totally Disabled Benefit Program	<b>IEA</b> Involuntary Emergency Admission
<b>BBH</b> Bureau of Behavioral Health	<b>IMR</b> Illness Management and Recovery
<b>C3</b> Client-Centered Conference	<b>IROS</b> Individual Recovery and Resiliency Oriented Services
<b>CD</b> Conditional Discharge	<b>IRWE</b> Impairment Related Work Expenses
<b>CMHC</b> Community Mental Health Center	<b>ISP</b> Individual Service Plan
<b>CMS</b> Centers for Medicare & Medicaid Services	<b>MAOIs</b> Monoamine Oxidase Inhibitors (anti-depressant medication)
<b>CSP</b> Community Support Program	<b>MEAD</b> Medicaid for Employed Adults with Disabilities
<b>DHHS</b> Department of Health and Human Services	<b>MMC</b> Medicaid Managed Care
<b>DRF</b> Designated Receiving Facility	<b>NAMI NH</b> National Alliance on Mental Illness New Hampshire
<b>EBP</b> Evidence-Based Practice	<b>NHH</b> New Hampshire Hospital
<b>FSS</b> Functional Support Services	

## Appendix A. Acronyms

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**NIMH**

National Institute of Mental Health

**PCP**

Primary Care Physician

**PSA**

Peer Support Agency

**SA**

Substance Abuse

**SAMHSA**

Substance Abuse and Mental Health  
Services Administration

**SE**

Supported Employment

**SMI**

Severely Mentally Ill

**SMI-LU**

Severe Mental Illness with Low Service  
Utilization

**SPMI**

Severe and Persistent Mental Illness

**SPMI-LU**

Severe and Persistent Mental Illness  
with Low Service Utilization

**SSA**

Social Security Administration

**SSDI**

Social Security Disability Income

**SSI**

Supplemental Security Income

**SSRIs**

Selective Serotonin Reuptake Inhibitors  
(anti-depression medication)

**THS**

Transitional Housing Services

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## Appendix B. Glossary

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**acute episode**

An individual experiences a sudden, generally unexpected, debilitating and precipitous event in a psychiatric disorder.

**BIP**

Balanced Incentive Programs - this grant purpose is to increase access to and use of long-term care services and supports in community settings.

**caregiver**

A person often but not always a family member involved in the direct care and assistance to an older adult and/or person with a disability.

**competitive employment**

The term refers to community-based employment in which an individual with a disability earns the same pay and benefits as everyone else who holds the same position.

**consumer**

Person who receives or has received mental health treatment.

**culturally competent**

An individual has attained the knowledge, skills and attitudes necessary to provide effective supports, services, education and technical assistance to populations in the geographic area served by the agency.

**delusions**

Bizarre or false beliefs. Unshakeable belief in things that are false or impossible.

**electronic medical record**

The cumulative documents collected and preserved by the community mental health program and containing information relative to the health record of a consumer's care and treatment in the digital format.

**eligibility**

The determination that a person meets the criteria for one or more of the eligibility categories in He-M 401.05 through He-M 401.109.

**evidence-based practice**

Mental health practices that have consistently demonstrated their ability to help consumers achieve desired outcomes in mental health service research trials, where such trials have been conducted by multiple researchers with similar outcomes.

**hallucinations**

An individual has a false sensory experience (feeling, smell, taste, vision or sound).

**intake**

The process used to determine eligibility for community mental health program services.

**involuntary emergency admission**

The procedure where temporary authority is granted to place an unwilling person in a hospital to prevent harm to him/herself or others.

## Appendix B. Glossary

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### **Medicaid Care Management**

Program will help NH recipients to coordinate their healthcare including wellness and prevention programs as part of their Medicaid benefit.

### **medically necessity**

The services and supports provided to a consumer are consistent with the generally accepted clinical practice for diagnosis and treatment of symptoms of mental illness.

### **least restrictive environment**

The program or service which least inhibits a client's freedom of movement, informed decisions, and participation in the community, while achieving the purposes of habilitation and treatment.

### **natural environments**

Integrated community settings where persons with and without mental illness live, work, and pursue leisure activity.

### **neuron**

An electronically excitable cell that processes and transmits information-they connect together to form a network. They are the core components of the nervous system.

### **neurotransmitters**

The chemicals which allow the transmission of signals from one neuron to the next across synapses (formed circuits with the central nervous system).

### **paranoia**

A disorder of thinking that causes a person to believe that other people or forces are observing him or her, influencing events, or planning harm to the person in some way.

### **peer support**

The process of consumers helping each other either through individual relationships and/or structured programs and centers.

### **person centered treatment**

Consumers of mental health services are the center of the system of care and consumer's needs and direction drive the care and service provided.

### **psychosis**

A loss of contact with reality; a disorder in the thinking process that causes delusions, hallucinations, or disjointed thinking.

### **psychotic**

An adjective used to describe a person exhibiting the symptoms of psychosis.

### **recovery**

A person with a mental illness develops personal and social skills that minimize susceptibility to symptoms of illness and decrease dependence on professional services.

### **SIM**

State Innovation Model - Center for Medicare and Medicaid supports the development and testing of innovative healthcare payments and service delivery models.

### **Ten Year Plan**

NH Department of Health and Human Services' collaborative effort that assessed the current status of the publicly funded mental health services and made recommendations of additional services and supports that are critical to meeting the needs of NH citizens.

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## Appendix C. Local, State and National Resources

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### Chapter Overview

*The resources in Appendix C are primarily arranged alphabetically by major topic. The information is subject to change. If you cannot reach a program or agency, visit our website*

***www.naminh.org, call NAMI NH I&R Line 1-(800) 242-6264, Ext. 4 or the 211 NH which is New Hampshire's statewide service for information and referral service website: <http://www.211nh.org> or dial 2 1 1.***

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## New Hampshire Department of Health and Human Services (DHHS)

The *New Hampshire Department of Health and Human Services* provides assistance for New Hampshire's citizens through a variety of services, supports, financial and medical assistance programs at the regional offices below.

General New Hampshire DHHS Information and Referrals: (603) 271-5557

ALL TDD access: 1-(800) 735-2964

Website: [www.dhhs.state.nh.us](http://www.dhhs.state.nh.us).

### ***District Offices***

<b>Berlin Office</b> 650 Main Street Suite 200 Berlin, NH 03570 Phone: (603) 752-7800 Toll Free: (800) 972-6111	<b>Claremont Office</b> 17 Water Street Suite 301 Claremont, NH 03743 Phone: (603) 542-9544 Toll Free: (800) 982-1001
<b>Concord Office</b> 40 Terrill Park Dr. Concord, NH 03301 Phone: (603) 271-6201 Toll Free: (800) 322-9191	<b>Conway Office</b> 73 Hobbs Street Conway, NH 03818 Phone: (603) 447-3841 Toll Free: (800) 552-4628
<b>Keene Office</b> 809 Court Street Keene, NH 03431 Phone: (603) 357-3510 Toll Free: (800) 624-9700	<b>Laconia Office</b> 65 Beacon Street West Laconia, NH 03246 Phone: (603) 524-4485 Toll Free: (800) 322-2121
<b>Littleton Office</b> 80 N. Littleton Road Littleton, NH 03561 Phone: (603) 444-6786 Toll Free: (800) 552-8959	<b>Manchester Office</b> 195 McGregor St. Suite 110 Manchester, NH 03102 Phone: (603) 668-2330 Toll Free: (800) 852-7493

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<b>Rochester Office</b> 150 Wakefield Street Suite 22 Rochester, NH 03867 Phone: (603) 332-9120 Toll Free: (800) 862-5300	<b>Salem Branch Office</b> 154 Main Street Salem, NH 03079 Phone: (603) 893-9763 Toll Free: (800) 852-7492
<b>Seacoast District Office</b> 50 International Drive Portsmouth, NH 03801 Phone: (603) 433-8300 Toll Free: (800) 821-0326	<b>Southern District Office</b> 3 Pine Street Extension, Suite Q Nashua, NH 03060 Phone: (603) 883-7726 Toll Free: (800) 852-0632

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## Resources-Alphabetic by Topic

### Adult Protective Services

The New Hampshire Department of Health and Human Services - Bureau of Elderly and Adult Services provides a variety of social and long-term supports to adults age 60 and older and to adults between the ages of 18 and 60 who have a chronic illness or disability. Services and supports are intended to assist people to live as independently as possible in safety and with dignity. Examples include home care; meals on wheels; transportation assistance; long-term care (nursing home and community-based care); information and assistance regarding Medicare and Medicaid; information about volunteer opportunities and investigation of reports of abuse, neglect or exploitation of incapacitated adults.

#### **NH DHHS-Bureau of Elderly & Adult Services**

129 Pleasant Street

Concord, NH 03301

Phone: (603) 271-9203

Toll Free: 1-(800) 351-1888

Website: <http://www.dhhs.nh.gov/dcbcs/beas/aboutprotection.htm>

If you suspect abuse or neglect call (603) 271-7014 or 1-(800) 949-0470

### Advocacy Organizations

#### **Disabilities Rights Center (DRC)**

The DRC is New Hampshire's designated Protection and Advocacy Agency and authorized by federal statute "to pursue legal, administrative and other appropriate remedies" on behalf of individuals with disabilities. The DRC is a statewide organization that is independent from state government or service providers. The DRC provides information, referral, advice, and legal representation and advocacy to individuals with disabilities on a wide range of disability-related problems.

## Appendix C. Local, State and National Resources

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Disability Rights Center  
18 Low Ave  
Concord, NH 03301  
Phone: (603) 228-0432  
Email: [advocacy@drcnh.org](mailto:advocacy@drcnh.org)  
Website: [www.drcnh.org](http://www.drcnh.org)

### **Governor's Commission on Disability**

The Commission's goal is to remove the barriers, architectural, attitudinal or programmatic, which bar persons with disabilities from participating in the mainstream of society. The Commission is the New Hampshire State Affiliate for the DBTAC New England ADA Center.

Governor's Commission on Disability  
57 Regional Drive  
Concord, NH 03301  
Phone: (603) 271- 2773  
Email: [Disability@nh.org](mailto:Disability@nh.org)  
Website: [www.nh.gov/disability](http://www.nh.gov/disability)

### **Granite State Independent Living (GSIL)**

Granite State Independent Living (GSIL) is a statewide non-profit service and advocacy organization that provides tools for living life on your terms - so you can navigate your own life and participate as fully as you choose in your community, just like everyone else. They have four core services - advocacy, information, education, and support that are embodied in an extensive menu of services that include: Employment, Transportation, Housing Program, Service Coordination and Advocacy.

Granite State Independent Living (GSIL)  
21 Chenell Drive  
Concord, NH 03302  
Phone: (603) 228-9680 or Toll Free: 1-(800) 826-3700  
Website: [www.gsil.org](http://www.gsil.org)

### **Human Rights Commission**

The New Hampshire Commission for Human Rights is a state agency established by RSA 354-A for the purpose of eliminating discrimination in employment, public accommodations and the sale or rental of housing or commercial property, because of age, sex, sexual orientation, race, creed, color, marital status, familial status, physical or mental disability or national origin. The commission has the power to receive, investigate and pass upon complaints of illegal discrimination and to engage in research and education designed to promote good will and prevent discrimination.

Human Rights Commission  
2 Chenell Drive  
Concord, NH 03301  
Phone: (603) 271-2767  
Email: [humanrights@nhsa.state.nh.us](mailto:humanrights@nhsa.state.nh.us)  
Website: [www.state.nh.us/hrc](http://www.state.nh.us/hrc)

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### **People First of New Hampshire**

People First of New Hampshire is a non-profit self-advocacy organization comprised of chapters and groups across led by people who experience disabilities for the purpose of self-advocacy.

People First of New Hampshire  
4 Park Street, Suite #205  
Concord, NH 03302  
Phone: (603) 568-2182 or 1-(800) 566-2128  
Email: [info@peoplefirstofnh.org](mailto:info@peoplefirstofnh.org)  
Website: <http://www.peoplefirstofnh.org>

## **Alcohol/Substance Abuse and Smoking Prevention and Treatment**

### **NH Department of Health and Human Services Bureau of Drug and Alcohol Services**

The Bureau of Drug and Alcohol Services (BDAS) works to reduce alcohol and other drug misuse and its social, health and behavioral consequences for the citizens of New Hampshire through public policy and resource development, education, and supporting initiatives that ensure the delivery of effective and coordinated prevention and treatment services.

NH DHHS Bureau of Drug and Alcohol Services  
105 Pleasant Street  
Concord, NH 03301  
Phone: (603) 271-6110 or 1-(800) 804-0909  
Website: <http://www.dhhs.nh.gov/dcbcs/bdas/contact.htm>

### **Alcoholics Anonymous 24 Hour Hot Line**

Alcoholics Anonymous® is a gathering of people “who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism.”

Alcoholics Anonymous  
Service Office  
1330 Hooksett Road  
Hooksett, NH 03106  
Phone: (603) 622-6967  
Toll Free 1-(800) 593-3330  
Email: [office@nhaa.net](mailto:office@nhaa.net)  
Website: [www.nhaa.net](http://www.nhaa.net)

### **The Granite State Area of Narcotics Anonymous**

Narcotics Anonymous (NA) carries the message of recovery that an addict, any addict, can stop using drugs, lose the desire to use and find a new way of life. NA is a spiritual, not religious, program that comes from the 12 steps and 12 traditions of Narcotics Anonymous.

## Appendix C. Local, State and National Resources

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The Granite State Area of Narcotics Anonymous  
For An Immediate Response, 1-(888) NA-HELP\_U or 1-(888) 624-3578  
Website: General Information: [www.gsana.org/contact\\_us.html](http://www.gsana.org/contact_us.html)  
Website: Meetings: <http://www.gsana.org/NHMeetings.html>

### **NH Al-Anon/Alateen**

Al-Anon Groups are a fellowship of relatives and friends of alcoholics who share their experience, strength, and hope in order to solve their common problems. We believe alcoholism is a family illness and that change attitudes can aid recovery.

NH Al-Anon/Alateen  
PO Box 220  
Concord, NH 03302  
For immediate Assistance: (603) 645-9518  
Email: [webcoordinator@nhal-anon.org](mailto:webcoordinator@nhal-anon.org)  
Website: [www.nhal-anon.org](http://www.nhal-anon.org)

### **Dual Recovery Anonymous Meetings (DRA)**

DRA is a fellowship of men & women who meet to support each other in our common recover from two NO-Fault illnesses: An emotional or psychiatric illness and chemical dependency.

Phone: Derry Friendship Center (603) 432-9794  
Website: <http://www.derryfriendshipcenter.org>

### **Try To STOP TOBACCO New Hampshire**

The toll free helpline offers telephone-based counseling, free print materials and referrals to local tobacco treatment programs for New Hampshire residents. Services are available in English with translation for other languages. Quit tips are available 24-hours-a-day (1-800-8GET-A-TIP). The website provides a form for tobacco users to self refer for free counseling, information about local tobacco treatment resources, fact sheets and provides a link to online quitting communities. NH residents can access this state-of-the-art friendly tool for tobacco users who want to quit on their own.

NH Division of Public Health Services  
Tobacco Prevention & Control Program  
29 Hazen Drive  
Concord, NH 03301-6504  
Phone: 1-(800) 784-8669 (English)  
1-(800) 8-DEJALO (Spanish & translation for other languages)  
TTY Line: 1-(800) 833-1477  
Website: [www.trytostopnh.org](http://www.trytostopnh.org)

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### **Substance Abuse and Mental Health Services Administration (SAMHSA)**

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. Prevention works, treatment is effective, and people recover from mental and substance use disorders. Behavioral health services improve health status and reduce healthcare and other costs to society.

US Department of Health and Human Services  
200 Independence Ave, SW  
Washington, DC 20201  
Phone: (202) 619-0257 or 1-(877) 696-6775  
Website: [www.samhsa.gov](http://www.samhsa.gov)

### **Substance Abuse Treatment Facility Locator**

The Substance Abuse Treatment Facility Locator provides an on line resource for locating drug and alcohol abuse treatment programs for every state in the USA and is updated annually.

Substance Abuse Treatment Facility  
Referral Line: 1-(800) 662-HELP (English and Spanish)  
TDD Access Line: 1-(800) 487-4889  
Website: [findtreatment.samhsa.gov/treatmentlocator/faces/about.jsx](http://findtreatment.samhsa.gov/treatmentlocator/faces/about.jsx)

### **National Clearinghouse for Alcohol and Drug Information (NCADI)**

NCADI is run by the Substance Abuse and Mental Health Services Administration (SAMHSA) offers a wide selection of alcohol and other drug prevention materials, most at no cost. Publications are searchable by audience, including specific resources for parents and caregivers.

The Higher Education Center for Alcohol and Other Drug Abuse and Violence  
Prevention Division of SAMHSA  
55 Chapel Street  
Newton, MA 02458-1060  
Phone: 1-(800) 676-1730  
Website: <http://store.samhsa.gov/home>

### **National Institute on Alcohol Abuse and Alcoholism (NIAAA)**

NIAAA provides leadership in the national effort to reduce alcohol-related problems by conducting and supporting research; coordinating and collaborating with other research institutes and federal programs on alcohol related issues; translating and disseminating research findings to healthcare providers, researchers, policymakers and the public.

NIAAA  
5635 Fishers Lane, MSC 9304  
Bethesda, MD 20892-9304  
Communication/Public Info: (301) 443-3860  
Email: [niaa\\_aware-r@exchange.nih.gov](mailto:niaa_aware-r@exchange.nih.gov)  
Website: [www.niaaa.nih.gov](http://www.niaaa.nih.gov)

### Community Mental Health Centers (CMHC)

Community Mental Health Centers are private not-for-profit agencies who offer a wide variety of programs such as individual and group therapy, medications, and symptom management. They also provide special intensive services. They are located in 10 regions in New Hampshire and have contracted with the NH Department of Health and Human Services, Bureau of Behavioral Health to provide publicly funded mental health services to individual and families who meet certain criteria for services. You should contact the CMHC in your area to learn more about their offering of services and supports.

<b>REGION I</b> <b>Northern Human Services</b> 87 Washington Street Conway, NH 03818 Phone: (603) 447-3347 Website: <a href="http://www.northrnhs.org">www.northrnhs.org</a>	<b>REGION VI</b> <b>Greater Nashua Mental Health Center At Community Council</b> 7 Prospect Street Nashua, NH 03060-3990 Phone: (603) 889-6147 Website: <a href="http://www.gnmhc.org">www.gnmhc.org</a>
<b>REGION II</b> <b>West Central Behavioral Health</b> 9 Hanover Street, Suite 2 Lebanon, NH 03766 Phone: (603) 448-0126 Website: <a href="http://www.wcbh.org">www.wcbh.org</a>	<b>REGION VII</b> <b>Mental Health Center Of Greater Manchester</b> 401 Cypress Street Manchester, NH 03103 Phone: (603) 668-4111 Website: <a href="http://www.mhcgmm.org">www.mhcgmm.org</a>
<b>REGION III</b> <b>Genesis Behavioral Health</b> 111 Church Street Laconia, NH 03246 Phone: (603) 524-1100 Website: <a href="http://www.genesisbh.org">www.genesisbh.org</a>	<b>REGION VIII</b> <b>Seacoast Mental Health Center, Inc.</b> 1145 Sagamore Avenue Portsmouth, NH 03801 Phone: (603) 431-6703 Website: <a href="http://www.smhc-nh.org">www.smhc-nh.org</a>
<b>REGION IV</b> <b>Riverbend Community Mental Health Center</b> 70 Pembroke Street PO Box 2032 Concord, NH 03302-2032 Phone: (603) 228-1551 Website: <a href="http://www.riverbendcmhc.org">www.riverbendcmhc.org</a>	<b>REGION IX</b> <b>Community Partners</b> 113 Crosby Road, Suite 1 Dover, NH 03820 Phone: (603) 749-4015 Website: <a href="http://www.dssc9.org">www.dssc9.org</a>
<b>REGION V</b> <b>Monadnock Family Services</b> 64 Main Street, Suite 301 Keene, NH 03431 Phone: (603) 357-6878 Website: <a href="http://www.mfs.org">www.mfs.org</a>	<b>REGION X</b> <b>Center For Life Management</b> 10 Tsienneto Road Derry, NH 03038 Phone: (603) 434-1577 Website: <a href="http://www.centerforlifemanagement.org">www.centerforlifemanagement.org</a>



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## Consumer Credit Counseling Services

### Consumer Credit Counseling Services of NH & VT

CCCS of NH & VT is a nonprofit community service organization seeking through a variety of services and supports to help those having difficulty managing their personal finances. Call to arrange an appointment with a certified credit counselor in any one of the 10 offices located in New Hampshire.

CCCS of NH & VT  
Administrative Office  
105 Loudon Road  
PO Box 818  
Concord, NH 03302  
Phone: 1-(800) 327-6778  
Website: [www.cccsnh-vt.org](http://www.cccsnh-vt.org)

### UNH Cooperative Extension Services

A multitude of programs on family, home and agriculture. Everything from food safety, nutrition, to financial solutions. Offices can be found in each county.

UNH Cooperative Extension Services Administrative Office:  
200 Bedford Street (Mill#3)  
Manchester, NH 03101  
Phone: (603) 629-9494  
General Information Line: 1-(877) 398-4769  
Email: [answers@unh.edu](mailto:answers@unh.edu)  
Website: <http://extension.unh.edu/>

## County Correctional Facilities

Belknap County House of Corrections	Laconia	(603) 527-5480
Carroll County House of Correction	Ossipee	(603) 539-2282
Cheshire County House of Corrections	Keene	(603) 903-1600
Coos County House of Corrections	West Stewartstown	(603) 246-3315
Grafton County House of Corrections	North Haverhill	(603) 787-6767
Hillsborough County House of Corrections	Manchester	(603) 627-5620
Merrimack County House of Corrections	Boscawen	(603) 796-3600
Rockingham County House of Corrections	Brentwood	(603) 679-2244
Strafford County House of Corrections	Dover	(603) 742-3310
Sullivan County House of Corrections	Claremont	(603) 542-8717

### Cultural Diversity

#### **New Hampshire Department of Health and Human Services Office of Minority Health & Refugee Affairs**

The Office of Minority Health & Refugee Affairs helps ensure that all residents of New Hampshire have access to DHHS services, improves the health of minorities and assists refugees in achieving economic self-sufficiency and social adjustment.

Office of Minority Health & Refugee Affairs  
NH DHHS  
97 Pleasant Street  
Concord, NH 03301  
Phone: (603) 271-3986  
TDD Number: 1-(800) 735-2964  
Website: [www.dhhs.nh.gov/omh/contact.htm](http://www.dhhs.nh.gov/omh/contact.htm)

#### **New Hampshire Health & Equity Partnership**

The New Hampshire Health & Equity Partnership is a public-private collaborative effort of philanthropic organizations, public health agencies, community based organizations, advocates and others concerned with health equity. The Partnership is guided in its work by the [Plan to Address Health Disparities and Promote Health Equity in New Hampshire](#). The goal of the plan is to define statewide priorities and prepare recommendations to advance health equity for NH's racial, ethnic, and linguistic minority communities.

New Hampshire Health & Equity Partnership  
The Foundation for Health Communities  
125 Airport Road  
Concord, NH 03301  
Phone: (603) 415-4277  
Email: [rsky@healthnh.com](mailto:rsky@healthnh.com)  
Website: <http://nhfhc.accountsupport.com/nh-health-equity-partnership.html>

#### **New Hampshire Minority Health Coalition**

The Coalition works to identify under served populations in the state with barriers to accessing appropriate healthcare, to advocate for adequate and appropriate services and to educate and empower these populations to be active participants in their own health.

New Hampshire Minority Health Coalition  
25 Lowell Street, 3rd Floor  
Manchester, NH 03105  
Phone: (603) 627-7703  
Toll Free: 1-(866) 460-9933  
Website: [www.nhhealthequity.org](http://www.nhhealthequity.org)

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## Office of Minority Health (OMH)

OMH programs are to improve and protect the health of racial and ethnic minority populations through the development of health policies and programs that will eliminate health disparities. The OMH Resource Center is a one stop shop for minority health literature, research, and referrals.

Office of Minority Health  
The Tower Building  
1101 Wootton Parkway, Suite 600  
Rockville, MD 20852  
Main Phone (240) 453-2882  
Information Line: 1-(800) 444-6472  
Email: [info@minorityhealth.hhs.gov](mailto:info@minorityhealth.hhs.gov)  
Website: <http://minorityhealth.hhs.gov>

## US Department of Health and Human Services Office of Civil Rights (OCR)

OCR educates health and social service workers and communities about the civil rights, health information privacy, patient safety, confidentiality laws. This office investigates civil rights, health information privacy, patient safety and confidentiality complaints to find out if there is discrimination or a violation of laws and takes action to correct problems.

US DHHS Office of Civil Rights  
Government Center  
JF Kennedy Federal Building, Room 1875  
Boston, MA 02203  
Phone: (617) 565-1340  
Voice/TTY: (617) 565-1343  
Website: <http://www.hhs.gov/ocr/>

## Dental Care

Ammonoosuc Community Health Services, Littleton	Phone: (603) 444-2464 x128 Website: <a href="http://www.achs-inc.org">www.achs-inc.org</a>	Adults only in the community health center service area
Concord Hospital, Concord	Phone: (603) 228-7200 x4461 Website: <a href="http://www.concordhospital.org">www.concordhospital.org</a>	Adult clients of the Concord Family Health Center and Riverbend CMHC
The Dental Resource Center, Laconia	Phone: (603) 527-7112	Adults and children enrolled in HealthLink
NHTI Dental Hygiene Clinic, Concord	Phone: (603) 271-7160 Website: <a href="http://www.nhti.edu/dental-clinic">www.nhti.edu/dental-clinic</a>	Adults only- teaching program
Poisson Dental Center at Catholic Medical Center, Manchester	Phone: (603) 663-6226	Manchester residents without access to dental care, referred through 8 community agencies
Indian Stream Community Health Center, Colebrook	Phone: (603) 237-8336 Website: <a href="http://indianstream.com/home.html">http://indianstream.com/home.html</a>	Clients of the Indian Stream Community Health Center

### Developmental Disabilities

NH Department of Health and Human Services Bureau of Developmental Services (BDS)  
The NH developmental services system offers individuals of all ages with developmental disabilities or acquired brain disorders and their families to experience as much freedom, choice, control and responsibility over the services and supports they received as desired. Services and supports include: service coordination; day and vocational services; personal care services; Early Supports and Services and Early Intervention; Assistive Technology Services; and specialty services and flexible family supports including respite services and environmental modifications. The main office is in Concord and there are 12 regional offices. To locate the office near you go to the DHHS BDS website.

NH Department of Health and Human Services  
Bureau of Developmental Services (BDS)  
Division of Community Based Care Services  
105 Pleasant Street  
Concord, NH 03301-3857  
Phone: (603) 271-9410 or 1-(800) 735-2964  
TDD Access Relay: 1-(800) 735-2964  
Website: <http://www.dhhs.nh.gov/dcbcs/bds/contact.htm>

### Education

#### New Hampshire Department of Education Bureau of Adult Education

The Bureau of Adult Education provides grants to school districts and private not-for-profit organizations for the purposes of offering educational services to adults who have not received a high school diploma or GED certificate, or do not read, write or speak English. Local adult education programs serve adult learners whose skills range from very basic to high school level. Adults are eligible for enrollment in any program supported by the Bureau of Adult Education if they are: at least 16 years of age; have not received a high school diploma or GED certificate; do not speak, read or write English and/or are not currently enrolled in school.

New Hampshire Department of Education  
Bureau of Adult Education  
101 Pleasant Street  
Concord, NH 03301  
Phone: (603) 271-3494  
TDD Access Relay: 711  
Website: <http://www.education.nh.gov/career/adult/index.htm>

#### New Hampshire Higher Education Assistance Fund Network Organization

The NHHEAF Network is comprised of three separate, private, nonprofit organizations dedicated to helping students and families plan and fund education beyond high school.

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New Hampshire Higher Education Assistance Fund Network Organization  
4 Barrell Court  
PO Box 877  
Concord, NH 03302-0877  
Phone: (603) 225-6612  
Toll Free: 1-(800) 525-2577  
Website: <http://www.nhheaf.org>

## Employment and Job Training

### **New Hampshire Department of Education Bureau of Vocational Rehabilitation (NHVR)**

The mission of New Hampshire Bureau of Vocational Rehabilitation is assist eligible New Hampshire citizens with disabilities secure suitable employment and financial and personal independence by providing rehabilitation services. NHVR provides services to both Individuals with Disabilities and Employers.

NH Department of Education Bureau of Vocational Rehabilitation (NHVR)  
21 South Fruit Street, Suite 20  
Concord, NH 03301  
Phone: (603) 271-3471 (Voice or TTY)  
Toll Free: 1-(800) 339-9900  
Website: <http://www.education.nh.gov/career/vocational/index.htm>

### **Services for Blind and Visually Impaired**

#### **Service for Blind and Visually Impaired**

21 South Fruit Street, Suite 20  
Concord, NH 03301  
Phone: (603) 271-3537 (Voice or TTY)  
Website: [http://www.education.nh.gov/career/vocational/blind\\_visu.htm](http://www.education.nh.gov/career/vocational/blind_visu.htm)

### **New Hampshire Department of Employment Security (NHES)**

NHES is a federally funded state agency. The mission of NHES is to operate a free public Employment Service through a statewide network of Job and Information Centers providing a broad range of assisted and self directed employment and career related services and labor market information to all customers; pays Unemployment Compensation benefits, and develops and disseminates labor market information and provide measurements of labor market outcome to asset business and state leadership and the public in making decisions which promote economic development and the efficient use of state labor resources.

New Hampshire Department of Employment Security  
32 South Main Street  
Concord, NH 03301  
Phone: (603) 224-3311 or 1-(800) 852-3400  
Email: [webmaster@nhes.state.nh.us](mailto:webmaster@nhes.state.nh.us)  
Website: <http://www.nh.gov/nhes/contactus.htm>

## Appendix C. Local, State and National Resources

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### **NH Division of Economic Development Office of Workforce Opportunity**

The Office of Workforce Opportunity's mission is to promote life-long learning by partnering with businesses, agencies, and organizations to bring the state's education, employment and training programs together into a workforce development system that will provide the means for residents of New Hampshire to gain sufficient skills, education, employment and financial independence.

Office of Workforce Opportunity  
New Hampshire Department of Resources & Economic Development  
172 Pembroke Road  
Concord, NH 03301  
Phone: (603) 271-7275  
Website: <http://www.nhworks.org/contact.cfm>

## **Family and Consumer Support, Advocacy, and Referral Services**

### **National Alliance on Mental Illness New Hampshire New Hampshire (NAMI NH)**

NAMI NH, a grassroots organization of families, consumers, professionals and other members, is dedicated to improving the quality of life of persons of all ages affected by mental illness and/or serious emotional disorders through education, support and public policy advocacy. NAMI NH works to ensure that individuals with mental illness have access to comprehensive, integrated healthcare and community-based supports without discrimination or stigma. They, also, offers a Speaker's Bureau, CONNECT Suicide Prevention Program, Survivor's of Suicide Support Groups and Professional Staff Development training,

**NAMI NH**  
85 North State Street  
Concord, NH 03301  
Phone: (603) 225-5359  
Information & Resource Line: 1-(800) 242-6264 Ext. 4  
Website: [www.naminh.org](http://www.naminh.org)

### **National Headquarters**

**National Alliance on Mental Illness (NAMI)**  
3803 N. Fairfax Drive, Ste. 100  
Arlington, VA 22203  
Phone: (703) 524-7600  
Website: [www.nami.org](http://www.nami.org)

### **NH Department of Health and Human Services Office of Consumer and Family Affairs**

The Office of Consumer & Family Affairs (OCFA) provides information, education and support for children and youth, families, adults and older adults who are dealing with the challenges of mental illness. This office will facilitate consumer and family input into

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all aspects of the state-funded mental health system, as well as, the Bureau of Behavioral Health's planning and policy development.

**NH DHHS Office of Consumer and Family Affairs**

129 Pleasant Street

Concord, NH

Phone: (603) 271-5138 or 1-(800) 852-3345 Ext. 5138

Website: <http://www.dhhs.nh.gov/dcbcs/bbh/ocfa.htm>

## **Financial and Medical Assistance Programs**

### **Local Welfare Department**

The town or city in which you reside provides interim, emergency assistance with basic needs for those unable to provide for themselves. Basic needs include shelter, food, medications, rent, utilities, etc. Assistance is usually issued in the form of vouchers for those items paid directly to a vendor. Individuals must apply for assistance and provide specific documentation and may be asked to apply for state assistance programs.

To locate your local welfare department, contact your Town or City Hall.

You can also get this information by contacting one of the Statewide Information and Referral programs.

### **Community Action Programs**

The Community Action Programs work with low income families and the elderly to assist them in their efforts to become or remain financially and socially independent. The Agencies accomplish this task by providing a broad array of services that are locally defined, planned and managed. To locate and learn about the services and programs of the Community Action Program in your area, visit website: <http://www.puc.nh.gov/consumer/communityactionagencies.htm>.

### **NH Department of Health and Human Services Division of Family Assistance (DFA)**

The DFA administers programs and services for eligible NH residents by providing financial, medical, food and nutritional assistance, help with child care costs and emergency help to obtain and keep safe housing. Family Assistance staff determines initial and continuing eligibility, the amount of benefits and deliver benefits using federal and NH guidelines and policies. Programs include: Food Stamp Program, Medical Coverage, and State Supplemental Programs.

To apply for assistance, you may go to your local district offices which are listed in the beginning of this Appendix or apply online at: [www.nh.easy.nh.gov](http://www.nh.easy.nh.gov).

### **State Office Contact Information:**

NH DHHS Division of Family Assistance

129 Pleasant Street

Concord, NH 03301

Client Services Phone: (603) 271-9700

Website: <http://www.dhhs.nh.gov/dfa/contact.htm>



## Appendix C. Local, State and National Resources

### Social Security Administration

In the State of New Hampshire there are 6 Social Security Field Offices, 1 Disability Determination Service, and one location for the Office of Disability Adjudication and Review. They administer retirement and disability programs. To learn more about eligibility, application and medical determination for programs, contact the field offices in your area. You can also visit the federal website: <http://www.ssa.gov>.

Concord SSA Office 70 Commercial Street, Suite 100 Concord, NH 03301 Phone: 1-(888) 397-9798	Manchester SSA Office 1100 Elm Street, Suite 201 Manchester, NH 03201 Phone: 1-(866) 814-5408
Nashua SSA Office 175 Amherst Street Nashua, NH 03064 Phone: 1-(877) 444-0134	Keene SSA Office 34 Mechanic Street Keene, NH 03431 Phone: 1-(877) 405-3651
Littleton SSA Office 177 Main Street Littleton, NH 03561 Phone: 1-(877) 405-7658	Portsmouth SSA Office 80 Daniel Street Federal Building, Room 200 Portsmouth, NH 03802 Phone: (603) 433-0716

### Guardianship

#### Office of Public Guardian

The Office of Public Guardian is a private non-profit corporation provides guardianship and advocacy services through the state to legally incapacitated adults, including those with developmental disabilities, mental illness, dementia and traumatic brain injury. Our professional staff provides depth of experience and a wide array of services to clients on fee for services basis, as well as, to qualified indigent clients through a contract with the State of New Hampshire.

Office of Public Guardian  
2 Pillsbury Street, Suite 400  
Concord, NH 03301  
Phone: (603) 224-8041  
Website: <http://www.opgnh.org/>

#### Tri-County CAP, Inc. Guardianship Services

Provides high quality Guardianship, Protective and Fiduciary services to incapacitated residents of New Hampshire. Offers 24 Hour Emergency Coverage.

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## Healthcare

### In SHAPE Programs

In SHAPE seeks to improve physical health and quality of life, reduce the risk of preventable diseases, and enhance life expectancy of individuals with serious Mental Illness. Each participant is teamed up with a trained health mentor to create a Self Health Action Plan for Empowerment (SHAPE) that includes physical activity, healthy eating goals, and attention to medical needs. The program enrolls adults in community wellness activities such as exercise, dance classes, weight loss programs, and smoking cessation activities. This program is offered through the community mental health centers. To obtain more information contact the Community Mental Health Center in your area. A listing is provided in this Appendix.

Tri-County Cap, Inc.  
34 Jefferson Road  
Whitefield, NH 03598-1221  
Phone: (603) 837-9561

Tri-County Cap, Inc.  
18 Low Avenue  
Concord, NH 03301  
Phone: (603) 224-0805  
Email: [info@gsgs.org](mailto:info@gsgs.org)  
Website: <http://www.gsgs.org/contactus.htm>

### Community Health Centers

Community Health Centers are non-profit, community-directed providers that remove common barriers to care by serving communities who otherwise confront financial, geographic, language, cultural and other barriers. They are open to all residents, regardless of insurance status or ability to pay; provide comprehensive primary and other healthcare services and tailor services to fit the special needs and priorities of their communities. To learn about the Community Health Center in your community, go to the BiState Primary Care Association website.

BiState Primary Care Association  
525 Clinton Street  
Bow, NH 03304  
Phone: (603) 228-2830  
Website: [www.bistatepca.org](http://www.bistatepca.org)

## Housing

### New Hampshire Housing Finance Authority (NHHFA)

NHHFA is a self supporting public benefit corporation. Although established by statute as a public instrumentality, the Authority is not a state agency and receives no operating funds from the state government. The Authority administers a broad range of programs designed to assist low and moderate income persons and families with obtaining decent, safe and affordable housing.

New Hampshire Housing Finance Authority (NHHFA)  
PO Box 5087  
Manchester, NH 03108  
Phone: (603) 472-8623  
Website: [www.nhhfa.org/contact.cfm](http://www.nhhfa.org/contact.cfm)

## Appendix C. Local, State and National Resources

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### **New Hampshire Department of Health and Human Services (BHHS)**

BHHS plans for and funds a wide range of homeless services through contracted agencies within New Hampshire's ten counties. BHHS advocates for the needs of homeless people and ensures effective use of resources through program and fiscal monitoring of funded programs. BHHS collaborates with other public agencies that serve homeless people, and with partner advocacy and service organizations to maximize effective use of resources.

New Hampshire Department of Health and Human Services Bureau of Homeless and Housing Service (BHHS)  
129 Pleasant Street  
Concord, NH 03301  
Phone: (603) 271-9196  
Homeless Hotline: 2 1 1 or 1-(866) 444-4211

### **Harbor Homes**

Harbor Homes is a non-profit community-benefit organization that provides low-income, homeless, and disabled New Hampshire community members with affordable housing, primary and behavioral healthcare, employment and job training, and supportive services. As a member of the Partnership for Successful Living, Harbor Homes offers a unique, holistic approach to care that results in better outcomes for our clients and the community.

Harbor Homes  
45 High Street  
Nashua, NH 03060  
Phone: (603) 882-3616  
Email: [hope@harborhomes.org](mailto:hope@harborhomes.org)  
Website: <http://harborhomes.org>

### **NFI North Transitional Housing Services**

The Transitional Housing Services serves the clinical, medical, vocational and residential needs of adult men and women (ages 18 years and older and above) with mental health issues. Services that are designed to be responsive to the unique needs of the individual and to effectively engage natural and community services support systems so that community integration is wholly obtainable. Individuals can be referred to this program through the NH DHHS Bureau of Behavioral Health or their community mental health center.

NFI North Transitional Housing Services  
99 Pleasant Street  
Concord, NH 03304  
Phone: (603) 229-3903 or (603) 224-9881  
Website: <http://www.nfinorth.com/nafinfi/Programs/BehavioralHealth/TransitionalHousingServicesNH.aspx>

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## Information and Referral Organizations-Statewide

### **NAMI NH**

Provides an Information & Resource Line and website at no cost to callers and connects them with the appropriate services and supports to meet their mental, physical and emotional needs.

NAMI NH  
85 North State Street  
Concord, NH 03301  
Phone: I&R Line 1-(800) 242-6264 Ext. 4  
Email: [info@naminh.org](mailto:info@naminh.org)  
Website: [www.naminh.org](http://www.naminh.org)

### **New Hampshire 2-1-1**

2-1-1 NH connects callers at no cost, to information about critical health and human services available in their community. To access this service, NH citizens can dial: 2-1-1 and speak to an information and referral specialist.

New Hampshire 2-1-1  
PO Box 211  
Manchester, NH 03105  
Phone: 1-(866) 444-4211  
Website: <http://www.211nh.org/>

### **New Hampshire ServiceLink Community Resource**

ServiceLink is a statewide network of locally administered community-based resources for seniors, adults with disabilities and their families. ServiceLink provides free information, referral and assistance in answering questions and connecting users to the appropriate services that support healthy and independent living. They have 12 offices and you can locate the office closest to you by visiting their website.

Contact ServiceLink at 1-(866) 634-9412  
Website: <http://www.nh.gov/servicelink/index.html>

### Insurance

#### Insurance

NH Department of Health and Human Services Office of Medicaid Business and Policy  
Medicaid is a federal and state funded healthcare program that serves a wide range of individuals and families who meet certain eligibility requirements. To apply for Medicaid, you must go to the NH DHHS District Office in your area. The listing of District Offices is located at the beginning of this Appendix.

Office of Medicaid Business & Policy  
129 Pleasant Street  
Concord, NH 03301  
Phone: (603) 271-8166  
Client Services: (603) 271-4328  
Website: <http://www.dhhs.nh.gov/ombp/medicaid/apply.htm>

#### U.S. Health and Human Services Medicare Program

Medicare is health insurance for people 65 or older; under 65 with certain disabilities; and anyone with End-Stage Renal Disease. The different parts of Medicaid help cover specific services: hospital, medical, prescription drug coverage. You can learn more about the programs and the eligibility determination process by visiting, the website: <http://www.medicare.gov>. or go to the Social Security Administration District Office in your area.

Concord SSA Office 70 Commercial Street Concord, NH 03301 Phone: (603) 225-8475	Manchester SSA Office 2 Wall Street Suite 301 Manchester, NH 03201 Phone: (603) 641-2180
Nashua SSA Office 175 Amherst Street Nashua, NH 03064 Phone: (603) 880-0295	Keene SSA Office 34 Mechanic Street Keene, NH 03431 Phone: (603) 352-3487
Littleton SSA Office 177 Main Street Littleton, NH 03561 Phone: (603) 444-2945	Portsmouth SSA Office 80 Daniel Street Federal Building, Room 200 Portsmouth, NH 03802 Phone: (603) 433-0716

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## **New Hampshire Insurance Department**

Their mission is to promote and protect the public good by ensuring the existence of a safe and competitive insurance marketplace through the development and enforcement of the insurance laws of the State of New Hampshire. They are committed to doing so in an honest, effective and timely manner.

New Hampshire Insurance Department  
21 Fruit Street Suite 14  
Concord, NH 03301  
Phone: (603) 271-2261  
Consumer Hotline: 1-(800) 852-3416  
Email: [consumerservices@ins.nh.gov](mailto:consumerservices@ins.nh.gov)  
Website: <http://www.nh.gov/insurance/contactus/index.htm>

## **Legal Resources**

### **Appellate Defender Program**

The Appellate Defender is charged with the responsibility of handling virtually all the indigent criminal appeals from New Hampshire state courts. The Appellate Defender, along with the Attorney General's office, appears more often before the New Hampshire Supreme Court than any other entity, accordingly it plays a very important role in the development of criminal, constitutional and statutory law in New Hampshire.

University of New Hampshire  
Two White Street - Law Center  
Concord, NH 03301  
Phone: (603) 228-1541  
Website: <http://law.unh.edu/appellatedefender/index.php>

### **New Hampshire Bar Association Lawyer Referral Service**

The NH Lawyer Referral Service will help you evaluate your situation and if you need an attorney will refer you to a lawyer in your area who handles your type of case and makes every effort to direct you to another source of assistance if a lawyer is not what you need. The NH Lawyer Referral Service charges a \$25.00 fee for MOST referrals. This fee includes a consultation with the attorney for up to 30 minutes. After the consultation the attorney charges his or her regular rates. You will not be charged the fee if the attorney is not able to provide you with a consultation. They have lawyers practicing in virtually ALL areas of law, including Medical Malpractice Law, Bankruptcy Law, and Criminal Law.

Request a referral by calling: (603) 229-0002 or  
Online request form: [www.nhbar.org/lawyer-referral/lrs\\_request.asp](http://www.nhbar.org/lawyer-referral/lrs_request.asp)  
Questions: Email: [Lrsreferral@nhbar.org](mailto:Lrsreferral@nhbar.org)

## Appendix C. Local, State and National Resources

### New Hampshire Legal Aid Legal Advice & Referral Center (LARC)

LARC is a private, nonprofit law firm that provides free legal services to eligible, low income people anywhere in New Hampshire. Our attorneys and paralegals provide legal advice by telephone in the following areas of law: Family; Benefits and Welfare; and Housing. Our client's information is kept completely confidential. We receive support from the federal government and provide services to clients with incomes and assets below levels which are set by Congress and tied to federal poverty guidelines. We cannot provide services to people who are incarcerated.

Legal Advice & Referral Center  
48 South Main Street  
Concord, NH 03301  
Phone: 1-(800) 639-5290  
Website: <http://www.nhlegalaid.org/LARC>

### New Hampshire Legal Assistance (NHLA)

NHLA is a non-profit law firm offering legal services in civil matters to seniors and eligible low-income persons. NHLA provides high quality legal services to vulnerable low income people, ranging from simple legal information and advice to vigorous and thorough representation in all of New Hampshire's courts and before many of the local, state and federal agencies which play large roles in the lives of low-income people.

New Hampshire Legal Assistance (NHLA)  
Administration Office:  
117 North State Street  
Concord, NH 03301  
Phone:(603) 224-4107  
Website: [www.nhla.org](http://www.nhla.org)

1131 Main Street Berlin, NH 03570	(603) 752-1102 (800) 698-8969	<a href="http://www.nhla.org">www.nhla.org</a> Click on Berlin
24 Opera House Square, Suite 206 Claremont, NH 03742	(603) 542-8795 (800) 562-3994	<a href="http://www.nhla.org">www.nhla.org</a> Click on Claremont
117 North State Street Concord, NH 03301	(603) 223-9750 (800) 921-1115	<a href="http://www.nhla.org">www.nhla.org</a> Click on Concord
271 Main Street Littleton, NH 03561	(603) 444-8000 (800) 548-1886	<a href="http://www.nhla.org">www.nhla.org</a> Click on Littleton
1361 Elm Street, Suite 307 Manchester, NH 03101	(603) 668-9200 (800) 562-3174	<a href="http://www.nhla.org">www.nhla.org</a> Click on Manchester
21 East Pearl Street, Suite 2 Nashua, NH 03060	(603) 598-3800 (800) 517-0577	<a href="http://www.nhla.org">www.nhla.org</a> Click on Nashua
154 High Street Portsmouth, NH 03802	(603) 431-7411 (800) 334-3135	<a href="http://www.nhla.org">www.nhla.org</a> Click on Portsmouth



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### **NH Department of Health and Human Services Office of Ombudsman**

The Office of Ombudsman responds to complaints and requests for assistance from clients, employees, and members of the general public to resolve disagreements in matters that involve DHHS. This Office is to ensure that existing systems are effective and that they resolve differences fairly. They may use unbiased investigation, mediation and other alternative dispute resolution methods and/or provide referral services.

NH DHHS Office of Ombudsman  
129 Pleasant Street  
Concord, NH 03301  
Phone: (603) 271-6941  
Website: <http://www.dhhs.nh.gov/oos/ombudsman/index.htm>

### **The Pro Bono Program of the New Hampshire Bar Association**

Pro Bono is a private (non-governmental) non-profit operated through, and supported by, the New Hampshire Bar Association. They coordinate private attorneys who VOLUNTEER to help low-income people with non-criminal legal problems and needs. They partner with NH Legal Assistance and Legal Advice & Referral Center to serve low-income families and individual with basic legal issues.

Pro Bono Program of the New Hampshire Bar Association  
2 Pillsbury Street, Suite 300  
Concord, NH 03301  
Phone: 1-(800) 639-5290  
Website: [www.nhlegalid.org/about/pro-bono](http://www.nhlegalid.org/about/pro-bono)

### **NH Civil Liberties Union (ACLU)**

The NHCLU and is the state affiliate of the American Civil Liberties Union. They are a nonpartisan organization that defends civil liberties in the courtroom and in the legislature and seeks to expand awareness of individual rights in the classroom, in civic groups and in the media.

NH Civil Liberties Union (UCLA)  
18 Low Avenue  
Concord, NH 03301  
Phone: (603) 225-3080  
Website: [www.nhclu.org](http://www.nhclu.org)

## Appendix C. Local, State and National Resources

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### **NH Public Defenders Office**

The NH Public Defenders Office well trained and highly skilled attorneys represent indigent criminal defendants and children in delinquency proceedings in every District, Family and Superior Court in New Hampshire. They also serve as appointed counsel in appellate cases in the New Hampshire Supreme Court. If you want to make an application for an appointed attorney, or if you have any questions at all about where you are eligible, go to the court where your charges are pending and ask to speak to someone in the Clerk's Office who can help you apply for an appointed attorney in your criminal case.

The NH Public Defenders Office has offices throughout the state.

Administrative Office:

10 Ferry Street, Suite 425

Concord, NH 03301

Phone: (603) 224-1236

Website: [www.nhpd.org](http://www.nhpd.org)

## **Mental Health**

### **NH Catholic Charities**

Provides a range of social services including individual and group therapy to persons regardless of creed, social or economic background. Through a network of offices and parishes throughout the state their services strive to heal, comfort, and empower persons in need and to advocate for social justice.

NH Catholic Charities

215 Myrtle Street

PO Box 686

Manchester, NH 03105

Phone: (603) 669-3030

Toll Free 1-(800) 562-5249

Website: [www.catholiccharitiesnh.org](http://www.catholiccharitiesnh.org)

### **NH Department of Health and Human Services Bureau of Behavioral Health (BBH)**

BBH seeks to promote respect, recovery, and full community inclusion for adults, including older adults who experience a mental illness and children with an emotional disturbance. BBH works to ensure the provision of efficient and effective services to those citizens who are most severely and persistently disabled by mental, emotional and behavioral dysfunction as defined by NH law and rules. To this end, BBH has divided the entire state into community mental health regions. Each of the ten regions has a BBH contracted Community Mental Health Center and many regions have Peer Support Agencies. See a listing of Community Mental Health Centers and Peer Support Agencies in this Appendix.

NH DHHS Bureau of Behavioral Health

129 Pleasant Street

Concord, NH 03301-3857

Main Office Phone: (603) 271-5000 or 1-(800) 852-3345

Website: <http://www.dhhs.state.nh.us/dcbcs/bbh/index.htm>

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### **New Hampshire Hospital (NHH)**

New Hampshire Hospital is a state operated, publicly funded hospital providing a range of specialized psychiatric services. NHH provides acute treatment services for children, adolescents, adults and elders with severe mental illness. Most people are admitted to NHH on an involuntary basis because they have been found to be dangerous to themselves or others.

New Hampshire Hospital (NHH)  
Department of Health and Human Services  
36 Clinton Street  
Concord, NH 03303  
Phone: (603) 271-5300  
TDD: 1-(800) 735-2964  
Website: <http://www.dhhs.state.nh.us/dcbcs/nhh/index.htm>

### **National Institute of Mental Health (NIMH)**

The mission of NIMH is to transform the understanding and treatment of mental illness through basic and clinical research, paving the way for prevention, recovery, and cure. Provides a wide variety of topics related to mental health publications, research and educational resources.

National Institute of Mental Health (NIMH)  
6001 Executive Boulevard  
Bethesda, MD 20892-9663  
Phone: (301) 443-4513  
TTY: (301) 443-8431  
Phone: Toll Free 1-(866) 615-6464  
Email: [nimhinfo@nih.gov](mailto:nimhinfo@nih.gov)  
Website: [www.nimh.nih.gov](http://www.nimh.nih.gov)

### **National Mental Health America**

National Mental Health America (formerly known as the National Mental Health Association) is the country's leading nonprofit dedicated to helping ALL people live mentally healthier lives. With 240 affiliates nationwide, we represent a growing movement of Americans who promote mental wellness for the health and well-being of the nation - everyday and in times of crisis.

National Mental Health America  
2001 N. Beauregard Street, 6th Floor  
Alexandria, VA 22311  
Phone: (703) 684-7722  
Website: [www.nmha.org](http://www.nmha.org)

## Appendix C. Local, State and National Resources

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### Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. Prevention works, treatment is effective, and people recover from mental illness on America's communities. Prevention works, treatment is effective, and people recover from mental and substance use disorders. Behavioral health services improve health status and reduce healthcare and other costs to society.

US Department of Health and Human Services  
200 Independence SW Avenue  
Washington, DC 20201  
Phone: (202) 619-0257  
Toll Free: 1-(877) 696-6775  
Website: [www.samhsa.gov](http://www.samhsa.gov)

### Self-Help Resources

#### NAMI Connection

NAMI Connection is a recovery support group exclusively for those who experience mental illness conditions. It is led by trained facilitators who are consumers in recovery. The purpose of the group is to bring consumers together to learn from and support one another in their recovery journey.

To join a group or for more information, please contact the NAMI NH Connection Coordinator at (603) 225-5359 or visit the NAMI NH website [www.naminh.org](http://www.naminh.org) and click on Support and the Consumer/Client to see a listing of current groups and meeting times.

#### HEARTS & MINDS

The NAMI Hearts & Minds program is an online, interactive, educational initiative promoting the idea of wellness in both mind and body.

Website: [http://www.nami.org/templatecfm?section=Hearts\\_and\\_Minds](http://www.nami.org/templatecfm?section=Hearts_and_Minds)

### New Hampshire Peer Support Agencies (PSAs) And Consumer Run Programs

Peer Support Agencies provide services to people with mental illness who are 18 years of age or older and self-identify as a recipient, former recipient or as at significant risk of becoming a recipient of publicly funded mental health services. The services are provided by and for people with a mental illness are designed to assist people with their recovery. They provide a wide range of services. The PSAs are located throughout New Hampshire. They are private not-for-profit agencies that have contracted with the NH Department of Health and Human Services, Bureau of Behavioral Health.

<b>REGION I</b> Serenity Steps 567 Main Street, Berlin 03570 <a href="http://www.alccenters.org/berlinctr">www.alccenters.org/berlinctr</a>	The Haven 27 Lombard Street, Apt 6 & 7, Colebrook 03576 <a href="http://www.alccenters.org/colebrookctr">www.alccenters.org/colebrookctr</a>
Conway Peer Support PO Box 241, 486 White Mountain Highway, Conway 03818 <a href="http://www.alccenters.org/conwayctr">www.alccenters.org/conwayctr</a>	Littleton Peer Support 267 Main Street, Unit 4, Littleton 03561 <a href="http://www.alccenters.org/littletonctr">www.alccenters.org/littletonctr</a>
<b>REGION II</b> Stepping Stone Peer Support 108 Pleasant Street, Claremont 03743 <a href="http://www.steppingstonenextstep.org">www.steppingstonenextstep.org</a>	Next Step Peer Support 109 Bank Street, Lebanon 03766 <a href="http://www.steppingstonenextstep.org">www.steppingstonenextstep.org</a>
<b>REGION III &amp; IV</b> Lakes Region Consumer Advisory Board DBA Cornerbridge Peer Support 328 Union Avenue, Laconia 03247 <a href="http://www.nhcornerbridge.org">www.nhcornerbridge.org</a>	Cornerbridge of Laconia 328 Union Avenue, Laconia 03247 <a href="http://www.nhcornerbridge.org">www.nhcornerbridge.org</a>
Concord Peer Support 55 School Street, Concord, 03301 <a href="http://www.nhcornerbridge.org">www.nhcornerbridge.org</a>	
<b>REGION V</b> Monadnock Area Peer Support Center 64 Beaver Street, PO Box 258, Keene, 03431 <a href="http://www.monadnockpsa.org">www.monadnockpsa.org</a>	<b>REGION VI</b> Hearts Peer Support Center of Greater Nashua 5 Pine Street Extension Unit 2K , Nashua 03060 <a href="http://www.heartspsa.org">www.heartspsa.org</a>
<b>REGION VII</b> On The Road to Recovery 13 Orange Street, PO Box 1721 Manchester 03104 <a href="http://www.otrtr.org">www.otrtr.org</a>	<b>REGION VIII</b> Seacoast Consumer Alliance Peer Support 544 Islington Street, Portsmouth 03801
<b>REGION IX</b> Tri-City Consumer's Action Co-Op 36 Wakefield Street, Rochester 03867 <a href="http://www.tricitycoop.org">www.tricitycoop.org</a>	<b>REGION X</b> On The Road to Recovery 12 Birch Street, Derry 03038 <a href="http://www.otrtr.org">www.otrtr.org</a>
<b>REGION X</b> Circle of L.I.F.E. Peer Support Center 11 Wall Street, PO Box 409, Derry 03038	

## Appendix C. Local, State and National Resources

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### **Granite Pathways**

Granite Pathways, a peer-support, self-help, empowerment community in Manchester, NH that provides through their programs support to adults with mental illness to pursue their personal goals through education, employment, stable housing, rewarding.

Granite Pathways  
2013 Elm Street  
PO Box 1008  
Manchester, NH 03105-1008  
Phone: (603) 665-5665  
Website: <http://granitepathways.org>

### **Mental Health Recovery and WRAP, Mary Ellen Copeland**

The mission is to promote personal, organizational, and community wellness and empowerment. The focus is on shifting the system of mental healthcare toward prevention and recovery through education, training, and research. WRAP teaches participants recovery and self-management skills and strategies.

Mental Health Recovery and WRAP  
PO Box 301  
W. Dummerston, VT 05357  
Phone: (802) 254-2092  
Email: [info@mentalhealthrecovery.com](mailto:info@mentalhealthrecovery.com)  
Website: [www.mentalhealthrecovery.com](http://www.mentalhealthrecovery.com)

### **National Mental Health Consumer Self-Help Clearinghouse**

A Consumer run national technical assistance center serving the mental health consumer movement.

National Mental Health Consumer Self-Help Clearinghouse  
1211 Chestnut Street, Suite 1207  
Philadelphia, PA 19107  
Phone: 1-(800) 553-4539  
Email: [info@mhselfhelp.org](mailto:info@mhselfhelp.org)  
Website: [www.mhselfhelp.org](http://www.mhselfhelp.org)

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## Suicide Prevention

Connect Suicide Prevention Project is a comprehensive, community based approach to suicide prevention, intervention and postvention developed by NAMI NH.

NAMI NH  
85 North State Street  
Concord, NH 03301  
Phone: (603) 225-5359  
Email: [info@naminh.org](mailto:info@naminh.org)  
Website: [www.theconnectproject.org](http://www.theconnectproject.org)

### NH Survivor of Suicide Loss Support Groups

There are many support groups across New Hampshire for those who have lost a family member, friend or relative to suicide. Some groups are peer-facilitated and others are led by professional counselors, all are comprised of fellow survivors who can offer great comfort through conversation and discussion of issues unique to bereavement of suicide. There are also general grief support groups for both adults and children that are not specific to suicide but address issues of grief and loss. Internet support groups offer another option for people who live in rural areas or prefer tapping into support from home or at different hours.

For additional information on survivor support groups, resources or events, please visit the Connect Suicide Prevention website: [www.theconnectproject.org](http://www.theconnectproject.org) or contact NAMI NH at (603) 225-5359.

### Victims Inc

Provides individuals who are specially trained to assist survivors of a sudden and traumatic death. They are sometimes able to provide immediate in-home support (especially in the Rochester/Seacoast area) to families dealing with the suicide of a loved one. They also sponsor a weekend overnight grief camp for children ages 6-15 in Rochester called Camp Purple Parachute.

Victims Inc.  
PO Box 455  
Rochester, NH 03866  
Phone: (603) 335-7777  
Email: [pat\\_rainboth@victimsinc.org](mailto:pat_rainboth@victimsinc.org)  
Website: [www.victimsinc.org](http://www.victimsinc.org)

### Suicide Prevention Resource Center (SPRC)

The SPRC provides prevention support, training and resources to assist organizations and individuals to develop suicide prevention programs, interventions and policies and to advance the National Strategy for Suicide Prevention.

Suicide Prevention Resource Center (SPRC)  
43 Foundry Avenue  
Waltham, MA 02453  
Phone: 1-(877) 438-7772  
Website: [www.sprc.org](http://www.sprc.org)



### Vehicles

#### **Good News Garage (a program of Lutheran Social Services)**

Several innovative programs that address transportation for low-income working families who are currently receiving Temporary Assistance to Needy Families or enrolled in a work related program or participating in the Families at Work program.

Good News Garage

325 Merrill Street

Manchester, NH 03103

Phone: 1-(877) 400-6065 or (603) 669-6937

Website: <http://www.goodnewsgarage.org/>

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## Appendix D. Forms You Might Find Useful

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### Medication Log

Name: \_\_\_\_\_

Allergies to medications? \_\_\_\_ \*YES \_\_\_\_ NO    \*If yes, please list the medication and the side effects experienced. \_\_\_\_\_

\_\_\_\_\_

Name of Medication Comments Symptoms it Treats	Prescribed By	Dosage and Frequency	Response	Date Started Date Ended
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### Relapse Prevention Plan

<p>Reminder of events or situation that triggered relapses in the past:</p> <ol style="list-style-type: none"><li>1.</li><li>2.</li><li>3.</li><li>4.</li></ol>
<p>Reminder of early warning signs that I experienced in the past:</p> <ol style="list-style-type: none"><li>1.</li><li>2.</li><li>3.</li><li>4.</li></ol>
<p>What I think would help me if I am experiencing an early warning sign:</p> <ol style="list-style-type: none"><li>1.</li><li>2.</li><li>3.</li><li>4.</li></ol> <p>Who I would like to assist me, and what I would like them to do:</p> <ol style="list-style-type: none"><li>1.</li><li>2.</li><li>3.</li><li>4.</li></ol>
<p>Who would I like to be contacted in case of an emergency:</p> <ol style="list-style-type: none"><li>1.</li><li>2.</li><li>3.</li><li>4.</li></ol>

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## Crisis Management Plan

What I am like and the things I do when I am well. 1. 2. 3.
Symptoms I experience when I am in crisis. 1. 2. 3.
Those people who have agreed to take control of my care when I am out of control. 1. 2. 3.
The names and phone numbers of my healthcare providers. 1. 2. 3. The names and dosages of the medications I am currently taking. 1. 2. 3.
Treatments that have helped me recover from past crises. 1. 2. 3. Treatments that have not helped me recover from past crises. 1. 2. 3.
Alternatives to consider before hospitalization. 1. 2. 3.
Hospitals at which I would prefer to be treated. 1. 2. 3.
Things that indicate I am ready to take responsibility for myself again. 1. 2. 3.

## Appendix D. Forms You Might Find Useful ---

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## Appendix E. Suggested Reading

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The following books and publications have been recommended by the National Alliance on Mental Illness (website: [www.nami.org](http://www.nami.org)) to further your understanding and knowledge about mental illness. Visit NAMI NH website: [www.naminh.org](http://www.naminh.org) or the NAMI NH Mental Health Resource Center at 85 North State Street, Concord, NH to review literature, publications, DVDs and materials that are available on loan to NAMI NH members.

### Benefits and Related Topics

*Disability and the Family: A Guide to Decisions for Adulthood;* Turnbull III, H. Rutherford, et al., 1989.

*Federal Benefits for Veterans and Dependents;* Dept. of Veterans Affairs 1999.

*Future Planning Guide: Assuring Future Care for Dependents with Disabilities;* Russell, L. Mark, 1989.

*Mental Disability Law: A Primer;* American Bar Association, 5th ed., 1995.

*Mental Illness and Managed Care;* A Primer for Families and Consumers. Malloy, Michael, 1995.

*A Parent's Guide to Wills and Trusts;* Silver, Don, 1992.

### The Brain

*The Biology of Mental Disorders;* New Developments in Neuroscience. U.S. Congress, 1992.

*Brave New Brain;* Conquering Mental Illness in the Era of the Genome. Andreasen, Nancy, 2001.

*Change the Brain Change Behavior;* How The Treatment Changes Brain Functioning; Miran, Michael, Ph.D., 2006

### Consumer Issues

*Surviving Mental Illness: Stress, Coping, and Adaptation;* Hatfield, Agnes B. and Harriet P. Lefley, 1993.

*Telling is Risky Business;* Mental Health Consumers Confront Stigma; Wahl, Otto F., 1999.

### Disorders/Personal Stories

*Adult ADD: A Reader Friendly Guide to Identifying, Understanding and Treating Adult. Attention Deficit Disorder;* Whiteman, Thomas A. and Michele Novotni, 1995.

## Appendix E. Suggested Reading

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*Anxiety, Phobias, and Panic; Taking Charge and Conquering Fear;* Peurifoy, Reneau Z., 1992.

*The Beautiful Mind: A Biography of John Forbes Nash Jr.; Winner of the Nobel Prize in Economics, 1994.* Nasar, Sylvia, 1998.

*The Bipolar Disorder Survival Guide;* Miklowitz, David J., 2002.

*Crazy: A Father's Search Through America's Mental Health Madness;* Earley, Pete. 2006.  
*The Depression Workbook.* Copeland, Mary Ellen, 1992.

*Freedom from Obsessive-Compulsive Disorder: A Personalized Recovery Program for Living with Uncertainty;* Grayson, Jonathan, 2003.

*I Hate You—Don't Leave Me: Understanding the Borderline Personality;* Kreisman, Jerold & Hal Straus, 1989.

*Lincoln's Melancholy: How Depression Challenged a President and Fueled His Greatness;* Shenk, Joshua Wolf, 2005.

*My Brother's Madness: A Memoir;* Pines, Paul, 2007.

*An Unquiet Mind;* Jamison, Kay Redfield, 1995.

### Dual Diagnosis

*Dual Diagnosis of Major Mental Illness and Substance Disorder;* Minkoff, Kenneth and Robert Drake, 1991.

### Family Guides

*Bipolar Disorder: A Guide for Patients and Families;* Mondimore, Francis, M.D., 1999.

*The Complete Family Guide to Schizophrenia: Helping Your Loved One Get the Most Out of Life;* Mueser, Kim T. and Susan Gingerich, 2006.

*A Family Guide-Choosing the Right Treatment; What families need to know about Evidence-Based Practices;* NAMI, 2007.

*I Am Not Sick, I Don't Need Help;* Helping the Seriously Mentally Ill Accept Treatment; Amador, Xavier, 2000.

*Just for This Day: Meditations for Families Experiencing Mental Illness;* NAMI Ohio.

*Loving Someone with Bipolar Disorder: Understanding & Helping Your Partner;* Fast, Julie A. and John D. Preston, 2004.

*Nothing to Hide: Mental Illness in the Family;* Beard, Jean J., Peggy Gillespie and Gigi Kaeser, 2002.



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## Health

*Health Lifestyles for Women with Psychiatric Disabilities;* Hutchinson, Don S., Sc.D., LRC, et al., 1999.

*Integrating Publicly Funded Physical and Behavioral Health Services: A Description of Selected Initiatives FINAL REPORT;* The Robert Wood Johnson Foundation, February 2007.

## Medication

*Breakthrough in Antipsychotic Medications: A Guide for Consumers, Families and Clinicians;* Weiden, Peter J., et al., NAMI 1999.

*Drugs and the Brain.* Snyder, Solomon H., M.D., 1996.

*Is It Me or My Meds?;* Living with Antidepressants; Karp, David Al, 2006.

## Public Policy

*Fulfilling the Promise; Transforming New Hampshire's Mental Health System,* 2008.

*Grading the States; A Report on America's Healthcare System on Mental Illness,* NAMI, 2006.

*Grading the States;* NAMI, 2009.

*New Hampshire's Prescription For Mental Health Care; Comprehensive, Integrated, and Coordinated Health Care;* Antal, Peter, Ph.D., October 2009.

## Research

*Bridging Science and Service;* NIH, NIMH, 1999.

*The Neuroscience of Mental Health II; A Report on Neuroscience Research;* NIMH, 1995.

*A Special Report: Schizophrenia;* NIMH, 1993.

## Spiritual Issues and Coping Skills

*The Burden of Sympathy: How Families Cope with Mental Illness;* Karp, David A., 2001.

*Just for This Day: Meditations for Families Experiencing Mental Illness;* NAMI Ohio.

*Writing It Down: A NAMI Notebook of Hope on Issues of Recover;* Karr, Ruth, ed.  
(A companion to the video, Getting on the Road to Recovery)

## Appendix E. Suggested Reading

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### **Suicide**

*Night Falls Fast: Understanding Suicide*; Jamison, Kay Redfield, 1999.

*Suicide: Survivors: A Guide for Those Left Behind*; Wroblewski, Adina, 1991.





85 North State Street, Concord, NH 03301

Phone: (603) 225-5359 or (800) 242-6264

Fax: (603) 228-8848

E-mail: [info@naminh.org](mailto:info@naminh.org)