



CONTINUUM RECOVERY SERVICES

FAMILY HANDBOOK



CONTINUUM
rebuilding lives

Welcome!

We hope you find this handbook to be helpful and a support to you as you navigate the complexities of recovery. We are looking forward to a collaborative journey together with you and your family member.

We know that it can be a frustrating and difficult path when trying to find the right treatment and care for a loved one. Many families who come to Continuum of Care for help have already been through numerous trials and tribulations searching for answers. Starting today, we hope to help lessen your burden. This handbook is intended to assist you in gaining a better understanding of the many systems of care and services offered.

Thank you for entrusting your loved one's care with Continuum of Care. We take an immense amount of pride in providing person-centered care in order to meet your loved one's unique needs. As we progress through your family member's treatment, please feel free to ask any questions regarding the services here, and let us know how we can better assist you.

Sincerely,

The Continuum of Care Team

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Navigating the Mental Health Treatment Field

The treatment industry can be challenging to navigate for clients, their families, and at times even for us as professionals. There are numerous factors that go into the selection of the right treatment facility. However, at its most fundamental level, it is essential to determine the appropriate level of care.

The question here is what services does the individual need? When answering this question, it is necessary to examine what is known as the “continuum of care” (not to be confused with the name of our organization). The continuum of care aids professionals in determining the appropriate treatment setting for their client. Below you will find the different treatment options available to clients and a quick review of what each level of care entails.

<p><u>OP Services</u> Individual, Group, Medication Management, or Family Therapy. Typically once per week for 1 hour.</p>	<p><u>Intensive Outpatient (IOP)</u> Typically 10-15 hours per week consisting of Individual, Group, & Family Therapy</p>	<p><u>Partial Hospital (PHP)</u> Typically 20-30 hours per week consisting of individual, group, & family therapy.</p>	<p><u>Extended Care</u> Typically 3 months to 1 year of treatment at a facility where the client resides for the duration of treatment</p>	<p><u>Residential</u> Typically 2-4 weeks of treatment at a facility where the client resides for the duration of treatment</p>	<p><u>Detoxification</u> Typically 5-7 days- medically monitored process of clearing of toxins from the body that assists a person who is dependent on one or more substances to withdraw from dependence</p>	<p><u>Psychiatric Hospitalization</u> Typically short term stabilization ranging from 72 hours to 30 days depending on the acuity and severity of issues that the client is suffering from</p>
Outpatient			Inpatient			

Understanding Mental Illness and Co-occurring Disorders

Mental Health or Mental illness are terms often used to describe psychiatric conditions that include but are not limited to: schizophrenia, anxiety, bi-polar and major depression, and more. These conditions can sometimes severely affect how a person feels, thinks, behaves, and interacts in the world and with other people. These conditions are diagnosed using a standardized criteria through the DSM (Diagnostic and Statistical Manual of Mental Disorders).

Many people living with mental health challenges may also experience times of institutionalization, homelessness, poverty, isolation, poor physical health, substance abuse, unemployment, and stigmatism. With that said, many also go on to live fully productive and normal lives. The severity of their issues can waiver and at times can significantly affect a person's capacity to care for themselves and their ability to continue to excel in employment and/or education.

As a family member, it is important to engage in your own self care, education and even family therapy so you can better determine and understand the complexities of mental illness. The more educated and knowledgeable you are of your loved one's struggles, the better you will be prepared to help them. Managing expectations is vital as symptoms and behaviors can cause immense stress and a disruption to your entire family.

Dual diagnosis or co-occurring disorder is a term we use to describe a person's condition that is affected by both a major mental illness and alcohol or other drug use. When a loved one is affected by both, it can complicate treatment and be very challenging for both providers and family members. This is because of the obvious health and safety concerns but also the symptoms of one problem can look like – or mask – the symptoms of the other. Co-occurring conditions can also lead to a cycle of self-destructive behaviors which is often debilitating for families and loved ones to endure. People with co-occurring disorders often experience more severe and chronic medical, social, and emotional problems than people experiencing a mental health condition or substance-use disorder alone. Because they have both disorders, they are vulnerable to more crises, health concerns, relapse and often an exacerbation of psychiatric symptoms.

Integrated treatment is found to be most effective in treating co-occurring disorders. It is a means of coordinating substance-use and mental health interventions simultaneously, rather than treating each disorder separately and without consideration for the other. Harm reduction approaches are often used for individuals who continue to use. This will be discussed later in the handbook.

Integrated treatment occurs when a person receives combined treatment for mental illness and substance use from the same clinician or treatment team. It helps people develop trust, find hope, gain knowledge, skills, and the support they need to manage their problems and to pursue meaningful life goals.

Dual diagnosis or co-occurring disorders is when a person is affected by both a major mental illness and alcohol or other drug use. When a loved one is affected by both treatment can be very challenging. This is because the symptoms of one problem can look like – or mask – the symptoms of the other. Co-occurring conditions can also lead to a cycle of self-destructive behaviors which can complicate both the mental illness and the addiction. People with co-occurring disorders often experience more severe and chronic medical, social, and emotional problems than people experiencing a mental health condition or substance-use disorder alone. Because they have two disorders, they are vulnerable to ongoing use, relapse and often an exacerbation of psychiatric symptoms.

Integrated treatment occurs when a person receives combined treatment for mental illness and substance use from the same clinician or treatment team. It helps people develop hope, knowledge, skills, and the support they need to manage their problems and to pursue meaningful life goals.

The mental health system is complex and is not easy to navigate. It can take months to secure the proper support and treatment, even years. As conditions are more often chronic, it can be disheartening and frustrating to see a loved one relapse after making progress. With that said, as an agency, we embrace the approach of long-term, integrated treatment from the same providers and treatment team. This helps for the continuity of care, therapeutic relationship, and ensuring quality care.

Our clients have told us how helpful it can be to have loved ones who are supportive, and patient. who are willing to be available and know when to allow them the space they need. Finding what role will be helpful in your loved ones treatment takes time and support, and is often formalized in family therapy. Loved ones that take on the “right role” can help build trust and break through the stress and frustration of recovery journey.

Relapse and re-hospitalization are sometimes common for people with serious and persistent mental illnesses, especially among patients who don't recognize they are ill (a condition known as anosognosia). Substance use will often complicate treatment efforts and may at times, make conditions and outcomes worst.

When a Crisis Occurs

When a loved one is experiencing a psychiatric crisis, it is hard to think straight, clearly and quickly. It is actually proven that when a person is in crisis the “thinking” portion of your brain (cerebral cortex) is hijacked, leaving one to rely on the portion of the brain responsible for the “fight or flight response.” This is important to keep this in mind when you are attempting to de-escalate a loved one.

In preparation to a crisis remember that having treatment records, emergency contacts, personal data, prescription information, diagnosis information and legal paperwork collected in a single source, at your fingertips, will make it faster and easier for you to respond effectively if a crisis develops.

If you decide that your loved one may be having a crisis or mental health emergency, you’ll want to consider the following questions:

1. Is your loved one in immediate danger to themselves or to others?
2. Can you manage the situation yourself or do you need help?
3. If you need help, what type of help do you need and from whom?

It can also be helpful to enlist a stable and reliable “back up” in advance who is willing to help in an emergency by joining you on the scene, staying home with your children or providing other support you need in order to focus on getting help for your loved one.

When calling for emergency personnel, always ask dispatch for a CIT (Crisis Intervention) officer or for a responder trained and experienced in Mental Health.

It is always important to stress to dispatch and emergency personnel that your loved one has mental health concerns and if you feel your loved one may need to be evaluated by your local emergency room or an alternative mobile response team. This is especially crucial as it prepares emergency personnel, allows them to send the right person for the job, and sets an expectation of care. Remember the more involved you are in your loved ones treatment the more of an expertise you can provide for the police. It can also be helpful to meet officers and emergency responders outside the home of place to allow a moment to update them personally of the situation. This allows a moment to build rapport and ensure the proper communication has been given. Be the expert, be the advocate and make suggestions. Not all law enforcement are trained in mental health so they may rely on your feedback to provide the safest and most effective intervention.

Other measures that will help you to be prepared include:

- Understanding the laws in your state;
- Understanding your loved one's illness, signs and symptoms;
- Know your local crisis units and mobile resources;
- Becoming familiar with the procedures and staff at the local emergency room or other facility where your loved one is likely to be taken by police or paramedics in an emergency and providing them with information. It is often helpful to call ahead and leave contact information, even if they have not yet arrived. Ask who attending doctor is and who you can contact in advance;
- Become familiar with the lingo. Have they decompensated, previous suicide attempts, gravely disabled, history of harm to self or others;
- Identifying diversion options where your loved one lives (e.g., alternatives to hospital "crisis programs" where individuals in crisis can possibly find immediate placement;
- Networking with other families through the local affiliate such the National Alliance on Mental Illness (NAMI).

De-escalation and Working Through a Crisis

Know your loved ones Warning Signs:

- Inability to perform daily tasks like bathing, brushing teeth, brushing hair, changing clothes;
- Rapid mood swings, increased energy level, inability to stay still, pacing; suddenly depressed, withdrawn; suddenly happy or calm after period of depression ;
- Increased agitation verbal threats, violent, out-of-control behavior, destroys property, pacing;
- Abusive behavior to self and others, including substance use or self-harm (cutting)
- Isolation from school, work, family, friends ;
- Loses touch with reality (psychosis), unable to recognize family or friends, confused, strange ideas, thinks they're someone they're not, doesn't understand what people are saying, hears voices, sees things that aren't there;
- Paranoia, suspicion and mistrust of people or their actions without evidence or justification;
- Extreme energy or lack of energy;
- Talking very rapidly or non-stop;
- Not eating or eating all the time, noticeable weight loss.

Preparing and handling a crisis:

- Learn all you can about the your family member's diagnosis;
- Avoid guilt and assigning blame to others;
- Be an active part of your loved ones treatment team and know when to step back
- Learn to recognize early warning signs of relapse, such as changes in sleeping patterns, increasing social withdrawal, inattention to hygiene, and signs of irritability;
- Do what your loved one wants, as long as it's reasonable and safe;
- Don't shout or raise your voice;
- Don't threaten; this may be interpreted as a play for power and increase fear or prompt an assault;
- Don't criticize or make fun of the person;
- Don't argue with other family members, particularly in your loved one's presence.
- Avoid direct, continuous eye contact or touching the person;
- Don't block the doorway or any other exit;

De-escalation tips for loved ones:

- Keep your voice calm;
- Avoid overreacting;
- Listen to the person;
- Express support and concern;
- Avoid continuous eye contact;
- Ask how you can help;
- Keep stimulation level low;
- Move slowly;
- Offer options instead of trying to take control;
- Avoid touching the person unless you ask permission;
- Be patient;
- Gently announce actions before initiating them;
- Give them space, don't make them feel trapped;
- Allow for a release if possible;
- Don't make judgmental comments;
- Don't argue or try to reason with the person.

Other tips to consider:

- If you are the trigger or are escalating the person see if someone with a good rapport can take over and remove yourself if you can.
- If there is an audience try and get the person or the audience away.
- Going outdoors can sometimes be helpful
- Respond to delusions by talking about the person's feelings, not about the delusions – may be helpful to say, "That must be so frightening," not "that's not real – nobody's going to hurt you."
- Utilize grounding techniques can sometimes be helpful- reassuring a person is safe or that you are there with them and help is coming
- Don't touch unless absolutely necessary – touch, in certain situations can be perceived as a threat and trigger a violent reaction.
- Don't stand over the person – If the person is seated, seat yourself to avoid being perceived as trying to control or intimidate.

Active listening techniques:

- **Pay attention and always assess the situation.** A goal of active listening is to set a quiet comfortable tone and allow time and opportunity for the other person to think and speak.
- **Avoid judgment.** Active listening requires an open mind, you can validate feelings which can show that you are listening and understand.
- **Reflect.** Paraphrase key points to show you are listening.
- **Clarify.** Ask questions
- **Summarize.** Restating key themes as the conversation proceeds confirms and solidifies your grasp of the other person's point of view.

DATA:

You and your loved one are not alone

- Among the **20.2 million adults** who experienced a substance use condition, **50.5% (10.2 million adults)** had a co-occurring mental illness.
- **1 in 5 adults—43.8 million or 18.5%**—experiences mental illness in a given year.
- **1 in 5 youth aged 13-18 (21.4%)** experiences a severe mental health condition at some point during their life; for children aged 8-15 that estimate is 13%;
- **46% of homeless adults** staying in shelters have a mental illness and/or substance use disorder.
- **20% of state prisoners** and **21% of local jail prisoners** have a recent history of a mental health condition.
- **70% of youth in juvenile justice systems** have at least one mental health condition.
- **60% of all adults** and almost **50% of all youth ages 8-15** with a mental illness received no mental health services in the previous year.
- **African-Americans and Hispanic-Americans** used mental health services at about half the rate of Caucasian-Americans in the past year and Asian Americans at about 1/3 the rate.
- **50% of adults with mental illness** report experiencing symptoms prior to the age of 14; **75%** prior to the age of 24.
- **One in four families** has at least one member with a mental disorder. Family members are often the primary caregivers of people with mental disorders. The extent of the burden of mental disorders on family members is difficult to assess and quantify, and is consequently often ignored. However, it does have a significant impact on the family's quality of life.
- According to a Swedish study, **one half of family members** claimed they had developed psychological or social problems (such as sleeping problems and depression) of their own, to such an extent that they also needed help and support
- There are more than **9 million men and women** in the US dealing with co-occurring disorders.

Treatment Modalities

Continuum of Care offers a wide range of treatment approaches and modalities. We pair traditional mental health treatment methods with complementary and alternative treatments (such as mindfulness and holistic Body-Mind-Spirit care) to create an integrative approach using evidence-based modalities such as cognitive-behavioral, dialectical-behavioral, solution-focused, and strategic family approaches.

Integrative body-mind-spirit is “a process of transformation that expands beyond the physical/biochemical view of illness and health based on scientific knowledge and also embraces ancient wisdom that emphasize holism.”

Cognitive Behavioral Therapy (CBT) is a treatment modality that focuses on how thoughts, feelings and behaviors influence each other. CBT teaches a person to recognize when their thoughts are negative and gives them techniques to redirect these thoughts. , the goal is to enhance coping skills to improve the way one thinks, feels, and responds by challenging and changing unhelpful cognitive distortions

Dialectical Behavior Therapy (DBT) is an evidence based therapy that helps individuals to accept themselves, feel safe and manage intense distressing emotions in order to manage destructive behaviors. DBT also strives to assist them in developing healthy relationships and applying learned skills to manage conflict.

Mindfulness-based Cognitive Behavioral Therapy (MBCT) is a modified form of cognitive therapy that incorporates mindfulness practices such as meditation and breathing exercises. Using these tools, MBCT, staff can teach individuals how to break away from negative thought patterns, reduce stress and engage in healthy alternatives.

Through mindfulness, one can recognize that holding onto negative feelings is ineffective and often self-destructive.

MBCT can help an individual learn mind management skills leading to heightened metacognitive awareness, acceptance of negative thought patterns and an ability to respond in skillful ways. During MBCT one can learn to decenter negative thoughts and feelings, allowing the mind to move from an automatic thought pattern to conscious emotional processing.

Strategic Family Therapy is a therapeutic approach that addresses complex family dynamics. Symptoms are clues and are viewed within the context of the family system. This systemic approach considers the transitional points throughout the family life cycle. The therapist hypothesizes and designs a mutually agreed upon plan that defines goals to measure change and the action steps to achieve them. The therapist works with the family

to identify patterns and dynamics that may be complicating the family unit. The goal in Strategic Family Therapy is to ultimately move the family to the next stage in the family life cycle.

Solution Focused Therapy (SFT) Is a strength-based intervention that helps individuals focus on the present and future, focusing on the past only to the degree necessary for communicating empathy and accurate understanding of the an individual's concerns. Through solution focused approaches, a therapist highlights existing strengths and resources to help individuals create a preferred future. The therapist is curious about times when changes occur and attempts to identify circumstances and behaviors that encourage the desired change. The ultimate goal of SFT is to help an individual to envision a desired future and create the necessary steps to achieve that outcome.

Motivational Interviewing (MI) is a widely used approach often used within mental health and substance use treatments. It is a specific conversational intervention that aims to strengthening a person's own motivation and commitment to change. It's exploring ambivalence, while not increasing resistance by confrontation. Through MI the goal is to listen and support the person's own ambivalence without coercion and help guide them towards changing their negative behavior.

Harm Reduction is a non-judgmental therapeutic approach which links a set of practices that focus first on engagement and building a therapeutic alliance. The goal is to minimize the physical, social, and legal harms and enhance the quality of life for individuals with mental health and substance use disorders who may be resistant to change.

Substance use strategies are developed that may include safer use or managed use in order to meet those who use substances "where they're at."

Mental Health strategies aim to reduce the harmful effects associated with various destructive or maladaptive behaviors while educating safety.

Harm reduction is often helpful in building trust and support to ensure help is there should the client feel empowered to change.

"People are generally better persuaded by the reasons which they themselves discovered, than by those which have come into the minds of others."

-Blaise Pascal (1669)

Working With Emergency Providers

Know the law:

In Connecticut “The law permits the involuntary commitment of people with psychiatric disabilities who are either dangerous to themselves or others or gravely disabled. A gravely disabled person is someone who may suffer harm because he or she fails to provide for basic human needs and refuses to accept necessary hospitalization.”

Connecticut is one of only four states that **do not** authorize involuntary treatment in the community, often called “assisted outpatient treatment (AOT)” or “outpatient commitment.” Such laws often make it possible for people with mental illness to receive medical care before they are so ill they require hospitalization or experience other consequences of non-treatment.

Why that matters:

Clients have a right to refuse medication and can only be involuntarily committed when they present as a danger to themselves or others or are deemed gravely disabled. According to the law, gravely disabled is defined by a condition in which a person cannot provide his/her basic needs of health and safety.

If you have concerns your child or loved one is a danger to self or others and/or may be gravely disabled, you should contact emergency services immediately. When calling 911 you can request a CIT officer or a responder trained in mental health crisis. As this is a developing model, all areas may not be able to accommodate the request, but by asking for a trained professional you will increase the chances of obtaining mental health informed care. If this is not an emergency requiring 911 you can also access mobile crisis through 211 in most areas.

The Crisis Intervention Team (CIT) program is a community partnership of law enforcement and mental health/addiction professionals. It is an innovative first-responder model of police-based crisis intervention training to help persons with mental illness/addiction access proper care and avoid entering the criminal justice system due to illness related behaviors.

Mobile Crisis, is a mental health service in the United States (typically operated by a hospital or community mental health agency) which service the community by providing immediate emergency mental health evaluations and/or consultation. These services are often available on a 24-hour basis and can be dispatched to where you are (hours of operation can vary state to state).

Mobile Crisis evaluations are typically requested due to a reasonable expectation of client safety due to mental health or substance use. They can also be requested if a person is thought to be gravely disabled. Criteria for requesting a Mobile Crisis assessment varies

depending upon individual mental health agencies and entities that regulate mental health services, as well as statutes created via legislative assemblies.

What to do when working with emergency providers:

- **Request a CIT trained officer**—Ask for someone with experience in mental health first aid.
- **Know your audience**—Emergency personnel may or may not have training or expertise in all psychiatric diagnoses and may need your help in understanding your loved one.
- **Build a relationship**—A good rapport could help the quality of care.
- **Provide them with information**— Include contact information, mental health and medical history as well as a list of current medications.
- **Tell them a story**— Stories often provide us with details and help create a sense of empathy.
- **Remain calm**—As mentioned in this packet, any crisis situation is better handled if you are calm and clear.
- **Manage expectations**—Outcomes vary depending on any given situation.
- **Follow up**—Find out where your loved one is being transferred to and who you can contact to follow up (ask for which hospital and which unit you could follow up with).
- **Know the lingo**— some helpful tips: is loved one at their current baseline (usual state of being), has there been recent substance use (how much and how often), duration of current presentation, have they been compliant with psychiatric medications, are they presenting as a danger to themselves or others, any recent changes in mood, has there been decompensation (decline in overall baseline functioning).
- **Advocate, advocate, advocate**—Advocate and allow treatment to continue progressing.

Transition and Discharge Planning

Effective discharge planning, at any level of behavioral health care, is a critical necessity that can be vital to a loved one's success. It is important that families and their loved ones are in agreement with the plans that come to fruition and more importantly, are all part of the process. Any concerns or doubts about the viability of a discharge plan should be communicated with the team. Alternative options or "back-up plans" can always be explored. It is often helpful to have discharge discussions begin during admission so that everyone is aware of the options, barriers and concerns. Below are some suggestions to keep in mind regarding discharge from specific levels of care. Bear in mind that there will always be overlap in these suggestions as some levels of care are often short-term/urgent care.

Discharging from a Psychiatric Emergency Room

When a crisis occurs we are often left with emergency resources to assist in getting urgent help for our loved ones. Emergency Rooms (or ED's) are considered the last remaining safety net in our communities. By design, they often lack the capability, training and resources to adequately provide a comprehensive and effective discharge. According to the American Journal of Emergency medicine, a Psychiatric ED revisit within 12 months was significantly higher among patients discharged who had requested an inpatient bed (54.0%), than those discharged from the ED (40.9%) or admitted to inpatient care (30.5%). It is also reported that the main reason Emergency Room providers may choose to not admit a patient is that 1) the patient does not meet criteria for an inpatient bed; 2) the patient has "stabilized" following a day or two in the ER; and 3) there is a lack of inpatient beds across the state and country forcing hospitals to only admit patients they consider the most vulnerable and at risk.

Patients and their loved ones can often feel left out of the discharge process. ED providers sometimes have minimal, if any, follow-up on important collaterals such as outpatient providers. Family members and outpatient providers can inform assessment with knowledge of history and current state, and are often the ones charged with carrying a disposition plan forward post-ED discharge.

Some important things to keep in mind when having a loved one discharge from a psychiatric emergency room are:

- Build a relationship and rapport with emergency room staff: creating a collaborative relationship with the providers will likely increase the quality of assistance being provided.
- If your loved one was initially scheduled for an inpatient bed, communicate your concerns and advocate assistance for a comprehensive plan in order to avoid another urgent episode that may result in returning to the ER.

- Ensure the patient's Conservator is aware and in agreement with discharge if applicable.
- If you are concerned your loved one is still at risk. request that outpatient provider's visit or be consulted in the matter.
- Ensure a social worker is involved to assist and advocate for length of stay and/or effective discharge planning.
- Ask to speak directly with the "attending" psychiatrist
- Request a discharge meeting.
- Request alternatives and community resources (Social Workers may know the community resources available including community crisis programs and/or mental health/substance use residential placements).

Discharging from an Acute Inpatient Hospitalization

Inpatient treatment is often a short-term locked level of care located in a secure unit of a treatment facility or hospital. These units serve individuals with severe mental health/addiction issues, who are in need of constant monitoring for their own personal safety and well-being. The main goal is to stabilize symptoms while developing a continuing treatment plan so that the individual can transition the care he or she requires in a less restrictive setting (i.e. returning home or to another level of care). While preparing to discharge from this intensive setting, it is important to keep in mind that this is not an end point in the individual's care, but a transition with multiple factors to take into account.

Considering that inpatient hospitalization is often under 2 weeks, here are some important things to keep in my mind when having a loved one prepare for discharge from an acute hospitalization:

- Build a relationship and rapport with inpatient staff: creating a collaborative relationship with the providers will likely increase the quality of assistance being provided.
- Know the social worker assigned to the case and the roles of other staff involved.
- Upon admission, request a family meeting to communicate any recent concerns you may have including medication changes, current mental status and potential options that may be available post discharge.
- Upon admission, request that a final meeting is scheduled prior to discharge. This is especially helpful to review any potential med changes and to ensure a proper plan is in place post discharge.
- Request current outpatient treaters be involved in the discharge process. It is often helpful, if feasible to have an outpatient treater visit the client prior to discharge. This allows them to make their own assessment on how the client is doing and if they feel they are ready for discharge.
- Ensure follow-up care is already scheduled with an outpatient team.
- Ensure Conservator is aware and in agreement with discharge, if applicable.

Discharging from Residential Treatment:

When outpatient care or IOP/PHP is simply not enough for individuals in recovery, loved ones often consider residential treatment as an option to assist in the stabilization process. Residential can also be considered as a step down from acute inpatient care when loved ones need a longer period to stabilize. When an individual completes residential treatment, whether for substance use, mental health, or co-occurring disorders, it is imperative that an adequate, safe and sensible discharge plan is in place. It is important to note that discharge should be discussed often and included in the treatment plan. Family meetings and therapy should also be an integral part of the residential stay. Often life after treatment is when recovery begins, and when the skills learned can be put into action.

Discharge is a critical aspect of treatment planning in a residential program and should be individualized according to each person's needs and interests. Successful aftercare treatment plans include: stable housing (which may be transitional housing and/or sober living), outpatient substance use and/or mental health treatment (which may be PHP, IOP, and/or individual sessions with a therapist), medication management, recovery coaching, 12 step meetings and other support groups.

Some important things to keep in my mind when having a loved one discharged from a residential facility are:

- Have key program staff including current treaters and prescribers, the client, and important loved ones participate in the discharge process.
- Ensure a final meeting is held to review alternatives and next steps: including safety planning (if applicable) and relapse prevention.
- Have important questions and concerns prepared for the final meeting
- Ensure Conservator is aware, if applicable.
- Ensure that appointments are already secured for follow up care with an outpatient team (IOP/PHP or individual therapist and psychiatric prescriber if applicable)
- Ensure your loved one has adequate medications to bridge them to their next provider's appointment.
- Ensure that you are informed about insurance coverage/or lack of coverage, and potential costs.
- Discuss after care options from the facility they are discharging from (i.e., do they have after care or alumni services available to them/you?).

Family Recommendations

According to NAMI, 1 in 25 Americans lives with a serious mental health condition and yet in any given year, only 60% of people with a mental illness get mental health care. Know that you are not alone. When a loved one is diagnosed with a serious mental illness it will be exhausting and difficult, and heart wrenching to witness the day-to-day struggles of such a chronic mental condition. Moreover, the stigma and barriers that confront you will only add to the frustration and emotional pain. With that said, the truth remains that serious mental illnesses often have a biological component. It is not the result of bad parenting, and there is likely not much you could have done differently to prevent it. Self-blame and grief is common. All of the research suggests that early intervention and healthy family support will provide better outcomes.

As an organization we strongly suggest treatment for the whole family. This means seeking help for yourself and your family is the best way to weave through the emotional roll-a-coaster. A qualified therapist can offer clarity, objectivity, solutions not previously seen and a place to safely deal with the emotions that occur. To keep it simple-the healthier you are, the better equipped you become. Blogger Victoria Maxwell writes: "When my mother was ill with the swings of severe depression, mania, and anxiety, I was worried as well as angry. I needed someone outside the family to freely discuss my frustrations and hurt without the fear of upsetting her.

In identifying your source of support, consider the following:

- A family support group
- Education classes
- Family therapy
- Individual therapy
- Advocacy

Resources

Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD) is a membership organization, produces the bi-monthly Attention magazine (for members) and sponsors an annual conference. Contact information for all local chapters is available online through CHADD's Resource Directory.

www.chadd.org

Children's Mental Health Network (CMHN) provides weekly news and unbiased analysis of key issues focused on children, youth and families' mental health and wellbeing. CMHN distills the high volume of information about issues that impact children and youth with emotional and behavioral challenges and their families in a way that makes sense in its most simplified form, focusing on the key elements requiring action and involvement.

www.cmhnetwork.org

Depression and Bipolar Support Alliance (DBSA) provides hope, help, support and education to improve the lives of people who have mood disorders.

www.dbsalliance.org

Disability benefits – child (under age 18)

<https://www.ssa.gov/benefits/disability/apply-child.html>

Early Assessment & Support Alliance (EASA) serves young people ages 12 to 25 (15-25 in Multnomah County) who have had a first episode of psychosis within the last 12 months or who are experiencing early at-risk symptoms for psychosis, and their families. The goal of EASA is to identify individuals with a new psychosis as soon as possible in order to minimize the negative impact on their lives.

www.easacommunity.org

Fact sheet library

www.nami.org/Learn-More/Fact-Sheet-Library First episode psychosis

www.nami.org/Learn-More/Mental-Health-Conditions/RelatedConditions/Psychosis/First-Episode-Psychosis Learn more

www.nami.org/Learn-More

www.nami.org/Learn-More

Families for Depression Awareness is a national nonprofit organization helping families recognize and cope with depression and bipolar disorder to get people well and prevent suicides. <http://familyaware.org>

Mental Health America (MHA) is an advocacy, education and support organization working to address the needs of people with mental health related needs and mental illness.

www.nmha.org

MentalHealth.org: Let's talk about it is dedicated to providing basic information about mental health, myths and facts, signs and symptoms and how to get help.

www.mentalhealth.org

Mental Health Medications

www.nimh.nih.gov/health/topics/mental-health-medications/index.shtml

National Alliance on Mental Illness (NAMI) is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. What started as a small group of families gathered around a kitchen table in 1979 has blossomed into the nation's leading voice on mental health. Today, we are an association of hundreds of local affiliates, state organizations and volunteers who work in your community to raise awareness and provide support and education that was not previously available to those in need.

www.nami.org

National Disability Rights Network (NDRN) works to improve the lives of people with disabilities by guarding against abuse; advocating for basic rights; and ensuring accountability in health care, education, employment, housing, transportation and within the juvenile and criminal justice systems. NDRN is the nonprofit membership organization for the federally mandated Protection and Advocacy (P&A) Systems and the Client Assistance Programs (CAP) for individuals with disabilities. **Collectively, the Network** is the largest provider of legally based advocacy services to people with disabilities in the United States.

www.ndrn.org

National Suicide Prevention Line: 800-273-TALK (8255).

National Institute of Mental Health (NIMH), a division of the National Institute of Health (NIH) has the mission of transforming the understanding and treatment of mental illness.

<https://www.nimh.nih.gov/index.shtml>

OCD Resource Center provides information and resources on obsessive compulsive disorder.

www.ocdresource.com

Parent to Parent (P2P) USA provides emotional and informational support to families of children who have special needs most notably by matching parents seeking support with an experienced, trained 'Support Parent'.

www.p2pusa.org

Recovery After an Initial Schizophrenia Episode (RAISE)

<https://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml>

Social Security Administration delivers a broad range of services online and has a network of over 1,400 offices including field offices, teleservice centers, processing centers and hearing offices. SSA also has a presence in U.S. embassies around the globe.

www.ssa.gov

Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation.

www.samhsa.gov

Suicide Prevention Resource Center (SPRC) is the nation's only federally supported resource center devoted to advancing the National Strategy for Suicide Prevention. They provide technical assistance, training and materials to increase the knowledge and expertise of suicide prevention practitioners and other professionals serving people at risk for suicide.

www.sprc.org

The Trevor Project is the leading national organization providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender and questioning (LGBTQ) young people ages 13-24.

www.thetrevorproject.org

Treatment of Children with Mental Illness

www.nimh.nih.gov/health/publications/treatment-of-children-with-mental-illnessfact-sheet/index.shtml

Yellow Ribbon Suicide Prevention Program is dedicated to preventing suicide and attempts by making suicide prevention accessible to everyone and removing barriers to help by empowering individuals and communities through leadership, awareness and education; and by collaborating and partnering with support networks to reduce stigma and help save lives.

www.yellowribbon.org