NAMI Stark County

National Alliance on Mental Illness

Building Hope for Recovery through Education, Support and Advocacy

NAMI Stark County
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www.namistarkcounty.org

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Patient/Peer and Family Outreach

- **Have a conversation. It might be the first time someone has talked openly about mental illness.**
- **Listen. It might be the first time someone has listened to them talk about mental illness.**
- **Provide support from NAMI Stark County staff with lived experience.**
- **Provide information about Self-Care, Coping Skills and Communication Skills**
- **Provide information Stark County resources**
- **Provide information NAMI Stark County Education Programs, Support Groups and Advocacy**

Please Note:

HIPAA, a federal law, provides you and your family members with some valuable protections related to how your health care information can be used and shared. Understanding these protections can help you understand your rights related to your personal health care information and what you can do if you believe they have been violated.

Release of Information must be signed by patient in order for release information to be shared, and with whom the information will be shared by the provider.

However, Family members have the right to provide information to the provider.

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If you or someone you know is in an emergency, call 988
Or Coleman Crisis Center Adult/Mobile Response Team 330-452-6000

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NAMI The National Alliance On Mental Illness is the nation's largest grassroots mental health organization dedicated to improving the lives of persons living with serious mental illness and their families. Founded in 1979, NAMI has become the nation's voice on mental illness, a nationwide organization. NAMI is dedicated to the eradication of mental illnesses and to the improvement of the quality for those whose lives are impacted by these mental illness disorders.

NAMI Stark County works to ***"Provide Hope for Recovery for Persons and Families Impacted by Mental Illness".*** We are dedicated to improving the lives of persons and families in Stark County who have been impacted by mental illness through free NAMI education programs and presentations, support groups and advocacy.

CIT Crisis Intervention Team

Mental Health Crisis

In case of emergency, call 911 Ask for CIT Officer.
For immediate assistance Coleman Crisis Center
Adult or Youth Mobile Response 330-452-6000.
Call or text 988 for support.

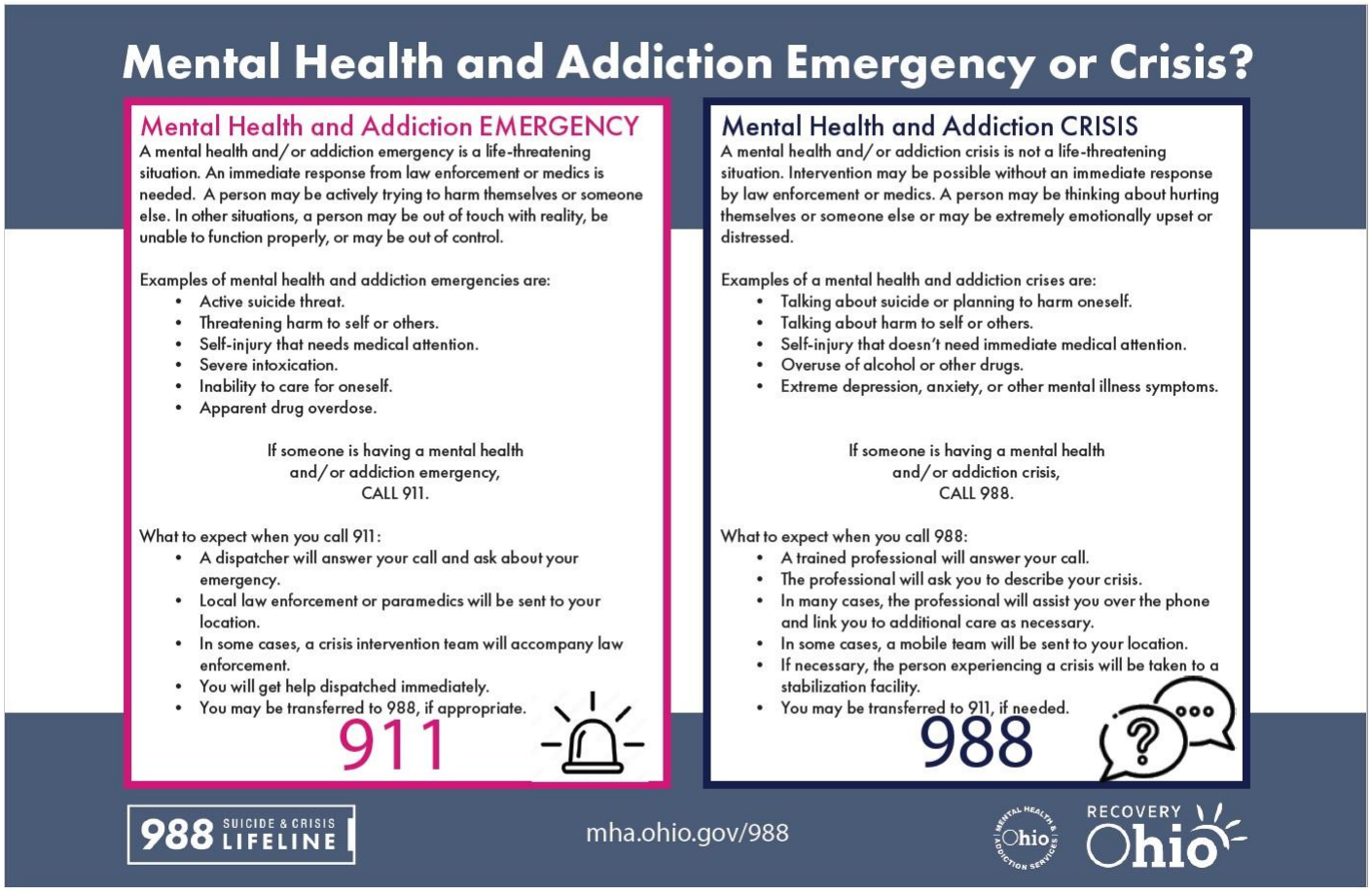
We at ***NAMI Stark County believe*** it is vital that people who have mental health conditions get the help that they need. People who have mental illness are often misunderstood or sometimes are ***not capable of communicating properly in a time of crisis.*** These CIT stickers visually indicate that a CIT Team Member may be needed.

Please call 330-455-6264 for CIT Crisis Team Sticker for home, school, work, or car.

In Case of Emergency—Call 911/988—Ask for CIT Officer
Give 911/988 operator Mental Health information about your loved one while on the phone and again when officers arrive.

It's time to talk about suicide and depression.
Need help?
In the U.S.,
call 1-800-273-8255 for the
National Suicide Prevention Lifeline.

Or Coleman Crisis Center
Hotline 330-452-6000
Adult/Mobile Response Team



NAMI Stark County Education Programs

Mental Health Education

NAMI Family-to-Family
8 week course is for family members and friends of adults with serious mental illness. It is taught by trained NAMI family members.

NAMI Peer-to-Peer
8-week course is for adults who have been diagnosed with a mental illness. It is taught by NAMI trained peers.

NAMI Basics
6-week course is for those with school age children with emotional/mental/neurobiological disorders.
It is taught by trained NAMI members.

NAMI Provider Course for organizations that provide services for people affected by mental illness.

NAMI SMARTS for ADVOCACY Make your voice heard. NAMI Smarts for Advocacy will enhance your advocacy skills and help you shape a powerful and personal story that will move policy makers and your community.

Mental Health FIRST AID
from NATIONAL COUNCIL FOR MENTAL WELLBEING

New NAMI Signature Programs

NAMI FaithNet
National Alliance on Mental Illness

NAMI Sharing Hope
National Alliance on Mental Illness

NAMI Hearts Minds
Mental Health is Physical Health

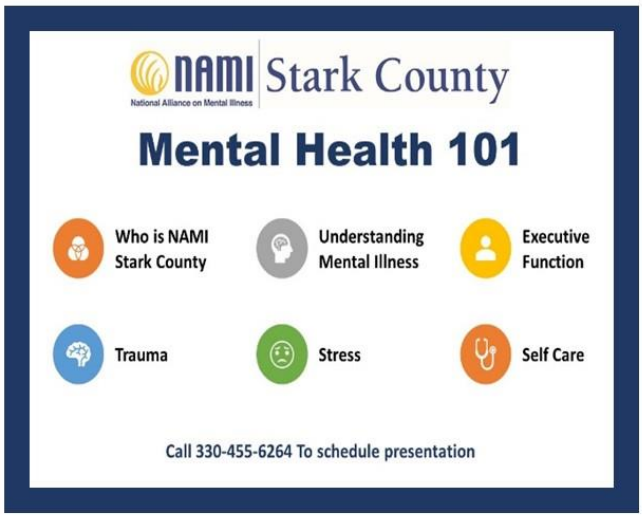
NAMI Stark County Support Groups

Mental Health Support Groups

For persons with a mental illness, family members and natural supports of someone with a mental illness; for persons dealing with both a mental illness.

Community Awareness & Presentations NAMI Stark County collaborates with other agencies, committees and coalitions who share common interest in helping support behavior health issues. We attend health and wellness fairs and provide mental health presentations and trainings.

Mental Health Presentations



System Navigator Help individuals and families transition to appropriate behavioral health services and provide emotional support and guidance individuals navigating through behavioral health system.

System Navigator

Rhoda Nutter

rnutter@namistarkcounty.org
330-455-6264

NAMI Stark County
National Alliance on Mental Illness

- ❑ Assist individuals with connecting them to necessary services while empowering them to continue long-term engagement independently.
- ❑ Develop relationships in order to increase client support in long-term engagement.
- ❑ Address barriers and gaps in accessing behavioral health services.
- ❑ Connect individuals and family's transition to appropriate behavioral health services. They will be able to provide emotional support and guidance to individuals navigating through the behavioral health system in Stark County.
- ❑ Work with Transitional Age Youth aging out of Foster Care
- ❑ Serve as a voice and advocate for individuals navigating the behavioral health system in Stark County.

Young Adult Coodinator Youth Move Stark County

YOUTH MOVE STARK COUNTY

YouthMOVE Stark County is a youth and young adult-led organization that offers:

- Advocacy
- Education
- Community engagement
- Peer support

We are a youth-serving system currently available for those between the ages of 14-30 years old.

Faith James, Young Adult Coordinator | fjames@namistarkcounty.org

Mental Health Advocacy

Mental Health Advocacy

- **Community Advocate**
- **Parent Advocate**
- **NAMI Smarts for Advocacy**

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PAC
NAMI Ohio
Parent Advocacy Connection

Adena Beach Parent Advocate
abeach@namistarkcounty.org
330-949-3029 or 330-455-6264
121 Cleveland Ave., S.W.
Canton, OH 44702
www.namistarkcounty.org

What is the Parent Advocacy Connection (PAC)?

PAC Mission is to empower, educate, encourage, and equip families to partner with professionals in promoting access to services that are family-centered, community-based, comprehensive, and culturally competent.

PAC is a NAMI Ohio grassroots program that offers trained Parent Advocates with lived experience who reflect the cultural and ethnic make-up of the families they serve. When children require services from multiple sources (i.e., mental health, schools, juvenile courts, developmental disabilities, and alcohol/drug addiction services agencies), it can be difficult for parents to navigate their way through these various service systems. Families may become overwhelmed and have difficulty expressing their concerns and the needs of their child(ren). Ohio's service coordination process recognizes this challenge and has made support for families available through the Parent Advocacy Connection (PAC).

What Do Parent Advocates Offer?

PAC Parent Advocates Will:

- Listen and support the parent's decisions without judgment
- Assist in navigating child-serving systems
- Help parents understand their rights
- Help organize and prepare for meetings
- Supply information about child-serving systems, children's behavioral health and development, and community
- Help parents identify resources
- Help reduce loneliness
- Provide hope and ideas
- Encourage self-care activities
- Render advocacy support
- Facilitate familial engagement with service providers
- Share their own personal lived experience
- Model collaboration between families and professionals
- Respect a family's culture
- Keep information confidential

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Volunteer/Intern Descriptions

Education Program Leader Volunteer/Intern - NAMI Family to Family, NAMI Peer to Peer, NAMI Basics, NAMI Homefront, NAMI Provider Education, NAMI Smarts and Mental Health First Aid Adult or Youth: All of our classes are facilitated by trained Volunteers/Interns. Our program leaders for our classes offer life-changing information for family members and for individuals living with a mental health condition.

Support Group Facilitator Volunteer/Intern - Family Support Group - Peer Connection Support Group – FaithNet - YouthMOVE Stark County Group: All of our support groups are facilitated by trained Volunteers/Interns. As an instructor: Program leaders of our support groups facilitate the exchange of group wisdom for family members and individuals living with a mental health condition.

Presenter Volunteer/Intern - Mental Health 101 and Mental Health Student Series, Sharing Hope and Hearts and Minds Presentations: All of our community presentations are delivered by trained Volunteers/Interns who have lived experience with mental illness, either as a person living with mental illness or a family member.

CIT & Law Enforcement Volunteer/Intern From time to time, we are asked to be part of panels that look at various aspects of mental health. If you have lived experience as an individual living with mental illness or as a family member and are willing to share your story, you can make a real impact in the community.

Office Volunteer/Intern We are always looking for Volunteers/Interns in the office and would always welcome technical assistance.

Supported Housing Volunteer/Intern Supportive housing units in Stark County monthly visits to do a craft and talk mental health. If you love crafts and like sharing about mental health, this position may be perfect for you.

NAMI Stark County and YouthMOVE Stark County Ambassador Volunteer/Intern: Another way we help get the word out about NAMI Stark County is by attending health fairs, county fairs, and other community events. We need Volunteers/Interns, known as **NAMI Stark County and YouthMOVE Stark County Ambassadors,** to staff the table and answer people's questions about NAMI Stark County and the services we offer.

NAMI Adopt-a-Site Volunteer/Intern: Most people hear about NAMI Stark County through word-of-mouth or providers. As an **Adopt-a-Site** leader, you can adopt one location in the community and make sure they are adequately supplied with brochures, handouts, and other information people need to get connected with us.

Fundraising Volunteer/Intern Moving Forward for Mental Health Walk & Annual Golf Outing: NAMI Stark County is funded entirely by grants and donations. Our biggest fundraiser is the **Moving Forward for Mental Health Walk**, which we hold annually in October. Our **Annual Golf Outing** is held in August. We need Volunteer/Interns to pull off a successful walk and golf outing. There are many Volunteers/Interns roles—everything from publicity to captaining a walk team to helping to set up the walk route the day before the event and captaining a team at the golf outing.

Board Member: Interested in joining our NAMI Stark County board?

Other ways to help: You likely have other gifts and talents that could benefit NAMI Stark County and the people we serve. We would love to talk with you about how you'd like to contribute!

NAMI Stark County 121 Cleveland Ave., S.W., Canton, OH 44702 330-455-6264 www.namistarkcounty.org

How is YOUR Workplace's Mental Health?

Mental illness is the leading cause of missed work.

76% of workers believe their company should be doing more to support the mental health of their workforce

78% of the workforce say the pandemic has negatively affected their mental health

85% of people say their mental health issues are causing sleep deprivation, poor physical health, reduced happiness at home, suffering family relationships or isolation from friends

Source : ORACLE

What can NAMI do for your Workplace?

- Work with HR and workers to get help
- Provide educational programs and presentations
- Provide individual support and resources
- Offer online groups
- Offer Mental Health First Aid Certification
- Provide printed mental health information
- Help you to know what to do in a workplace mental health emergency

ALL NAMI Stark County Programs ARE FREE OF CHARGE

What can your Workplace do with NAMI?

- Host a workplace educational program
- Support NAMI Fundraisers
- Become a NAMI Volunteer and/or Board Member
- Provide NAMI with a community grant
- Help us end stigma towards mental illness

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330-455-6264

Tips for Calling 911 for Someone Experiencing a Mental Health Crisis

When Making the Call

- Try to speak as calmly and clearly as possible and control the volume of your voice
- Request a Crisis Intervention Team (CIT) officer
- Stay on the phone until the dispatcher tells you it is okay to hang up
- Be prepared to provide the following information:
  - Your name, address and phone number
  - The name of the person in crisis and your relationship to him/her
  - A description of the individual in crisis (age, gender, clothing)
  - If the person has a mental health and/or physical health condition
  - Any prescribed medication the person is taking or is not taking and for how long
  - Any alcohol or substances being used or abused
  - Any history of interactions with the police
  - If you feel threatened
  - If the person in crisis hears voices
  - If the person in crisis fears someone or something
  - If the person has a history of suicide attempts or self-injury
  - If there are any weapons in the house try to safely remove them before calling
  - What the person is currently doing and saying and where he/she is in the house or on the property

While Waiting for Help

- Stay calm and try to keep the environment as calm as possible
- Let the person know you are getting help and everyone will be kept safe
- If you plan to stay with the person in crisis as he/she receives help, let the person know
- Ask the person who is experiencing the crisis what he/she needs right now
- Ask the person if he/she has any wellness techniques that have helped in the past
- Ask if the person has a Crisis Plan and ask if he/she would like you to read it out loud while waiting for help to arrive

When the Police Arrive

- Turn all the lights in the home on so that all occupants can be clearly visible to the arriving officers
- Do not have anything in your hands if you come out of the house to meet the officers
- Do not run up to the officers
- Identify yourself as calmly as possible
- Tell the officers:
  - Who you are and what your relationship is to the person experiencing the mental health crisis
  - What is happening and why you called 911
  - What immediate symptoms or behaviors caused you to call for help
  - If the person has a mental health condition and whether he/she is receiving treatment
  - What medication is being taken, if any
  - If any medication has been stopped and for how long
  - Any history of suicide attempts
- Be prepared to share the contact information of the person's psychiatrist, physician and/or case manager
- If the person has a Crisis Plan share it with the officer
- Spend as much time as necessary answering all of the officers' questions. Answer directly and concisely. Do not ramble.
- Offer any advice you deem helpful
- Although it is difficult in times of crisis, be as patient as possible

Source: Adapted from NAMI Virginia Informational Brochure

Crisis Intervention Team (CIT) Background

Law enforcement faces daily encounters in the community with individuals with serious mental illness, making up an estimated 7-10% of all encounters. *"The Crisis Intervention Team (CIT) is an innovative first-responder model of police-based crisis intervention with community, health care, and advocacy partnerships." (University of Memphis 2007)* Often referred to as "The Memphis Model," CIT was developed in Memphis, TN in 1988 and is being used increasingly throughout Ohio, the United States and around the world to improve law enforcement responses to individuals with mental illness. CIT training helps ensure that individuals will be successfully diverted away from jail and into a community treatment setting as a result of the responding officer's ability to recognize this complex illness and appropriately diffuse the situation. Additionally, CIT reduces the potential for injury or death to an officer or the person with mental illness in crisis.

Understanding Your Role as a Family Member or Guardian of Someone Who Is Hospitalized

Recently, a NAMI member, who is the legal guardian of a son with a long history of hospitalizations, e-mailed NAMI Ohio. In his e-mail, he shared that after his son's most recent hospitalization at Summit Behavioral Healthcare State Hospital, he discovered that the hospital was not following many of its policies with respect to family/guardian involvement. With the assistance of a civil rights attorney, he helped to develop a protocol for future use by the hospital, which he says is "a vast improvement over previous practice and a model for other hospitals."

The gentleman was kind enough to share the materials that were developed as part of the negotiation with the hospital, including two brochures entitled Family Involvement in Patient Care and Treatment and Guardian Involvement in Patient Care and Treatment. The brochures are now distributed at the outset of patient admissions, which provide summaries of the treatment program and policies relevant to family involvement. Below are excerpts from those brochures.

Family Involvement in Patient Care and Treatment

As a family member of a person who is admitted for treatment, your involvement with the patient's treatment depends on his or her consent. A patient has a right of privacy so hospital staff must get written permission from the patient in order to give information to you. However, you may provide staff information about the patient that you think would be helpful in his or her treatment without the permission of the patient. In fact, many hospitals welcome this type of information from concerned family members and view it as important to help in the patient's treatment plan and recovery.

If the Patient Agrees to Share Information

Hospital staff asks the patient at the time of admission to identify any family member that he or she would like to receive information about his or her hospitalization. If the patient agrees and completes a written release of information form, a social worker from the hospital should contact the family member as soon as possible to discuss the patient's treatment. If the patient does not agree to share information at the time of admission, staff can bring this up with the patient again later in treatment when the patient might wish to reconsider.

Guardian Involvement in Patient Care

As a legal guardian of a person who is admitted for mental health treatment in a hospital, you have the right to authorize or approve the provision of all medical, health, or other professional care, counsel, treatment or services to the patient. If the patient has been admitted to the hospital under Ohio law for involuntary hospitalization ("civil commitment law"), the legal guardian may apply for voluntary admission on behalf of the patient.

As the legal guardian, you should be given all of the information that the patient receives regarding care and treatment. You should be notified of and invited to participate in treatment team meetings for the patient in which the treatment plan is developed and progress toward recovery is discussed. Upon request, you should be provided with copies of the treatment plan. As the legal guardian, you are encouraged to provide any information about the patient that you think would be helpful in his or her treatment. Most hospitals welcome this information and view it as important to help in the patient's treatment plan and recovery.

Source: NAMI Ohio News Briefs Spring/Summer 2015

One out of every four families in America has a family member with a serious Mental Illness. Two out of every 100 adults will be affected by serious brain diseases between the ages of 18 and 30.

Mental Illness has nothing to do with intelligence.

It's not Your Fault.

NAMI is the National Alliance on Mental Illness, the nation's largest grass roots mental health organization dedicated to improving the lives of persons living with serious mental illness and their families. Founded in 1979, NAMI has become the nation's voice on mental illness, a nationwide organization with affiliates in every state and in more than 1,100 local communities across the country. NAMI is dedicated to the eradication of mental illnesses and to the improvement of quality of life of all whose lives are affected by these diseases.

NAMI Stark County works to "Provide Hope for Recovery for Persons and Families Impacted by Mental Illness". We are dedicated to improving the lives of persons and families in Stark County who have been touched by mental illness through NAMI public education and information; family and peer education, support and advocacy on behalf of people living with mental illness and for the health of our community; and visible public events that raise funds and awareness.

What is Mental Illness? Mental Illnesses are medical conditions and brain disorders that disrupt a person's thinking, feeling, mood, ability to relate to others, and daily functioning. People who have a mental illness can be very confused and frightened by their illness and usually suffer a great deal. People, through ignorance and misunderstanding, reject and discriminate against those with a mental illness, causing further suffering.

In any given year, about five million American adults experience an acute episode of one of five serious mental illnesses: Schizophrenia, Bipolar Disorder, Major Depression, Obsessive/Compulsive Disorder and Panic/Anxiety Disorder. Many of America's children – more than three million suffer from these disorders, often referred to as emotional disturbance.

Anyone Can Develop Mental Illness You can't catch a mental illness like a cold. Many factors combine to cause mental illness. Heredity may be a factor as it is in diabetes or cancer. Life stresses and physical illness also may be contributing factors. Contrary to old myths, mental illness is NOT caused by character, poor child rearing or an individual's behavior.

Treatment Works: People Recover At present, there is no effective prevention or cure for mental illness. However, mental illnesses are diagnosed and treated as precisely and effectively as many other medical disorders. Effective counseling, therapy and self-help community programs help people live productive and rewarding lives.

Challenges facing those with a Brain Disorder:

- Mental Illness can be difficult to treat. It usually takes a lot of trial and error with medications to finally come up with a "cocktail" of medications that will help.
- Those with brain disorders and their families deal with issues of stigma on a continual basis.

- Those with brain disorders suffer different levels of disabilities. Many have cognitive defects, problems with short term memory and "impaired gaiting" (difficulty blocking out extraneous stimuli in order to concentrate on what is necessary at the time.
- Socialization is often difficult for people with mental illness. This can be due to a number of reasons. Lack of socialization is a typical symptom in schizophrenia. However, many people have this problem due to stigma or other reasons.
- Many people with brain disorders can live independently. Again, this depends on the level of disability. There are those who must have continuous care but there are many others who maintain an apartment or home.
- Many people with brain disorders work. Adjustments made based upon the person's level of disability or functional ability. Some may work in a sheltered workshop and others who are "higher functioning" may have full time jobs.
- Economic self-sufficiency can be difficult for those with a brain disorder. There are no cures for these disorders and even though treatment may be working, there are no guarantees that the trend will continue. Economic self-sufficiency as it relates to someone with a brain disorder depends upon that person's level of disability at any given time.

Executive Function

- The foundations for learning are attention, memory and executive function.
- Executive Dysfunction (EDF) continues to be one of the most overlooked contributors to academic, behavioral and social problems for both youth and adults.
- A number of neurological conditions (especially ADHD) have been linked to deficits in the executive dysfunctions.
- Executive Functions are the higher order processes that enable us to plan, sequence, initiate and sustain our behavior towards some goal.
- Executive Functions can be thought of as a diverse group of highly specific cognitive processes collected together to direct cognition, emotion and motor activity including mental functions.
- Associated with the agility to engage in purposeful, organized, strategic, self-regulated and goal-directed behavior.

Executive Function Dysfunction is increased in:

- Illness and fatigue states
- Attention Deficit Hyperactivity Disorders (ADHD)
- Autism Spectrum Disorders
- Learning Disability
- Fetal Alcohol Syndrome
- Side effects of medications
- Drugs or Alcohol
- Brain Injury (traumatic or Acquired)
- Dementia, tumors
- Partial complex epilepsy, frontal origin
- Tic Disorders
- Genetic Disorders
- ***Mental Illness***
- ***Stress***

What is Family Support?

- Empathy
- Compassion
- Acceptance
- Understanding
- Sharing the duties
- Taking time for yourself
- No blame
- Establishing a Support Network
- Therapy

What do family caregivers typically do?

- Transportation
- Grocery Shopping
- Housework
- Manage finances
- Preparing meals
- Helping with medication
- Managing services
- Financial Support
- Housing
- Child Care

Why do family members need support?

- Having a family member with a mental illness can be very stressful.
- Whether the ill person is a son, daughter, husband, wife, brother or sister, you are affected by their illness too.
- A person with a neuro-biological brain disorder often needs much love, help and support. At the same time, the problems, fears and behavior of your ill relative may strain your patience and your ability to cope.
- There are many different kinds of mental illness, and each has its own symptoms. During periods when your relative is ill, he/she may be demanding and disruptive or extremely withdrawn or inactive. In fact, an ill person's behavior may keep on changing because the symptoms may fluctuate.

Family Guidelines During Recovery **Here are some things everyone can do to help make things run more smoothly:**

- **Go Slow.** Recovery takes time. Rest is important. Things will get better in their own time.
- **Keep it cool.** Enthusiasm is normal; tone it down. Disagreement is normal; tone it down too.
- **Give 'em space.** Time out is important. It's ok to offer. It's ok to refuse.
- **Set Limits.** Everyone needs to know what the rules are. A few good rules keep things calmer.
- **Ignore what you can't change.** Let some things slide. Don't ignore violence.
- **Keep it simple.** Say what you have to say clearly, calmly, positively.
- **Follow Doctor's orders.** Take medications as they are prescribed. Take only medications that are prescribed.
- **Carry on business as usual.** Reestablish family routines as quickly as possible. Stay in touch with family members.
- **No street drugs or alcohol.** They make symptoms worse.
- **Pick up on early signs.** Note changes. Consult with family physician or mental health provider.
- **Solve problems step by step**. Make changes gradually. Work on one thing at a time.
- **Lower expectations, temporarily**. Use a personal yardstick. Compare this month to last month rather than this year to last year.
- **Keep it cool at home**. If work gets hectic, remember to keep a low-keyed environment at home.
- **Punctuality and attendance are crucial**. Everyone in the family needs to help out.

Work is hard. **Developing work skills is difficult. Social skills can wait.**

It probably escapes no one's notice that most of these guidelines are good advice for any family.

Setting Limits on Intolerable Behaviors

- While sometimes symptoms of a brain disorder, certain behaviors must not be tolerated.
- Be firm but concise and use simple sentences so that you are clearly understood.
- Lecturing and reasoning probably won't work
- Recognize the person's personal space and maintain your own. Never corner a highly agitated person unless you're capable of restraining him/her if necessary.
- Don't do anything that could be seen as threatening, either verbally or physically.

Intolerable Behaviors

- Physical violence
- Illegal drug use
- Sexual abuse
- Theft
- Destroying property
- Creating fire hazards or setting fires

Safety Issues

- If possible, respond to the situation with another person.
- Approach the person slowly and from a vantage point from which you can be seen. Don't startle them.
- Be prepared for unexpected behavior.
- Don't stand in a defensive posture. Try to be relaxed and let your hands be seen. Don't make unnecessary quick moves.
- Don't back yourself, or the person in crisis, into a corner.
- Identify exits and any items in the room with which the person could hurt themselves or someone else.
- Use physical force only if absolutely necessary.

Request CIT Officer when calling 911/988

CIT Officers receive intensive training to handle individuals with mental illness with the goal of diversion to treatment rather than jail.

Grief

Family members may mourn the loss of a "normal" family life, as well as the loss of goals and dreams for the consumer and family unit. Grieve for your losses, and then allow yourself to dream new dreams.

To be effective, family members need to attend to their own well-being. Families who neglect their own needs can become "burned out" and have less energy to help their loved one.

STAGES OF EMOTIONAL RESPONSES TO TRAUMA

I. DEALING WITH CATASTROPHIC EVENTS

Crisis/Chaos/Shock Denial; "normalizing" Hoping Against Hope

NEEDS:

- ***Support**
- ***Comfort**
- ***Empathy for confusion**
- ***Help finding resources**
- ***Crisis intervention**
- ***Prognosis**
- ***Empathy for pain**
- ***NAMI**

II. LEARNING TO COPE

Anger/Guilt/Resentment Recognition Grief

NEEDS:

- ***Vent feelings**
- ***Keep hope**
- ***Education**
- ***Self-care**
- ***Networking**
- ***Skill training**
- ***Letting go**
- ***Co-op from System**
- ***NAMI**

III. MOVING INTO ADVOCACY

Understanding Acceptance Advocacy/Action

NEEDS:

- ***Activism**
- ***Restoring balance in life**
- ***Responsiveness from System**
- ***NAMI**

Take care of your life!

- Don't let you loved one's illness or disability always take center stage
- Remember to be good to yourself
- Love, Honor and Value Yourself.
- When people offer to help, accept the offer and suggest specific things they can do.
- Educate yourself about your loved one's condition
- Information is empowering
- There's a difference between caring and doing.

How to Care for Yourself - Engage in a relaxing activity:

- Read a book
- Rest
- Take a walk
- Exercise
- Meditate or pray
- Sports
- Hobbies
- Spending time with friends.
- Relax in a bubble bath
- Get a massage
- Enjoy nature
- Work on a garden
- Call a friend
- Rent or go to a movie
- Continue to participate in religious or spiritual activities recreational activities
- Plan and do fun things for yourself

To be able to care for the people you love, you must first take care of yourself. It's like the advice we're given on airplanes: put on your own oxygen mask before trying to help someone else with theirs. Taking care of yourself is a valid goal on its own, and it helps you support the people you love.
Caregivers who pay attention to their own physical and emotional health are better able to handle the challenges of supporting someone with mental illness. They adapt to changes, build strong relationships and recover from setbacks. The ups and downs in your family member's illness can have a huge impact on you. Improving your relationship with yourself by maintaining your physical and mental health makes you more resilient, helping you weather hard times and enjoy good ones. Here are some suggestions for personalizing your self-care strategy.

Understand How Stress Affects You

Stress affects your entire body, physically as well as mentally. Some common physical signs of stress include:

- Headaches
- Low energy
- Upset stomach, including diarrhea, constipation and nausea
- Aches, pains, and tense muscles
- Insomnia

Begin by identifying how stress feels to you. Then identify what events or situations cause you to feel that way. You may feel stressed by grocery shopping with your spouse when they're symptomatic or going to school events with other parents who don't know your child's medical history. Once you know which situations cause you stress, you'll be prepared to avoid it and to cope with it when it happens.

Protect Your Physical Health

Improving your physical wellbeing is one of the most comprehensive ways you can support your mental health. You'll have an easier time maintaining good mental habits when your body is a strong, resilient foundation.

- Exercise daily. Exercise can take many forms, such as taking the stairs whenever possible, walking up escalators, and running and biking rather than driving. Joining a class may help you commit to a schedule, if that works best for you. Daily exercise naturally produces stress-relieving hormones in your body and improves your overall health.

- Eat well. Eating mainly unprocessed foods like whole grains, vegetables and fresh fruit is key to a healthy body. Eating this way can help lower your risk for chronic diseases and help stabilize your energy levels and mood.
- Get enough sleep. Adults generally need between seven and nine hours of sleep. A brief nap—up to 30 minutes—can help you feel alert again during the day. Even 15 minutes of daytime sleep is helpful. To make your nighttime sleep count more, practice good "sleep hygiene," like avoiding using computers, TV and smartphones before bed.
- Avoid alcohol and drugs. They don't actually reduce stress and often worsen it. If you're struggling with substance use, click here for helpful resources.
- Practice relaxation exercises. Deep breathing, meditation and progressive muscle relaxation are easy, quick ways to reduce stress. When conflicts come up between you and your family member, these tools can help you feel less controlled by turbulent feelings and give you the space you need to think clearly about what to do next.

Recharge Yourself

When you're a caregiver of someone with a condition like mental illness, it can be incredibly hard to find time for yourself, and even when you do, you may feel distracted by thinking about what you "should" be doing instead. But learning to make time for yourself without feeling you're neglecting others—the person with the illness as well as the rest of your family—is critical.

Any amount of time you take for yourself is important. Being out of "caregiver mode" for as little as five minutes in the middle of a day packed with obligations can be a meaningful reminder of who you are in a larger sense. It can help keep you from becoming consumed by your responsibilities. Start small: think about activities you enjoyed before becoming a caregiver and try to work them back into your life. If you used to enjoy days out with friends, try to schedule a standing monthly lunch with them. It becomes part of your routine and no one has to work extra to make it happen each month.

The point is not what you do or how often you do it, but that you do take the time to care for yourself. It's impossible to take good care of anyone else if you're not taking care of yourself first.

Practice Good Mental Habits

Avoid Guilt

Try not to feel bad about experiencing negative emotions. You may resent having to remind your spouse to take his medication, then feel guilty. It's natural to think things like "a better person wouldn't be annoyed with their spouse," but that kind of guilt is both untrue and unproductive. When you allow yourself to notice your feelings without judging them as good or bad, you dial down the stress and feel more in control. When you feel less stressed, you're better able to thoughtfully choose how to act.

Notice the Positive

When you take the time to notice positive moments in your day, your experience of that day becomes better. Try writing down one thing each day or week that was good. Even if the positive thing is tiny ("It was a sunny day"), it's real, it counts, and it can start to change your experience of life.

Gather Strength from Others

NAMI support groups exist to reassure you that countless other people have faced similar challenges and understand your concerns. Talking about your experiences can help. The idea that you can, or should be able to, "solve" things by yourself is false. Often the people who seem like they know how to do everything are actually frequently asking for help; being willing to accept help is a great life skill. If you're having trouble keeping track of your sister's Medicaid documents and you've noticed your coworker is well-organized, ask them for tips about managing paperwork.

You may feel you don't have the time to stay in touch with friends or start new friendships. Focus on the long-term. If you can meet up with a friend once a month or go to a community event at your local library once every two months, it still helps keep you connected. It also gives you the chance to connect with people on multiple levels. Being a caregiver is an important part of your life, but it's not the whole story.

PRINCIPLES OF FAMILY CONSULTATION AND COLLABORATION (S.T.R.I.D.E.)

S : Support: The professional needs to support, sustain and protect families—support them by acknowledging their pain and protect them from blame from others. Families deserve to be understood in a deep, empathetic way; professionals should openly discuss and repudiate issues of blame and guilt.

T : Teamwork: Families and partners are key contributors to the treatment team and the treatment plan. Families are often the best source of information about their family member's illness and should be viewed as collaborators in the recovery network.

R : Respect: The professional needs to honor family loyalty and forbearance, to endorse family expertise and to recognize families gain experience as they cope with the travails of mental illness.

I : Information: Helping professionals should give information that will directly reduce family burden; give diagnosis/prognosis, information on biological mechanisms thought to cause the illness, treatment options, medications, resources, referrals to self-help groups, respite care, options for community living.

D : Development: Helping professionals can assist the family in developing the capacity for adaptation and coping; help them through the steps of emotional responses; validate the "normalcy" of their reactions to the catastrophe of mental illness.

E : Empowerment: Helping professionals can give families a blueprint for advocacy as a class of people, that is, as caregivers of people with brain disorders. Professionals can encourage families to advocate for their family members who are ill; they can work to change professional attitudes towards families of individuals with severe and persistent mental illness.

Caring about someone living with a mental illness can feel like a roller coaster, with a wide range of emotions.

These common emotions often fluctuate in intensity and duration:

worry anxiety protectiveness loneliness resentment

shame anger guilt hopefulness depression

frustration helpless fear powerlessness

confusion embarrassment

Families may also feel unappreciated for the energy they spend caring for the consumer.

Individuals with a mental illness often become self-absorbed, and they may experience family members' assistance as intrusive. Consequently, consumers may be ungrateful and act in a critical manner toward others who are trying to help.

Some family caregivers experience depression. About one-third of caregivers say that caregiving is somewhat or very stressful. In addition, women are more likely than men to suffer emotional stress related to caregiving.

Famous People Who Have Experienced Mental Illness:

Selena Gomez SHAWN MENDES Lizzo KE$HA

Billie Elish Robert Downey, Jr. Sally Field Linda Hamilton

Ronda Rousey **Daniel Radcliffe** Demi Lovato Patty Duke

Michael Phelps Carrie Fisher Leonardo DiCaprio Sting

JANE PAULEY Lady GaGa **Elton John** Adele

Alonzo Spellman **Ben Stiller** Darryl Strawberry

John-Claude VanDamme Ashley Judd Brian Wilson

ROBIN WILLIAMS Kurt Cobain

Supporting Recovery

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

What our loved ones need for recovery

At a national NAMI Conference some years ago, a panel of individual living with mental illness offered a list of the “necessary ingredients” of rehabilitation programs that lead to recovery. This is what they asked for:

- A safe and stable environment
- The best medical treatments
- Someone who sees me as special, who will share themselves
- An educated, supported family
- Something to get involved in: work, community, advocacy
- Education about the effective management of my illness
- Focus on individual strength and self-determination
- The 3 “P’s” We are not the *problem*: We are people with potential
- Sustaining hope and a vision of what is possible

Remember You're in the Process of Learning

Helping a family member is difficult, even if you do everything "right." No book, therapist or website can tell you how to prepare for the situations that may arise. It may help to think of this experience as a learning process. Every person with a mental health condition experiences it slightly differently. One person may fear losing a job, while another may be more worried about how relationships will change. If you ask questions and listen to the answers, you can learn about your family member's unique concerns.

You can also acquire better skills for offering support, as you learn what works well in your family and what doesn't. If you come from a family that's uncomfortable talking about mental illness or emotions, remember you have the ability to improve your communication. Similarly, even if you feel like you don't know how to offer encouragement right now, you can develop and improve through practice.

Remember Support is Not Control

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

They may not choose the treatment options that we would prefer, but by acknowledging their right to decide, we create a respectful, healing environment within the family. We improve their immediate quality of life by treating them with dignity. We're also encouraging them to commit to their chosen course of action.

The reality is that we can only control our own actions. We have to learn to give the people around us responsibility for decisions that only they can make. It's ultimately up to them to decide on their goals and strategies. You can encourage your family members, but you must let go of the feeling that you have to solve their problems for them.

Remember, an Illness is Influencing Your Family Member's Behavior

Even when we know someone has a mental health condition, it can be hard to recognize his or her efforts to be well. Sometimes we wonder if a family member is "trying to be difficult." We may find ourselves looking for something to blame: should we blame our family member or the mental health condition itself. In general, we should try to give family the benefit of the doubt. Remember that no one chooses to experience these symptoms.

Things You Can Do to Be Supportive

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

- **Learn as much as possible about mental health and your family member's condition**. Knowledge gives you practical insight and understanding. Learn about available treatments. What therapies and medications can help? Do people with this condition typically spend time in residential treatment? What options are available for supportive housing or employment?
- **Show interest in your family member's treatment plan**. Doctors and other medical providers cannot talk to family members without a patient's permission, so ask your family member to arrange this permission. Talk to the medical team about what to expect from the treatment plan. In particular, ask about possible side effects of medication. Find out how to call the provider if you notice behavioral or emotional changes you're concerned about.
- **Encourage your family member to follow the treatment plan**. This might mean offering transportation to therapy sessions, or reminders to take medications as prescribed. Because daily prodding about medication can easily insult or anger an adult, handle this carefully. Talk to your family member about his or her preferences. Try to set up a simple system to reassure you that treatment is continuing as planned.
- **Strive for an atmosphere of cooperation within the family.** Cooperation means not just offering support. It also means communicating with everyone in the family and distributing responsibility equally. Don't try to "spare" family members from stress by leaving the caretaking to one individual. Assign everyone in the household roles to play according to their abilities. Include your family member with the illness as well, making his or her responsibilities to the family clear.
- **Listen carefully.** Simply listening is one of the best ways to show your support. If your family member says hurtful things, it helps to listen for the emotion behind the words rather than focusing on the words themselves. Try to recognize and acknowledge the pain, anxiety or confusion rather than getting into unnecessary arguments.
- **Resume "normal" activities and routines.** Don't let life revolve around your family member's mental health condition. Return to a regular routine within the family. Spend time together on activities unconnected to illness, such as watching a movie, eating dinner out or visiting a favorite park. Practice living life *with* a mental health condition, rather than struggling *against* mental illness.

- **Don't push too hard.** At the same time, remember that it takes time to heal from an acute episode. Allow your family member to rest. Offer him or her opportunities to ease back into routine activities rather than requiring participation. A gentle approach encourages recuperation.
- **Find support**. Outside support and encouragement is critical for everyone in the family, not only the person with the mental health condition. Whatever your role in the family, stress is easier to handle when you regularly talk to people who understand your experience. Peer-led support groups are available for people living with mental illnesses and also for their family members.
- **Express your support out loud**. Spoken encouragement can reduce stress levels. You don't need to say anything fancy. Practice a few simple, gentle statements: "I'm sorry you feel bad and I want to help," "It isn't your fault. It's an illness that can happen to anyone," "Hang in there because you'll feel better down the road."
- **Keep yourself and your family member safe**. If there's a risk of violence, make safety a priority. Regarding physical or verbal abuse, set limits that you can keep. For instance, state that you will leave and call the police if your family member becomes physically violent. Discussing your plans for these situations ahead of time can make them more manageable.
- **Prepare a crisis plan** that includes important phone numbers such as the local crisis intervention team. Include your family member in the planning of this document. Make everyone in the family aware of what they should do in case of an emergency.
- **Don't give up**. A person with a mental health condition benefits enormously from having social support. Remind your family member that you're there to help and you're not giving up. When setbacks occur with one treatment strategy, look for alternative strategies. Try something new and encourage your family member not to give up. A good life is possible.

Maintaining a Healthy Relationship

Relating to someone you love who has a mental illness can be difficult and frustrating, but there are strategies you can use to improve your communication with them. There may be a lot you don’t know about how your relative sees things when they’re symptomatic. These tips can help you build a stronger foundation for your relationship.

To get started on a better path in your relationship with your family member, first acknowledge that you can’t change them, only yourself. But the changes you make can improve your lives together. It’s critical to know as much as you can about their illness so you understand what they may be going through.

Don’t Buy Into Stigma

Be clear with yourself about who the person you care about really is. Even if we’re very close to someone with mental illness and advocate for his rights, we may also have our own preconceptions and false beliefs about mental illness. We have to learn to separate the illness from the person.

Understand Confusing Behavior

Because many of the symptoms of mental illness express themselves through social behavior, it’s natural to feel hurt by the symptoms. We tend to assume behavior is conscious and deliberate.

For example, when you invite your brother to dinner with friends and you feel embarrassed by his obsessive checking of whether he locked his car, you're tempted to see him as someone who's choosing to embarrass you. This may be how some friends and strangers see him, too—that's the effect of stigma. When people around you see your relative this way, it can be hard to remember the truth: that he has an illness, and that the behavior is part of his symptoms. That doesn't excuse cruel or violent behavior, but it's an important reality to keep in mind.

See Opportunities for Improvement

You and your relative can still make conscious choices that improve your situation. You may agree to cooperate on communicating better, you may each work on keeping up friendships and other supportive relationships, you may each see a psychologist for talk therapy. The fact that you can control some things some of the time doesn't negate the fact that the illness is real, not a character flaw, or anyone's fault. Your relative's capacity to make positive choices will depend on how severe her symptoms are at any given time.

Get Support from Other People

You know there's more to your loved one than her illness. You may value her sense of humor, her familiarity with your past, her ability to listen and her advice. When someone has a mental illness, she may feel it threatens her identity and self-respect. As with any other illness, your loved one will have periods when she's learning to cope with her illness' challenges. During these times, she may seem self-absorbed and unable to give her usual attention and energy to others.

Both you and your relative will be better able to cope if you expand your own support network, beyond her. Strengthen your connections with other friends and family. This takes some pressure off your relative to help you as she did before she was ill. She can instead put that energy toward moving toward living well. At the same time, you may resent her less and feel strengthened by getting the social support you need.

Expect Decent Behavior

Making adjustments to accommodate for your relative's illness doesn't erase the need for basic structures and expectations. Tell your relative the standards you need him to meet so you can live well together. Make sure your loved one knows that you see him as a whole person, and that you expect him to follow those standards.

Two of the most important standards to meet are that your home is a safe space and that you have a plan for what to do when safety of your loved one or the family is threatened. Prepare yourself and your family to handle crises. Tell your relative about the standards you expect for daily life. For example, that you won't continue an interaction with your father if he starts screaming at you. Use the communication tips below to have more productive conversations with your relative.

Learn to Communicate Effectively

Developing good communication skills will improve all of your relationships, but they're especially important when mental illness is in the mix. Effective communication is largely about building good habits. You can make choices that improve your chances of getting the results you want. Maybe you want to be able to ask

your granddaughter to shower without getting into an argument or tell your husband his smoking worries you without him giving you the cold shoulder.
A very good way to approach this is to use statements that give your perspective, rather than imposing perceived behavior. For example, try "I am concerned because you don't seem interested in what I'm saying.", instead of "You're not listening." Making thoughtful changes to how you communicate can move you closer to your goals.

See It from Their Perspective

Learn as much as you can about your relative's illness and what they experience. Because of their symptoms, they may perceive things differently than you think. They may be feeling strong emotions like fear, have low self-esteem or be experiencing a delusion or hallucination. All this may be going on even if they don't express it.
Put yourself in their shoes and try to think about how they're feeling, rather than only what they're saying. Adjusting your communication style with their possible experience in mind respects them and makes it more likely that they'll really hear and understand you.
If your friend or relative has done something that bothers you, give them the benefit of the doubt by first assuming the problem is not that they're not motivated to change, but that they're not yet able. It can be tempting to assume that the person is deliberately being difficult. Maybe your loved one doesn't particularly like cleaning up, but she means well. She gets distracted in the moment and forgets to clean, even though she knows she's supposed to. Ask her if something is making it harder for her to clean. If she simply forgets, would a sign on the kitchen door or fridge help? What does she think the sign should say? Ask her for ideas, so you're cooperating on something.
You'll notice that in this example, you're still able to express the core of how you feel: you're upset by the person's actions, and you want them to behave differently because you'll feel better. This method of communication is less likely to pile on the resentment—both theirs and yours—and more likely to get you both what you want.

Focus On Your Larger Goals

When you're upset, try to remind yourself what your true, long-term goal is. It may be to live peacefully with your partner, or to encourage your child to eat more healthily. Your true goal is probably not to win an argument or to remind them of how much you put up with for their sake, but when we're upset, we can get defensive.
Start conversations soon after something happens that upsets you, but after you've had a few minutes to cool down and talk calmly. You'll be more likely to agree on recent facts, and you won't let dissatisfactions build and worsen into resentment. Pursuing your larger goals doesn't mean burying your feelings; it means communicating your most important feelings well.

Use Direct, Simple and Clear Language

To have a more productive conversation, start off on the right foot. Get the person's attention first ("Can I talk to you?"). Cover one topic at a time and share small amounts of information at once ("I want to talk

about tonight's dinner"). Say exactly what you mean ("It's been a long time since we cooked together, and I miss doing that. Would you help me make dinner tonight?") rather than hinting at it ("You never do anything with me anymore").

Describe What You Want and Why

State the facts of the situation, because usually that's an area in which you can agree ("These forms are due back to your school tomorrow, and you haven't filled them out yet."). Say exactly what action you're requesting the person to take, and how you'd feel if they'd do that ("Please read and sign them before we have lunch. I'd feel relieved knowing they're done, and we can enjoy the rest of the afternoon knowing you're ready for school").

Describing a positive outcome can be very motivating. For example, you could say that you'd appreciate their help taking the trash out or that if they joined you for a walk you'd be happy to be spending time together. Ask the person for suggestions on how to improve the situation; if they help create the idea, they're more likely to give it a try.

Source: NAMI.org

Who are these Providers/Professionals?

- **Marriage and Family Therapist** Ohio law licenses this category. However, social workers, counselors, psychologist and psychiatrists are able to provide this level of therapy under the scope of their license.
- **Psychiatrist Aid/Mental Health Technician/Therapeutic Program Worker May** work in a hospital/residential or crisis setting. Not licensed as a job and usually work under the license of the Registered Nurse. Can vary from high school diploma to degreed.
- **Caseworker/Case Manager/Community Support Specialist (CSP) These** titles are not licensed. Person in this position may range from no college education to Masters level education with a license. In mental health they are the single point of contact for the case. Not therapists but work therapeutically.
- **Ohio Certified Peer Recovery Supporter is** an individual who has *lived experience* with mental illness and has also completed formal training in the peer specialist model of mental health supports. These individuals use their unique set of recovery experiences in combination with solid skills training to support peers who experience mental illness as well. We are now calling this role **Peer Supporters**, as we merge with the addiction recovery coaching certification program. Peer Supporters actively work within an organization's collaborative support structure as a defined part of the recovery team.
- **Therapist/Counselor In** Ohio the general term can describe individuals ranging from occupational therapist to aroma therapist. You must know exactly the qualifications and the licensure of this person.
- **Psychiatric Nurse generally** a Registered Nurse who works with psychiatric patients. Master level nurses may be certified in mental health. Nurse Practitioner with prescriptive privileges can prescribe medication and works with a psychiatrist.
- **Social Worker Ohio** law says you must be licensed unless you work in specific government jobs. Independent Social Workers are licensed to do therapy independently. Social Workers are the largest provider of mental health services.

- **Psychologist Clinical** psychologist has a doctorate degree in a type of psychology. There are Masters level individuals who were "grandfathered" into the license. They specialize in therapy, some do research. These are clinical Educational psychologists not clinical. They do testing. They are not medical doctors.
- **Psychiatrist Any** licensed medical doctor (M.D. or D.O.) can practice psychiatry or any other medical specialty. Board certified psychiatrists have completed an additional 2 years of intensive training in medication and therapy. In most public health areas psychiatrists provide medication.

What is a Treatment Team?
Term used to describe the group of professionals that work together for individuals with Mental Illness. Treatment team members may include psychiatrists, psychologists, therapists, mental health technicians, case managers and social workers, among others.

What is a Treatment Team Meeting?
Treatment plan especially designed for individual, based on individual strengths and needs, developed by the provider with input from the family and treatment team.

What is a Discharge Planning?
Plan developed prior to an individual's discharge from a treatment facility that outlines the services that will be needed upon discharge and establishes how/where those services will be provided.

Family Rights
Family members and natural supports have a right to respect individual with mental illness self-worth, dignity and privacy.
Family members and natural supports have a right to comprehensive information, education, training and support to facilitate understanding, advocacy and care of individual with mental illness.

With the consent of individual family members and natural supports are entitled to:
- Notification of individual's admission to inpatient psychiatric facility, release, transfer, serious illness, injury or death.
- Have access to individual including telephone calls and unopened correspondence
- Be consulted by service providers about treatment plan
- Exchange information with service providers concerning treatment plan
- Receive copies of information and records regarding individual and approval of the treating physician, psychologist or clinician
- Be given information regarding the diagnosis, prognosis, prescribed medication and side effects, treatment and progress of individual
- Obtain copy of written aftercare plan when individual is discharged from and inpatient psychiatric facility.
- Provide clothing, personal possessions and a reasonable sum of money for individual to use in the facility
- Arrange support services such as respite care, counseling and services in the community
- Be assigned as guardian with consent of individual
- Advised of the time and place of treatment team meetings, discharge planning meeting, certification hearings, judicial review, conservatorship proceedings and other due process proceedings

- ❖ Participate in assisting individual returning to the most constructive and satisfying lifestyles of their own definition and choice in the least restrictive environment, preferably in their own community

If client initially unable to authorize the release of information, daily efforts shall be made to secure the individuals consent or refusal of release of information.

When client refused consent for family members and natural supports:

- ❖ Provide service providers information about individual with mental illness
- ❖ Seek further options regarding the diagnosis and the care of the individual with mental illness
- ❖ Have a right to place limits on their availability to the individual with mental illness
- ❖ Family members and natural supports have a right to comprehensive information, education, training and support to facilitate understanding, advocacy and care of those individuals they care for with mental illness

Family members and natural supports have a responsibility to:

- ❖ Respect the dignity of individual with mental illness
- ❖ Consider the opinions of the professionals and service providers and recognize their skills in providing care and treatment for individual with mental illness
- ❖ Co-operate as far as possible with reasonable treatment for individual with mental illness

Trauma

What is Trauma? The experience of violence and victimization including sexual abuse, physical abuse, severe neglect, loss, domestic violence and/or the witnessing of violence, terrorism or disasters.

DMS IV-TR Person's response involves intense fear, horror and helplessness. Extreme stress that overwhelms the person's capacity to cope.

Types of Trauma

- ❖ Pre and Perinatal Trauma
- ❖ Single Episode Trauma
- ❖ Development or Complex Trauma
- ❖ Historical Trauma
- ❖ Intergenerational Trauma

Traumatic Events

- ❖ Render victim's helpless by overwhelming force
- ❖ Involve threats to life or bodily integrity, or close personal encounter with violence or death
- ❖ Disrupt sense of control, connecting and meaning
- ❖ Confront human beings with the extremities of helplessness and terror
- ❖ Evoke the responses of catastrophe

Prevalence of Trauma

- ❖ 90% of public mental health clients have been exposed to trauma
- ❖ Most have had multiple experiences of trauma
- ❖ 34 % - 53% report childhood sexual or physical abuse
- ❖ 43% - 81% report some type of victimization

What is Trauma-Informed Care?

Most individuals seeking public behavioral health services and many other public services, such as homeless and domestic violence services, have histories of physical and sexual abuse and other types of trauma-inducing experiences. These experiences often lead to mental health and co-occurring disorders such as chronic health conditions, substance abuse, eating disorders, and HIV/AIDS, as well as contact with the criminal justice system.

When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization.

What are Trauma-Specific Interventions?

Trauma-specific interventions are designed specifically to address the consequences of trauma in the individual and to facilitate healing. Treatment programs generally recognize the following:

- The survivor's need to be respected, informed, connected, and hopeful regarding their own recovery
- The interrelation between trauma and symptoms of trauma (e.g., substance abuse, eating disorders, depression, and anxiety)
- The need to work in a collaborative way with survivors, family and friends of the survivor, and other human services agencies in a manner that will empower survivors and consumers

Following are some well-known trauma-specific interventions based upon psychosocial educational empowerment principles that have been used extensively in public system settings. Please note that these interventions are listed for informational and educational purposes only. NCTIC does not endorse any specific intervention.

http://www.samhsa.gov/

- Addiction and Trauma Recovery Integration Model (ATRIUM)
- Essence of Being Real
- Risking Connection
- Sanctuary Model
- Seeking Safety
- Trauma, Addictions, Mental Health, and Recovery (TAMAR) Model
- Trauma Affect Regulation: Guide for Education and Therapy (TARGET)
- Trauma Recovery and Empowerment Model (TREM and M-TREM)

How can I become "trauma-informed" and help others?

While there is not a cure for human suffering, healing can occur. Becoming trauma-informed is the first step in helping children and adults work through the emotional and physical challenges they face after exposure to a traumatic event or series of events and can be key to promoting resiliency and recovery. Families and professionals can often inspire someone to recover and move forward. You can become a champion for this cause by helping local organizations and communities become trauma-informed. The transformational change can have dramatic impact over the lifespan of trauma survivors in Ohio.

When a program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma impacts the life of an individual seeking services. Trauma survivors often have a history of multiple trauma-inducing experiences, and in addition to mental health issues, they may deal with health problems, substance abuse, eating disorders, HIV/AIDS issues, and contact with the criminal justice system. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may make worse, so that these services and programs can be more supportive and avoid re-traumatization.

Descriptions of Mental Illnesses

Mental illnesses are biologically based brain disorders. They cannot be overcome through willpower and are not related to a person's character or intelligence. They are medical conditions that disrupt a person's thinking, feeling, mood, daily functioning and ability to relate to others. People affected can be of any age, race, religion or income.

Mental illness comes in a variety of forms and is accompanied by a number of related symptoms. Symptoms vary depending on the type and severity of the condition. Some general symptoms that may suggest a mental disorder include:

- Confused thinking
- Long-lasting sadness or irritability
- Extreme highs and lows in mood
- Excessive fear, worrying or anxiety
- Social withdrawal
- Dramatic changes in eating or sleeping habits
- Strong feelings of anger
- Delusions or hallucinations (seeing or hearing things that are not really there)
- Increasing inability to cope with daily problems and activities
- Thoughts of suicide
- Denial of obvious problems
- Many unexplained physical problems
- Abuse of drugs and/or alcohol

If you are experiencing any of these symptoms or know someone who is, make an appointment with a health care professional. Early diagnosis is key. Most people diagnosed with a mental illness can experience relief from their symptoms by actively participating in individual treatment plans.

ADHD

While some behaviors associated with ADHD are normal, someone with ADHD will have trouble controlling these behaviors and will show them much more frequently and for longer than 6 months.

Signs of inattention include:

- ❖ Becoming easily distracted and jumping from activity to activity.
- ❖ Becoming bored with a task quickly.
- ❖ Difficulty focusing attention or completing a single task or activity.
- ❖ Trouble completing or turning in homework assignments.
- ❖ Losing things such as school supplies or toys.

- Not listening or paying attention when spoken to.
- Daydreaming or wandering with lack of motivation.
- Difficulty processing information quickly.
- Struggling to follow directions.

Signs of hyperactivity include:

- Fidgeting and squirming, having trouble sitting still.
- Non-stop talking.
- Touching or playing with everything.
- Difficulty doing quiet tasks or activities.

Signs of impulsivity include:

- Impatience.
- Acting without regard for consequences, blurting things out.
- Difficulty taking turns, waiting or sharing.
- Interrupting others.

There are several factors believed to contribute to ADHD:

- Genetics. **Research shows that genes may be a large contributor to ADHD. ADHD often runs in families and some trends in specific brain areas that contribute to attention.**
- Environmental factors. **Studies show a link between cigarette smoking and alcohol use during pregnancy and children who have ADHD. Exposure to lead as a child has also been shown to increase the likelihood of ADHD in children.**

ADHD occurs in both children and adults, but is most often and diagnosed in childhood. Getting a diagnosis for ADHD can sometimes be difficult because the symptoms of ADHD are similar to typical behavior in most young children. Teachers are often the first to notice ADHD symptoms because they see children in a learning environment with peers every day.

There is no one single test that can diagnose a child with ADHD, so meet with a doctor or mental health professional to gather all the necessary information to make a diagnosis. The goal is to rule out any outside causes for symptoms, such as environmental changes, difficulty in school, medical problems and ensure that a child is otherwise healthy.

ADHD is managed and treated in several ways:

- **Medications**, including stimulants, non-stimulants and antidepressants
- **Behavioral therapy**
- **Self-management, education programs and assistance** through schools or work or alternative treatment approaches

Around two-thirds of children with ADHD also have another condition. Many adults are also impacted by the symptoms of another condition. Common conditions associated with ADHD include the following.

- Learning disabilities
- Oppositional defiant disorder: refusal to accept directions or authority from adults or others

- Conduct disorder, persistent destructive or violent behaviors
- Anxiety and depression
- Obsessive-compulsive disorder
- Bipolar disorder
- Tourette's syndrome
- Sleep disorders
- Bed-wetting
- Substance abuse

Symptoms from other conditions make treating ADHD more difficult. Talking to a skilled professional to help establish an accurate diagnosis can help increase the effectiveness of treatment.

Schizophrenia

Schizophrenia is a serious and challenging medical illness that affects about 1% of the world's population ages 18 and older. Schizophrenia can interfere with a person's ability to think clearly, distinguish reality from fantasy, 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 females. Most people with Schizophrenia experience the illness throughout their lifetimes and are often stigmatized by lack of public understanding about the disease. Schizophrenia is certainly not caused by bad parenting or personal weakness.

Schizophrenia is most often treated with the class of medications known as "neuroleptics" or "antipsychotics". Many of these same medications are used to treat other mental illnesses as well.

Positive Symptoms: These are mental experiences that are imposed on us by the illness, or behaviors that are added to us that were not there before.

Delusions Examples:

- Belief that a person can read my or others' thoughts
- Belief that people are plotting against me
- Belief that others are secretly monitoring or in some way threatening me
- Belief that others can control my or others' minds

Hallucinations Examples:

- Seeing something that isn't really there
- Hearing something that isn't really there
- Smelling something that isn't really there
- Feeling something that isn't really there

Negative symptoms: This refers to valuable aspects of our personality that have been taken way by the illness. Examples:

- Emotional flatness
- Lack of expression
- Inability to start and follow through with activities
- Speech that is brief and devoid of content
- Lack of pleasure or interest in life

Cognitive Symptoms: These symptoms pertain to thinking processes.

Examples: Difficulty with cognitive functions

- Difficulty with certain memory functions
- Difficulty organizing thoughts
- Lack of insight into the condition itself

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Major Depression

Major Depression is a serious medical illness affecting 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 interfere with a person’s thoughts, behaviors, moods, 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. Depression occurs twice as frequently in women as in men. Without treatment, the number of times Depression occurs, as well as the severity of symptoms tends to increase over time. Left untreated, Depression can lead to suicide.

Antidepressants generally do not work overnight, and some people need to take them for quite a while, even when they are feeling better.

CHECKLIST:

- 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
- Persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders and chronic pain

Depression is most often treated with antidepressant medication.

Bipolar Disorder

Now let’s move on to Bipolar Disorder, which used to be called Manic Depression. Bipolar Disorder 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. The illness affects both men and women equally. Bipolar Disorder is chronic and generally a lifelong condition with recurring episodes of mania and depression. Bipolar Disorder most often begins in adolescence or early adulthood, but occasionally does occur in children.
People who live with Bipolar Disorder are usually prescribed at least a mood stabilizer. For many people with a Bipolar diagnosis, the addition of other medications to further control highs and lows is necessary.

Bipolar Disorder is divided into experiences of mania and experiences of depression. We have already discussed symptoms of Depression, so let's focus on the symptoms of mania. Mania is the word that describes the active phase of Bipolar Disorder.

CHECKLIST:

- 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 activities such as spending sprees, sexual indiscretion and alcohol abuse
- Decreased sleep without experiencing fatigue In Bipolar Disorder there can also be something called a mixed state. This happens when symptoms of mania and depression occur at the same time, causing a state of agitated depression.

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It is rare, but there are individuals who experience only mania and never depression. These folks are diagnosed with Unipolar Mania because the "up" mood never alternates with a swing down into depression. More commonly, people have Bipolar 2, where depression never swings up into mania.

Some individuals experience what is called rapid cycling. When four or more episodes of illness occur within a 12-month period, the individual is said to have Bipolar Disorder with rapid cycling. Rapid cycling is more common in women than men.

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There are four basic types of bipolar disorder:

Bipolar I Disorder—defined by manic or mixed episodes that last at least seven days, or by manic symptoms that are so severe that the person needs immediate hospital care. Usually, depressive episodes occur as well, typically lasting at least 2 weeks.

Bipolar II Disorder—defined by a pattern of depressive episodes and hypomanic episodes, but no full-blown manic or mixed episodes.

Bipolar Disorder Not Otherwise Specified (BP-NOS)—diagnosed when symptoms of the illness exist but do not meet diagnostic criteria for either bipolar I or II. However, the symptoms are clearly out of the person's normal range of behavior.

Cyclothymic Disorder, or Cyclothymia—a mild form of bipolar disorder. People with cyclothymia have episodes of hypomania as well as mild depression for at least 2 years. However, the symptoms do not meet the diagnostic requirements for any other type of bipolar disorder.

Schizoaffective Disorder

Schizoaffective Disorder is one of the more common chronic mental illnesses. As the name implies, it is characterized by a combination of symptoms of Schizophrenia and an affective, or mood, disorder. There has been a controversy about whether schizoaffective disorder is a type of

Schizophrenia or a type of mood disorder. Today most clinicians and researchers agree that it is primarily a form of Schizophrenia. To diagnose Schizoaffective Disorder, a person needs to have primary symptoms of

Schizophrenia (like delusions, hallucinations, disorganized speech, or disorganized behavior) along with a period of time when he or she also has symptoms of Major Depression or a manic episode.

Accordingly, there may be two subtypes of Schizoaffective Disorder:

a) Depressive subtype, characterized by major depressive episodes only

b) Bipolar subtype, characterized by manic episodes with or without depressive symptoms or depressive episodes With a diagnosis of Schizoaffective Disorder, medications are likely to be a combination of a mood stabilizer and additional antidepressant and/or antipsychotic medication, depending on symptoms.

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Psychotic Disorders

Psychosis occurs when a person is detached from reality. In general terms, psychosis is a mental illness that markedly interferes with a person’s capacity to meet life’s everyday demands. The signs and symptoms include hallucinations, delusions or certain types of very abnormal behavior. Other symptoms might include paranoia, mania, depression, emotional changes or personality changes.

Mood Disorders

Feelings of sadness and discouragement are normal emotional reactions to difficult situations. However, if these feelings last more than a few weeks or get so bad that they begin to control a person's life, it could be a sign of a mood disorder. A high percentage of people who suffer from mood disorders can be effectively treated, but many go untreated because they do not recognize the illness or notice the patterns. They might blame what they are feeling on the flu, stress, lack of sleep or poor diet. People who have mood disorders may display one or more of the following behaviors: feelings of worthlessness, hopelessness, helplessness, total indifference and/or extreme guilt; prolonged sadness; unexplained crying spells; jumpiness of irritability; inability to concentrate; loss of appetite or great increase in appetite; constant fatigue or insomnia or thoughts of death or suicide attempts.

Cognition Disorders

This mental illness category involves disturbances in the mental processes related to thinking, reasoning and judgment. Although symptoms of these disorders vary, they are generally marked by impaired awareness, perception, reasoning, memory and judgment. Other symptoms include the inability to concentrate, altered sleep patterns, motor system impairment, disorientation and personality or emotional changes.

Borderline Personality Disorder

Borderline Personality Disorder (BPD) is a serious mental illness that can cause a lot of suffering, carries a risk of suicide and needs an accurate diagnosis along with targeted treatment. BPD is estimated to affect 1-2 percent of Americans. More females are diagnosed with this disorder by a ratio of about 3 to 1, though

some clinicians believe that men may be under diagnosed. The illness is characterized by intense and stormy relationships, low self-esteem, self-sabotaging acts, mood fluctuations and impulsivity. A common feature of Borderline Personality Disorder is severe difficulty managing emotions under stress.

CHECKLIST:

- Frantic efforts to avoid real or imagined abandonment
- A pattern of unstable and intense interpersonal relationships
- Identity disturbances
- Impulsivity in at least two areas that are self-damaging
- Recurrent suicidal behavior gestures, threats, or self-mutilating behaviors
- Mood instability
- Chronic feelings of emptiness
- Inappropriate, intense anger
- Temporary stress related paranoid ideation or severe dissociate symptoms

Note: People with BPD only have paranoid thinking under severe stress and do not have this kind of symptom on a regular basis. Dissociative symptoms are when a person's consciousness splits off (i.e. a trauma survivor driving down a one-way street without realizing it.)

Anxiety Disorder

This is the most common of all mental illnesses and the most treatable. Anxiety disorder leaves a person unable to cope with daily life due to abnormal fears of life. Anxiety in moderation is a perfectly normal response because it prepares you for any action that might be threatening; however, anxiety disorders cause overwhelming fear and an inability to cope with daily chores. In fact, anxiety disorder can completely paralyze and disable a person. It produces unrealistic fears, excessive worry, flashbacks from past trauma leading to easy startling, changes in sleep patterns, intense tension and ritualistic behavior. Anxiety disorder also results in a slew of related physical symptoms such as shaking, sweating, racing heart, dizziness, nausea, vomiting, etc.

Generalized Anxiety Disorders

GAD affects 3.1% of the U.S. population in any given year. With GAD it is common to experience excessive worry about everyday things. There may be undue tension around money, health, family, work, or other issues. Though people with GAD may be aware that this worry is way outside the normal range, we are unable to control the feelings of constant apprehension. Women are twice as likely to develop GAD as men.

CHECKLIST:

- Muscle tension
- Fatigue
- Restlessness
- Difficulty sleeping
- Irritability
- Edginess
- Gastrointestinal discomfort or diarrhea

GAD is most often treated with antidepressants or anxiolytics (anti-anxiety medications). GAD also responds well to Cognitive-Behavioral therapy. Stress reduction exercises, relaxation techniques and yoga are other common additions to treatment for this disorder.

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Panic Disorder

People with this disorder suffer from attacks of sheer terror and are plagued by fears of having additional attacks. Attacks can occur while a person is awake or sleeping. It is estimated that 2 to 5 percent of Americans have Panic Disorder, and there is a higher rate of Panic Disorder in women than men.
A panic attack is an uncontrollable panic response to ordinary, non-threatening situations. It typically reaches a peak within a few minutes and then begins to subside, but a person may feel anxious and jittery for many hours after experiencing a panic attack. As you look at the checklist below it becomes easy to understand why so many people fear they are having a heart attack, as so many physical symptoms are involved.

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CHECKLIST:

- A fear of imminent danger or doom
- The need to escape
- Heart palpitations
- Sweating
- Trembling
- Shortness of breath or a smothering feeling
- Chest pain or discomfort
- Nausea or abdominal discomfort
- Dizziness or lightheadedness
- A sense of things being unreal, depersonalization
- A fear of losing control or “going crazy”
- A fear of dying
- Tingling sensation
- Chills or heat flush

For Panic Disorder to be diagnosed, a person must experience recurrent, unexpected panic attacks, followed by:

- Concern that the attacks will strike again, **or**
- Worry that these attacks imply life-threatening illness or losing one’s mind, **or**
- Avoidance of situations related to the attacks. Since many of the symptoms of a panic attack mimic those for heart disease, thyroid problems, and breathing disorders, is it any wonder that a person experiencing a panic attack would feel it necessary to make a visit to the emergency room? People

who have panic attacks often begin to avoid the things they think triggered the panic attack and then stop doing the things they used to do or the places they used to go.

Post Traumatic Stress Disorder

Over a lifetime, about 10 percent of women and 5 percent of men are diagnosed with PTSD. Members of the military who serve in wars or violent conflicts are at risk of developing PTSD. According to a 2008 national survey conducted by the RAND Corporation, fourteen percent of military members returning from service in Iraq or Afghanistan met the current criteria for
PTSD. People are diagnosed in this category after witnessing or experiencing an event, or series of events, that are severely threatening to their physical wellbeing. This is why victims of physical and sexual abuse, or those faced with other life-threatening circumstances, are also at great risk for developing PTSD.

The experience of this illness is relentless, and in this regard, it is similar to the other illnesses we have discussed. People who live with PTSD often have disturbed sleep due to nightmares about their traumatic experiences. They have “waking dreams” in which they re-experience the trauma itself. Intrusive thoughts and/or images that recall the trauma may occur, as well as flashbacks into the traumatic experience. PTSD is exhausting body senses are often on high alert. People with PTSD startle easily, are irritable and easily aggravated, and may have difficulty concentrating.

CHECKLIST:

1) Persistent re-experiencing- one or more of the following:

- Recurrent nightmares or flashbacks
- Recurrent images or memories of the event: often these images or memories occur even when the person would rather not be thinking about the event
- Intense distress of reminders of the trauma and/or

Physical reactions to triggers that symbolize or resemble the event

2) Avoidant/Numbness Responses- three or more of the following

- Efforts to avoid feelings or triggers associated with the trauma
- Avoidance of activities, places, or people that remind the person of the trauma of Inability to recall an important aspect of the trauma
- Markedly diminished interest in activities
- Feelings of detachment or estrangement from others
- Restricted range of feelings

Difficulty thinking about the long-term future: sometimes this expresses itself by a failure to plan for the future or taking risks because the person does not fully believe or consider the possibility that they will be alive for a normal life span

3) Increased Arousal- two or more of the following:

- Difficulty falling asleep or staying asleep
- Outbursts or anger/irritability
- Difficulty concentrating
- Increased vigilance that may be maladaptive

Exaggerated startle responses

With acute PTSD, the person has symptoms less than three months. With chronic PTSD, the individual has symptoms for more than three months. With delayed onset PTSD, the individual has onset of symptoms at least six months after the traumatic event.

In order to be diagnosed with PTSD, the symptoms must be active for more than one month after the trauma and is associated with a decline in social, occupational or other important areas of functioning.

Obsessive Compulsive Disorder

People with Obsessive-Compulsive Disorder suffer with intrusive thoughts that won't go away (obsessions). These thoughts often lead to performing ritual behaviors and routines (compulsions) to get rid of tension associated with the obsessions. Most people with OCD have some awareness that these thoughts and behaviors are outside the norm, however, there is a feeling of powerlessness and an inability to push thoughts away or stop the accompanying behavior.
Obsessions and the rituals connected to them can interfere greatly with a person's quality of life. We may spend several hours per day thinking about obsessions or acting out compulsions. This can make concentration on the tasks at hand difficult.

The most common obsessions are:

- Fear of contamination
- Excessive concern about objects "having to be" in a certain order
- Thinking we have injured someone
- Fear of having left something on or unlocked
- Frightening impulses to hurt a loved one
- Gross sexual imagery
- Inability to throw anything away Compulsions
- Compulsive hand washing
- Compulsive showering
- Compulsive house cleaning
- Excessive ordering and arranging
- Repeated checking and re-checking
- Repetitive counting
- Touching and activity rituals
- Excessive slowness in daily activities like eating and brushing teeth
- Constant demands for reassurance that the perceived threat has been removed

The ritual compulsions of OCD vary from mild (known only to the person engaging in them) to constant and extreme (occupying hours of time and involving significant others in ritual activity). A diagnosis of OCD is made when obsessions and compulsions become so marked that they interfere with social and occupational activities or cause intense distress.

The ability to recognize the behavior as "excessive and unreasonable" is another criteria for the diagnosis of OCD. Nevertheless, there are also occasions where we get so caught up in the anxiety that we fail to recognize the excess.

With OCD the family situation can become particularly tricky if the person with the disorder has attempted to pull the family into compulsive rituals. This has the effect of alienating the family and worsening the illness, since the more a ritual behavior is repeated, the more central a compulsion becomes.

Autism

Autism is a developmental disorder with symptoms that appear within the first three years of life. Its formal diagnostic name is autism spectrum disorder. The word “spectrum” indicates that autism appears in different forms with varying levels of severity. That means that each individual with autism experiences their own unique strengths, symptoms, and challenges. Understanding more about ASD can help you better understand the individuals who are living with it.

How autism spectrum disorders are described

Psychiatrists and other clinicians rely on the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) to define autism and its symptoms. The DSM-5 definition recognizes two main symptom areas:

- Deficits in social communication and interaction
- Restricted, repetitive behaviors, interests, or activities

These symptoms appear early in a child’s development—although diagnosis may occur later. Autism is diagnosed when symptoms cause developmental challenges that are not better explained by other conditions.

The definition of autism has been refined over the years. Between 1995 and 2011, the DSM-IV grouped Asperger’s Syndrome and Pervasive Developmental Disorder Not Otherwise Specified (PDD-NOS) with autism. Asperger’s syndrome was an autism spectrum disorder marked by strong verbal language skills and, often, high intellectual ability. PDD-NOS was a more general diagnosis for people who did not fit clearly into the other two categories.

However, the DSM-5 no longer recognizes Asperger’s syndrome or PDD-NOS as separate diagnoses. Individuals who would previously have received either of these diagnoses may now receive a diagnosis of autism spectrum disorder instead.

Autism symptoms and behaviors:

- Individuals with autism may present a range of symptoms, such as:
- Reduced eye contact
- Differences in body language
- Lack of facial expressions
- Not engaging in imaginative play
- Repeating gestures or sounds
- Closely focused interests
- Indifference to temperature extremes

These are just a few examples of the symptoms an individual with autism may experience. Any individual could have some, all, or none of these symptoms. Keep in mind that having these symptoms does not necessarily mean a person has autism. Only a qualified medical professional can diagnose autism spectrum disorder.

Most importantly, an individual with autism is first and foremost an individual. Learning about the symptoms can help you start to understand the behaviors and challenges related to autism, but that’s not the same as

getting to know the individual. Each person with autism has their own strengths, likes, dislikes, interests, challenges, and skills, just like you do.

How autism is diagnosed

There is no known biological marker for autism. That means that no blood or genetic test can diagnose the disorder. Instead, clinicians rely on observation, medical histories, and questionnaires to determine whether an individual has autism.

Physicians and specialists may use one or several of the following screening tools:

Modified Checklist for Autism in Toddlers, Revised (M-CHAT), a 20-question test designed for toddlers between 16 and 30 months old.

The Ages and Stages Questionnaire (ASQ), a general developmental screening tool with sections targeting specific ages used to identify any developmental challenges a child may have.

Screening Tool for Autism in Toddlers and Young Children (STAT), an interactive screening tool, comprising 12 activities that assess play, communication, and imitation.

Parents' Evaluation of Developmental Status (PEDS) is a general developmental parent-interview form that identifies areas of concern by asking parents questions.

The American Academy of Pediatrics encourages autism screening for all children at their 18 and 24-month well-child checkups. Parents and caregivers can also ask their pediatrician for an autism screening if they have concerns. In rare cases, individuals with autism reach adulthood before receiving a diagnosis. However, most individuals receive an autism diagnosis before the age of 8.

Prevalence of autism

For many years, a diagnosis of autism was rare, occurring in just one child out of 2,000. One reason for this was the diagnostic criteria. Autism was not clearly defined until 1980 when the disorder was included in the DSM-III. Before that time, some cases of autism spectrum disorder may have been mistaken for other conditions.

Since the '80s, the rate of autism has increased dramatically around the world. In March 2020, the US Federal Centers for Disease Control announced that 1 in every 54 children in the United States is affected by autism.

Although autism is more likely to affect boys than girls, children of all genders have been diagnosed with ASD. Several recent studies investigate the impact of race, ethnicity, and socioeconomic disparities on the diagnosis of autism spectrum disorder.1,2,3,4

A short history of autism

Researchers have been working on autism and autism-like disorders since the 1940s. At that time, autism studies tended to be small in scale and used varying definitions of the disorder. Autism was also sometimes lumped in with other conditions.

Focused research into ASD became more common in the 1980s when the DSM-III established autism as a distinct diagnosis. Since then, researchers have explored the causes, symptoms, comorbidities, efficacy of treatments, and many other issues related to autism.

Researchers have yet to discover a cause for autism. Many of the ideas put forth thus far have been disproven. Likely a combination of genetic, neurological, and environmental factors are at work, which is the case with many psychiatric disorders and conditions.

Autism Prognosis

Autism is a lifelong condition, and a wide variety of treatments can help support people with ASD. The symptoms and comorbidities—conditions occurring in the same individual—are treatable. Early intervention delivers the best results. Parents and caregivers should seek out the advice of a qualified medical professional before starting any autism treatment.

Advances in understanding autism, its symptoms, and comorbidities have improved outcomes for individuals with autism. In recent years, more children with autism have attended school in typical classrooms and gone on to live semi-independently. However, the majority remain affected to some degree throughout their lifetime.

Co-occurring conditions

When a person has more than two or more disorders, these conditions are known as comorbidities. Several comorbidities are common in people with autism.

These include:

- Anxiety
- Depression
- Epilepsy
- Gastrointestinal and immune function disorders
- Metabolic disorders
- Sleep disorders

Identifying co-occurring conditions can sometimes be a challenge because their symptoms may be mimicked or masked by autism symptoms. However, diagnosing and identifying these conditions can help avoid complications and improve the quality of life for individuals with autism.

Autism in pop culture

Movies and books featuring characters with autism have helped bring autism spectrum disorder into the public consciousness. Some have ignited controversy; others have increased the public's general understanding of autism. A few have done both. At ARI, we hope that people will rely on evidence-based research to understand autism spectrum disorder better.

Learn more about autism spectrum disorder by watching one of our expert-led webinars. They help you learn about ASD from clinicians, researchers, and therapists who research autism and support individuals with ASD.

https://autism.org

Anosognosia

When someone rejects a diagnosis of mental illness, it's tempting to say that he's "in denial." But someone with acute mental illness may not be thinking clearly enough to consciously choose denial. They may instead be experiencing "lack of insight" or "lack of awareness." The formal medical term for this medical condition is anosognosia, from the Greek meaning "to not know a disease."

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

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

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

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

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

Anosognosia affects 50% of people with schizophrenia, and 40% of people with bipolar disorder. It can also accompany illnesses such as major depression with psychotic features. Treating these mental health conditions is much more complicated if lack of insight is one of the symptoms. People with anosognosia are placed at increased risk of homelessness or arrest. Learning to understand anosognosia and its risks can improve the odds of helping people with this difficult symptom.

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

Dual Diagnosis

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

Either substance abuse or mental illness can develop first. A person experiencing a mental health condition may turn to drugs and alcohol as a form of self-medication to improve the troubling mental health symptoms

they experience. Research shows though that drugs and alcohol only make the symptoms of mental health conditions worse.

Abusing substances can also lead to mental health problems because of the effect's drugs have on a person's moods, thoughts, brain chemistry and behavior.

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

Men are more likely to develop a co-occurring disorder than women. Other people who have a particularly high risk of dual diagnosis include individuals of lower socioeconomic status, military veterans and people with more general medical illnesses.

The defining characteristic of dual diagnosis is that both a mental health and substance abuse disorder occur simultaneously. Because there are many combinations of disorders that can occur, the symptoms of dual diagnosis vary widely.

The symptoms of substance abuse may include:

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

Some standard alcohol and drug screening tools are used in mental health clinics to identify people at risk for drug and alcohol abuse.

The symptoms of a mental health condition also can vary greatly. Knowing the warnings signs, such as extreme mood changes, confused thinking or problems concentrating, avoiding friends and social activities and thoughts of suicide, can help identify if there is a reason to seek help.

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

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

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

A person experiencing a serious mental illness and dangerous or dependent patterns of abuse may benefit most from an inpatient rehabilitation center where she can receive concentrated medical and mental health care 24/7. These treatment centers provide her with therapy, support, medication and health services with the goal of treating her addiction and its underlying causes.

Supportive housing, like group homes or sober houses, is another type of residential treatment center that is most helpful for people who are newly sober or trying to avoid relapse. These treatment centers allow for more freedom while still providing round-the-clock care.

Psychotherapy is almost always a large part of an effective dual diagnosis treatment plan. Education on a person's illness and how their beliefs and behaviors influence their thoughts has been shown in countless studies to improve the symptoms of both mental illness and substance abuse.

Cognitive behavioral therapy (CBT) in particular is effective in helping people with dual diagnosis learn how to cope and to change ineffective patterns of thinking.

Dealing with a dual diagnosis can feel challenging and isolating. Support groups allow members to share frustrations, successes, referrals for specialists, where to find the best community resources and tips on what works best when trying to recover. They also form friendships and provide encouragement to stay clean.

Here are some groups that can offer support:

- Double Trouble in Recovery is a 12-step fellowship for people managing both a mental illness and substance abuse.
- Alcoholics Anonymous and Narcotics Anonymous are 12-step groups for people recovering from alcohol or drug addiction.
- Smart Recovery is a sobriety support group program for people with a variety of addictions

Psychosis

An episode of psychosis is when a person has a break from reality and often involves seeing, hearing and believing things that aren't real. Approximately 3 in 100 people will experience an episode of psychosis during their lives. Young adults are placed at an increased risk to experience an episode of psychosis because of hormonal changes in the brain that occur during puberty, but a psychotic episode can occur at any age.
Psychosis is not an illness, but a symptom. A psychotic episode can be the result of a mental or physical illness, substance use, trauma or extreme stress.

Symptoms of a psychotic episode can include incoherent speech and disorganized behavior, such as unpredictable anger, but psychosis typically involves one of two major experiences:

Hallucinations are seeing, hearing or physically feeling things that aren't actually there. For example:

- Voices telling you to commit acts of violence or self-harm.
- Feeling like something is crawling under your skin.
- Seeing someone take the shape of something he is not, such as a demon.

Delusions are strong beliefs that are unlikely to be true and may seem irrational to others. For example:

- Believing external forces are controlling your thoughts, feelings and behavior.

- Believing that trivial remarks, events or objects have personal meaning or significance.
- Thinking you have special powers, are on a special mission or even that you are God.

Most people think of psychosis as a sudden break from reality, but there are often warning signs that precede an episode of psychosis. Knowing what to look for provides the best opportunity for early intervention. Some indications are:

- A worrisome drop in grades or job performance.
- Trouble thinking clearly or concentrating.
- Suspiciousness or uneasiness with others.
- A decline in self-care or personal hygiene.
- Spending a lot more time alone than usual.
- Strong, inappropriate emotions or having no feelings at all.

Several factors can contribute to psychosis:

- **Genetics.** Many genes are associated with the development of psychosis, but just because a person has a gene doesn't mean they will experience psychosis. Studies are still being conducted to determine the exact genes that cause psychosis.
- **Trauma.** A traumatic event such as a death, war or sexual assault can trigger a psychotic episode. The type of trauma—as well as a person's age—also affect whether a traumatic event will result in psychosis.
- **Substance use.** The use marijuana, LSD, amphetamines and other substances can increase the risk of psychosis in people who are already vulnerable.
- **Physical illness or injury.** Traumatic brain injuries, brain tumors, strokes, HIV and some brain diseases such as Parkinson's, Alzheimer's and dementia can sometimes cause psychosis.

Psychosis is a symptom, not an illness. A diagnosis identifies an illness, and symptoms are components of an illness. Health care providers draw on information from medical and family history along with a physical examination to make a diagnosis. If causes such as a brain tumor, infection or epilepsy are ruled out, a mental illness might be the cause.

Identifying and treating psychosis as early as possible leads to the best outcomes. Early intervention is always the best approach to treating a mental health condition, because there is a chance of preventing the illness from progressing.

There are many specialized centers that focus exclusively on psychosis and crisis treatment in youth. The American Psychiatric Association, your state chapter of the APA, primary care doctor, insurance carrier and the state or county mental health authority are other resources that can help find you help.

Therapy is essential to treating psychosis. Some more common therapies include:

- **Cognitive behavioral therapy** (CBT), which teaches people to observe and then change ineffective patterns of thinking. For psychosis, CBT teaches someone to critically evaluate their experience to determine whether or not the experience is real or not.
- **Supportive psychotherapy** teaches a person to cope with the experience of developing and living with psychosis. The therapist attempts to reinforce a person's healthy ways of thinking and reduce internal conflict.

- **Cognitive enhancement therapy** (CET), which seeks to build brain capacity through the use of computer exercises and group work. Increasing cognitive functions, such as the ability to organize thoughts, is the ultimate goal.
- **Family psychoeducation and support**, which helps individuals who are living with psychosis and their families work on bonding, collaborating, problem solving and learning from each other. NAMI's **Family-to-Family** program is available across the nation and has been shown to improve family functioning and outcomes in key measures. Family-to-Family is an evidence-based practice where the positive results were still seen 9 months after taking the class.

Self-harm

People often keep their habit a secret, but the urge to self-harm isn't uncommon, especially in adolescents and young adults. Many overcome it with treatment.
Whether a person has recently started hurting his or herself or has been doing it for a while, there is an opportunity to improve health and reduce behaviors. Talking to a doctor or a trusted friend or family member is the first step towards understanding your behavior and finding relief.

Self-harm or self-injury means hurting yourself on purpose. One common method is cutting yourself with a knife. But any time someone deliberately hurts herself is classified as self-harm. Some people feel an impulse to burn themselves, pull out hair or pick at wounds to prevent healing. Extreme injuries can result in broken bones.

Hurting yourself—or thinking about hurting yourself—is a sign of emotional distress. These uncomfortable emotions may grow more intense if a person continues to use self-harm as a coping mechanism. Learning other ways to tolerate the mental pain will make you stronger in the long term.

Self-harm also causes feelings of shame. The scars caused by frequent cutting or burning can be permanent. Drinking alcohol or doing drugs while hurting yourself increases the risk of a more severe injury than intended. And it takes time and energy away from other things you value. Skipping classes to change bandages or avoiding social occasions to prevent people from seeing your scars is a sign that your habit is negatively affecting work and relationships.

Self-harm is not a mental illness, but a behavior that indicates a lack of coping skills. Several illnesses are associated with it, including borderline personality disorder, depression, eating disorders, anxiety or posttraumatic distress disorder.

Self-harm occurs most often during the teenage and young adult years, though it can also happen later in life. Those at the most risk are people who have experienced trauma, neglect or abuse. For instance, if a person grew up in an unstable family, it might have become a coping mechanism. If a person binge drinks or does drugs, he is also at greater risk of self-injury, because alcohol and drugs lower self-control.

The urge to hurt yourself may start with overwhelming anger, frustration or pain. When a person is not sure how to deal with emotions, or learned as a child to hide emotions, self-harm may feel like a release. Sometimes, injuring yourself stimulates the body's endorphins or pain-killing hormones, thus raising their mood. Or if a person doesn't feel many emotions, he might cause himself pain in order to feel something "real" to replace emotional numbness.

Once a person injuries herself, she may experience shame and guilt. If the shame leads to intense negative feelings, that person may hurt herself again. The behavior can thus become a dangerous cycle and a long-time habit. Some people even create rituals around it.

Self-harm isn't the same as attempting suicide. However, it is a symptom of emotional pain that should be taken seriously. If someone is hurting herself, she may be at an increased risk of feeling suicidal. It's important to find treatment for the underlying emotions.

There are effective treatments for self-harm that can allow a person to feel in control again. Psychotherapy is important to any treatment plan. Self-harm may feel necessary to manage emotions, so a person will need to learn new coping mechanisms.

The first step in getting help is talking to a trusted adult, friend or medical professional who is familiar with the subject, ideally a psychiatrist. A psychiatrist will ask that person questions about their health, life history and any injurious behaviors in the past and present. This conversation, called a diagnostic interview, may last an hour or more. Doctors can't use blood tests or physical exams to diagnose mental illness, so they rely on detailed information from the individual. The more information that person can give, the better the treatment plan will be.

Depending on any underlying illness, a doctor may prescribe medication to help with difficult emotions. For someone with depression, for instance, an antidepressant may lessen harmful urges.

A doctor will also recommend therapy to help a person learn new behaviors, if self-injury has become a habit. Several different kinds of therapy can help, depending on the diagnosis.

- Psychodynamic therapy **focuses on exploring past experiences and emotions**
- Cognitive behavioral therapy **focuses on recognizing negative thought patterns and increasing coping skills**
- Dialectical behavioral therapy **can help a person learn positive coping methods**

If your symptoms are overwhelming or severe, your doctor may recommend a short stay in a psychiatric hospital. A hospital offers a safe environment where you can focus your energy on treatment.

Perhaps you have noticed a friend or family member with frequent bruises or bandages. If someone is wearing long sleeves and pants even in hot weather, they may be trying to hide injuries or scarring.

Keep in mind that this is a behavior that might be part of a larger condition and there may be additional signs of emotional distress. He or she might make statements that sound hopeless or worthless, have poor impulse control, or have difficulty getting along with others.

If you're worried a family member or friend might be hurting herself, ask her how she's doing and be prepared to listen to the answer, even if it makes you uncomfortable. This may be a hard subject to understand. One of the best things is tell them that while you may not fully understand, you'll be there to help. Don't dismiss emotions or try to turn it into a joke.

Gently encourage someone to get treatment by stating that self-harm isn't uncommon and doctors and therapists can help. If possible, offer to help find treatment. But don't go on the offensive and don't try to make the person promise to stop, as it takes more than willpower to quit.

Sleep Disorders

Many people experience problems sleeping including not getting enough sleep, not feeling rested and not sleeping well. This problem can lead to difficulties functioning during the daytime and have unpleasant effects on your work, social and family life. Problems sleeping can be secondary to a medical illness such as sleep apnea, or a mental health condition like depression. Sleep issues can be a sign of an impending

condition such as bipolar disorder. In addition to affecting sleep itself, many medical and mental health conditions can be worsened by sleep-related problems.
One of the major sleep disorders that people face is insomnia. Insomnia is an inability to get the amount of sleep needed to function efficiently during the daytime. Over one-third of Americans report difficulty sleeping. Insomnia is caused by difficulty falling asleep, difficulty staying asleep or waking up too early in the morning.

Insomnia is rarely an isolated medical or mental illness but rather a symptom of another illness to be investigated by a person and their medical doctors. In other people, insomnia can be a result of a person's lifestyle or work schedule.

Sometimes insomnia or other sleep problems can be caused by sleep apnea, which is a separate medical condition that affects a person's ability to breathe while sleeping. A doctor or sleep specialist can diagnose sleep apnea and provide treatment to improve sleep.

Short-term insomnia is very common and has many causes such as stress, travel or other life events. It can generally be relieved by simple sleep hygiene interventions such as exercise, a hot bath, warm milk or changing your bedroom environment. Long-term insomnia lasts for more than three weeks and should be investigated by a physician with a potential referral to a sleep disorder specialist, which includes psychiatrists, neurologists and pulmonologists who have expertise in sleep disorders.

More than one-half of insomnia cases are related to depression, anxiety or psychological stress. Often the qualities of a person's insomnia and their other symptoms can be helpful in determining the role of mental illness in a person's inability to sleep. Early morning wakefulness can be a sign of depression, along with low energy, inability to concentrate, sadness and a change in appetite or weight. On the other hand, a sudden dramatic decrease in sleep which is accompanied by increase in energy, or the lack of need for sleep may be a sign of mania.

Many anxiety disorders are associated with difficulties sleeping. Obsessive-compulsive disorder (OCD) is frequently associated with poor sleep. Panic attacks during sleep may suggest a panic disorder. Poor sleep resulting from nightmares may be associated with posttraumatic stress disorder (PTSD).

Substance abuse can also cause problems with sleep. While alcohol is sedating in limited quantities, intoxication with alcohol can make you wake up numerous times in the night and disturbs your sleep patterns. Hallucinogenic drugs, such as LSD, ecstasy and Molly, and are also associated with interruptions in sleep. Some sedative medications may cause sleepiness during intoxication but can disturb sleep and cause serious problems sleeping in people who are addicted to or withdrawing from these medications.

Poor sleep has been shown to significantly worsen the symptoms of many mental health issues. Severe sleep problems can decrease the effectiveness of certain treatments. Treatment of sleep disorders has also been studied in relationship to schizophrenia, ADHD and other mental illnesses. All of the scientific data shows the connection between medical and mental illnesses: good sleep is necessary for recovery—or prevention—in both types of conditions.

The first-line treatment for insomnia is good sleeping habits and taking care of any underlying conditions that may be causing the problems with sleeping. But when these are not enough, other treatment options can be considered.

- **Good sleeping habits.** A first-line treatment for treatment of insomnia, these can include maintaining a regular sleep schedule, avoiding stimulating activities like exercise before bed, and having a comfortable sleep environment.
- **Relaxation techniques.** Deep breathing, progressive muscle relaxation and mindfulness can help people become aware of their body and decrease anxiety about going to sleep.
- **Medication.** Many psychiatric drugs are used to promote sleep in people with insomnia. One should be careful regarding the risk of becoming “over-sedated” by using other drugs and alcohol when taking some of these medications. Doctors don't generally recommend staying on medication for more than a few weeks but there are a few medications that have been approved for long term use.
- **Herbal remedies.** Melatonin and valerian root are two herbal remedies that are available at many pharmacies and other locations. The effectiveness of these treatments has not been proven for most people, and neither treatment has been approved by the FDA.
- **Sleep restriction.** This is a form of therapy that increases “sleep efficiency” by decreasing the amount of time that a person spends in bed awake. This involves very strict rules regarding the amount of time that a person can lay in bed for at night which gradually increases over time.
- **Cognitive behavioral therapy.** This therapy can help you control or eliminate negative thoughts and worries that keep you awake.
- **Light therapy.** Also known as phototherapy, this can be specifically helpful in people with a condition called “delayed sleep phase syndrome.”
- **Exercise is associated with improved sleep quality**. Talk with your health care provider about the kind of exercise that will work for you.

Eating Disorders

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

Symptoms

Eating disorders are a group of related conditions that cause serious emotional and physical problems. Each condition involves extreme food and weight issues; however, each has unique symptoms that separate it from the others.

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

The emotional symptoms of anorexia include irritability, social withdrawal, lack of mood or emotion, not able to understand the seriousness of the situation, fear of eating in public and obsessions with food and exercise. Often food rituals are developed or whole categories of food are eliminated from the person’s diet, out of fear of being “fat".

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

Bulimia Nervosa. People living with bulimia will feel out of control when binging on very large amounts of food during short periods of time, and then desperately try to rid themselves of the extra calories using forced vomiting, abusing laxatives or excessive exercise. This becomes a repeating cycle that controls many aspects of the person's life and has a very negative effect both emotionally and physically. People living with bulimia are usually normal weight or even a bit overweight.
The emotional symptoms of bulimia include low self-esteem overly linked to body image, feelings of being out of control, feeling guilty or shameful about eating and withdrawal from friends and family.

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

Binge Eating Disorder (BED). A person with BED losses control over their eating and eats a very large amount of food in a short period of time. They may also eat large amounts of food even when he isn't hungry or after he is uncomfortably full. This causes them to feel embarrassed, disgusted, depressed or guilty about their behavior. A person with BED, after an episode of binge eating, does not attempt to purge or exercise excessively like someone living with anorexia or bulimia would. A person with binge eating disorder may be normal weight, overweight or obese.

Causes

Eating disorders are very complex conditions, and scientists are still learning about the causes. Although eating disorders all have food and weight issues in common, most experts now believe that eating disorders are caused by people attempting to cope with overwhelming feelings and painful emotions by controlling food. Unfortunately, this will eventually damage a person's physical and emotional health, self-esteem and sense of control.

Factors that may be involved in developing an eating disorder include:

- **Genetics.** People with first degree relatives, siblings or parents, with an eating disorder appear to be more at risk of developing an eating disorder, too. This suggests a genetic link. Evidence that the brain chemical, serotonin, is involved also points a contributing genetic and biological factors.
- **Environment.** Cultural pressures that idealize a particular body type place undue pressure on people to achieve unrealistic standards. Popular culture and media images often tie thinness (for women) or muscularity (for men) to popularity, success, beauty and happiness.
- **Peer Pressure.** With young people, this can be a very powerful force. Pressure can appear in the form of teasing, bullying or ridicule because of size or weight. A history of physical or sexual abuse can also contribute to some people developing an eating disorder.
- **Emotional Health.** Perfectionism, impulsive behavior and difficult relationships can all contribute to lowering a person's self-esteem and make them vulnerable to developing eating disorders.

Eating disorders affect all types of people. However there are certain risk factors that put some people at greater risk for developing an eating disorder.

- **Age.** Eating disorders are much more common during teens and early 20s.
- **Gender.** Women and girls are more likely to have a diagnosed eating disorder. However, it is important to recognize that men and boys may be under-diagnosed due to differences in seeking treatment.
- **Family history.** Having a parent or sibling with an eating disorder increases the risk.
- **Dieting.** Dieting taken too far can become an eating disorder.
- **Changes.** Times of change like going to college, starting a new job, or getting divorced may be a stressor towards developing an eating disorder.

- **Vocations and activities.** Eating disorders are especially common among gymnasts, runners, wrestlers and dancers.

Diagnosis

A person with an eating disorder will have the best recovery outcome if they receive an early diagnosis. If an eating disorder is believed to an issue, a doctor will usually perform a physical examination, conduct an interview and order lab tests. These will help form the diagnosis and check for related medical issues and complications.

In addition, a mental health professional will conduct a psychological evaluation. They may ask questions about eating habits, behaviors and beliefs. There may be questions about a patient's history of dieting, exercise, bingeing and purging.

Symptoms must meet the criteria in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in order to warrant a diagnosis. Each eating disorder has its own diagnostic criteria that a mental health professional will use to determine which disorder is involved. It is not necessary to have all the criteria for a disorder to benefit from working with a mental health professional on food and eating issues.

Often a person with an eating disorder will have symptoms of another mental health condition that requires treatment. Whenever possible, it is best to identified and address all conditions at the same time. This gives a person comprehensive treatment support that helps ensure a lasting recovery.

Treatment

Eating disorders are managed using a variety of techniques. Treatments will vary depending on the type of disorder, but will generally include the following.

- Psychotherapy**,** such as talk therapy or behavioral therapy.
- Medicine**,** such as antidepressants and anti-anxiety drugs. Many people living with an eating disorder often have a co-occurring illness like depression or anxiety, and while there is no medication available to treat eating disorders themselves, many patients find that these medicines help with underlying issues.
- **Nutritional counseling and weight restoration monitoring** are also crucial. Family-based treatment is especially important for families with children and adolescents because it enlists the families' help to better ensure healthy eating patterns, and increases awareness and support.

Related Conditions

People with eating disorders often have additional illnesses:

- Depression
- Anxiety disorders
- Borderline personality disorder
- Obsessive-compulsive disorder
- Substance use disorders/ Dual Diagnosis

Treating these illnesses can help make treating an eating disorder easier. Some of the symptoms of eating disorders may be caused by another illness.

Dissociative Disorders

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

Up to 75% of people experience at least one depersonalization/derealization episode in their lives, with only 2% meeting the full criteria for chronic episodes. Women are more likely than men to be diagnosed with a dissociative disorder.
The symptoms of a dissociative disorder usually first develop as a response to a traumatic event, such as abuse or military combat, to keep those memories under control. Stressful situations can worsen symptoms and cause problems with functioning in everyday activities. However, the symptoms a person experiences will depend on the type of dissociative disorder that a person has.

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

Symptoms
Symptoms and signs of dissociative disorders include:

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

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

- **Dissociative Amnesia.** The main symptom is difficulty remembering important information about one's self. Dissociative amnesia may surround a particular event, such as combat or abuse, or more rarely, information about identity and life history. The onset for an amnesic episode is usually sudden, and an episode can last minutes, hours, days, or, rarely, months or years. There is no average for age onset or percentage, and a person may experience multiple episodes throughout her life.
- **Depersonalization disorder.** This disorder involves ongoing feelings of detachment from actions, feelings, thoughts and sensations as if they are watching a movie (depersonalization). Sometimes other people and things may feel like people and things in the world around them are unreal (derealization). A person may experience depersonalization, derealization or both. Symptoms can last just a matter of moments or return at times over the years. The average onset age is 16, although depersonalization episodes can start anywhere from early to mid childhood. Less than 20% of people with this disorder start experiencing episodes after the age of 20.
- **Dissociative identity disorder.** Formerly known as multiple personality disorder, this disorder is characterized by alternating between multiple identities. A person may feel like one or more voices are trying to take control in their head. Often these identities may have unique names, characteristics, mannerisms and voices. People with DID will experience gaps in memory of every day events, personal information and trauma. Women are more likely to be diagnosed, as they more frequently present with acute dissociative symptoms. Men are more likely to deny symptoms and trauma histories, and commonly exhibit more violent behavior, rather than amnesia or fugue states. This can lead to elevated false negative diagnosis.

Causes

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

Diagnosis
Doctors diagnose dissociative disorders based on a review of symptoms and personal history. A doctor may perform tests to rule out physical conditions that can cause symptoms such as memory loss and a sense of

unreality (for example, head injury, brain lesions or tumors, sleep deprivation or intoxication). If physical causes are ruled out, a mental health specialist is often consulted to make an evaluation.

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

Treatment
Dissociative disorders are managed through various therapies including:

- Psychotherapies such as cognitive behavioral therapy (CBT) and dialectical behavioral therapy (DBT)
- **Eye movement desensitization and reprocessing** (EMDR)
- Medications such as antidepressants can treat symptoms of related conditions

Related Conditions

Because dissociative disorders appear on the trauma spectrum, many patients may have conditions associated with trauma, as well as additional trauma-based conditions.

- Posttraumatic stress disorder (PTSD)
- Borderline personality disorder (BPD)
- Substance use disorders / Dual Diagnosis
- Depression
- Anxiety

Risk of Suicide

Each year more than 34,000 individuals take their own life, leaving behind thousands of friends and family members to navigate the tragedy of their loss. Suicide is the 10th leading cause of death among adults in the U.S. and the 3rd leading cause of death among adolescents. Suicidal thoughts or behaviors are both damaging and dangerous and are therefore considered a psychiatric emergency. Someone experiencing these thoughts should seek immediate assistance from a health or mental health care provider.

Suicide and suicidal thoughts are relatively common. Having suicidal thoughts does not mean someone is weak or flawed.

Know the Warning Signs

- **Threats or comments about killing themselves, also known as suicidal ideation, can begin with seemingly harmless thoughts like "I wish I wasn't here" but can become more overt and dangerous**
- **Increased alcohol and drug use**
- **Aggressive behavior**
- **Social withdrawal from friends, family and the community**
- **Dramatic mood swings**
- **Talking, writing or thinking about death**

- **Impulsive or reckless behavior**

Any person exhibiting these behaviors should get care immediately:

- **Putting their affairs in order and giving away their possessions**
- **Saying goodbye to friends and family**
- **Mood shifts from despair to calm**
- **Planning, possibly by looking around to buy, steal or borrow the tools they need to commit suicide, such as a firearm or prescription medication**

If you are unsure, a licensed mental health professional can help assess risk.

Research has found that about 90% of individuals who die by suicide experience mental illness. Oftentimes it is undiagnosed or untreated. Experiencing a mental illness is the number one risk factor for suicide.

A number of other things may put a person at risk of suicide:

- Substance abuse, **which can cause mental highs and lows that exacerbate suicidal thoughts**
- Intoxication **(more than one in three people who die from suicide are found to be intoxicated)**
- Access to firearms **(the majority of completed suicides involve the use of a firearm)**
- Chronic medical illness
- Gender **(though more women than men attempt suicide, men are 4 times more likely to die by suicide)**
- History of trauma
- Isolation
- Age **(people under age 24 or above age 65 are at a higher risk for suicide)**
- Recent tragedy or loss
- Agitation and sleep deprivation

Mental health professionals are trained to help a person understand their feelings and can improve mental wellness and resiliency. Depending on their training they can provide effective ways to help.

Psychotherapy such as cognitive behavioral therapy and dialectical behavior therapy, can help a person with thoughts of suicide recognize unhealthy patterns of thinking and behavior, validate troubling feelings, and learn coping skills.

Medication can be used if necessary to treat underlying depression and anxiety and can lower a person's risk of hurting themselves. Depending on the person's mental health diagnosis, other medications can be used to alleviate symptoms.

If you or someone you know is in an emergency, call 988
Or Coleman Crisis Center Adult/Mobile Response Team 330-452-6000

24-HOUR

STARK COUNTY

Mobile Response Team

330-452-6000

Intervention response services help children, young people & adults right where they are

At times children, young people, adults and their families need help restoring calm. The Mobile Response Team of professionals trained in crisis intervention, information and referral will provide behavioral health services wherever you are, anytime of day or night.

SERVICES ARE

- Available 24 hours every day, including weekends and holidays
- Available to anyone regardless of ability to pay:
  - Parents, foster families, caregivers
  - School staff & educators
  - Retail, business & workplaces
  - Medical offices & clinics
  - First responders, EMTs & police
  - Community members

FUNDERS AND PARTNERS

SAMHSA Ohio CRISIS CENTER StarkMHAR StarkMHAR.org

Definitions

addiction: Dependence on a chemical substance to the extent that a physiological and/or psychological need is established. This may be manifested by any combination of the following symptoms: tolerance, preoccupation with obtaining and using the substance, use of the substance despite anticipation of probable adverse consequences, repeated efforts to cut down or control substance use, and withdrawal symptoms when the substance is unavailable or not used.

adherence: (ad – here – rents) The degree to which the client follows the prescribed course of medication administration. It is used as an alternative term to “compliance,” which has overtones of client passivity and obedience, and “noncompliance,” which has overtones of deviancy.

adjunctive agent – a second drug prescribed to bolster the effectiveness of the first.

adrenergic: (ad – dren – nerge – ic) Referring to neural activation by adrenaline, which is involved in the regulation of autonomic processes and in the central control of cardiac functions.

advocacy – active support for a cause or position; activities to support individuals with mental illness including rights protection, legal and service assistance and system or policy change.

affect: (aff – fect) Behavior that expresses a subjectively experienced feeling state (emotion); affect is responsive to changing emotional states, whereas mood refers to a pervasive and sustained emotion. Common affects are euphoria, anger, and sadness.

akathisia: (ack – ka – thees – ya) Complaints of restlessness accompanied by movements such as fidgeting of the legs, rocking from foot to foot, pacing, or inability to sit or stand. Symptoms develop within a few weeks of starting or raising the dose of a neuroleptic medication or of reducing the dose of medication used to treat extrapyramidal symptoms See extrapyramidal symptoms).

akinesia: (ack – kin – nees – ya) A state of motor inhibition; reduced voluntary movement.

Alcohol/Other Drug Abuse – Can be used to indicate a substance abusing / mentally ill (SAMI) client.

alogia: (ah – loge – ya) Literally, speechlessness. Most commonly used to refer to the lack of spontaneity in speech and diminished flow of conversation that occurs as negative symptoms in schizophrenia.

amphetamines – medication that stimulates dopamine release in the central nervous system causing elevated mood and increased wakefulness, alertness, concentration, and physical performance; they have a high potential for abuse; clinically used to treat ADHD and narcolepsy.

antiparkinsonian drugs: (an – tie – park - in – so – nee – an) Pharmacologic agents that reduce Parkinson-like symptoms. In psychiatry, these agents are used to combat the untoward Parkinson-like and extrapyramidal side effects that may be associated with treatment with neuroleptic drugs.

Anosognosia - "lack of insight" or "lack of awareness" - is believed to be the single largest reason why individuals with schizophrenia and bipolar disorder do not take their medications. A result of anatomical damage to the brain, it affects approximately 50% of individuals with schizophrenia and 40% of individuals with bipolar disorder. When taking medications, awareness of illness improves in some patients.

anxiolytics (anxio – lit – tics): Drugs that have an antianxiety effect and are used widely to relieve emotional tension. The most commonly used antianxiety drugs are the benzodiazepines.

Asperger's disorder: A developmental disorder characterized by gross and sustained impairment in social interaction and restricted, repetitive, and stereotyped patterns of behavior, interests, and activities; occurs in the context of preserved cognitive and language development.

Assertive Community Treatment (ACT): A team based approach to the provision of treatment, rehabilitation and support services. ACT/PACT models of treatment are built around a self-contained multi-disciplinary team that serves as the fixed point of responsibility for all patient care for a fixed group of clients. In this approach, normally used with clients with severe and persistent mental illness, the treatment team typically provides all client services using a highly integrated approach to care. A key aspect is low caseloads and the availability of the services in a range of settings.

autism: (aught – tism) A form of developmental disorder in which the subjective predominates and the "me" is favored, sometimes resulting in the exclusion of the "not me." The subject is unable to turn his or her energies to outside reality. Introversion and avoidance of contact may be marked; occurs in the context of severely restricted cognitive and language development.

autonomic (ought – toe – naw – mick) nervous system: Regulates the involuntary processes of the internal organs and blood vessels. Many of the functions controlled by the autonomic nervous system are self-regulating or autonomous. It is comprised of two primary subsystems: the sympathetic and parasympathetic systems, which sometimes work in cooperation but other times are antagonistic in their contrasting roles of "arousal" and "rest."

avolition (av – vo – lish – un): A symptom of mental illness that is particularly common in schizophrenia. This symptom is expressed as extreme apathy and loss of normal drive and interest. An avolitional patient often finds it difficult to get started at tasks or, if he begins a task, often gives up before he has finished it.

axis (ax – sis): The name given to each of the five levels of annotating a psychiatric diagnosis used in the Diagnostic and Statistical Manual of Mental Disorders (DSM).

benzodiazepines: (ben – zoe – die – azza – peens) The generic name for a group of drugs that have potent hypnotic, sedative, and anxiolytic action. They are also called *anxiolytics or antianxiety drugs*.

beta-blockers: (bay – ta) Refers to a class of drugs that reduces anxiety by blocking the beta receptors in the autonomic nervous system. They block those receptors that stimulate heartbeat and those that dilate blood vessels and air channels in the lungs. They are as strong as benzodiazepines, despite the greater dosages needed, and they are not addicting. They are, however, short-acting and do not remain long in the system. They are most effective for specific situations of unmanageable anxiety.

Care / Group Home – a congregate living environment licensed by a county or state department to provide care to children or adolescents. Reasons for this placement level of care are more environmental in nature than psychiatric. Child residential Care / Group Home may provide supervision, social services, and accommodations, but treatment services are provided separately and service intensity will vary from client to client. **Adult Residential Care/ ACF: Adult Care Facility (Adult Group Home/Adult Family Home) -** a congregate living environment licensed by a state department to provide care to adults. Reasons for this placement level of care are more environmental in nature than psychiatric. Home may provide supervision, social services, and accommodations, but treatment services are provided separately, and service intensity will vary from client to client. **Adult Residential Care (Type 2, 3) –** licensed by the state, includes room & board and may or may not include personal care or mental health services. May also be called Residential Support, Next-Step Housing, or Supervised Group Living.

catatonic behavior: (catta – tahn – nic) Marked motor abnormalities, generally limited to those occurring as part of a psychotic disorder. This term includes catatonic excitement (apparently purposeless agitation not influenced by external stimuli), stupor (decreased reactivity and fewer spontaneous movements, often with apparent unawareness of the surroundings), negativism (apparent motiveless resistance to instructions or attempts to be moved), posturing (the person's assuming and maintaining an inappropriate or bizarre stance), rigidity (the person's maintaining a stance of posture against all efforts to be moved), and waxy flexibility (the person's limbs can be put into positions that are maintained).

chronic: Continuing over a long period of time or recurring frequently. Chronic conditions often begin inconspicuously, and symptoms may be less pronounced than in acute conditions

Cognitive behavioral therapy (CBT) – a research based approach to therapy that is generally short-term and focused on addressing specific thoughts and behavior involved in maintaining an individual's problems and reducing that behavior.

Cognitive deficits – impairment of judgment, memory, reasoning and comprehension due to a variety of causes.

Cognitive distortion – interpreting an event in a distorted way that leads to a faulty conclusion.

Cognitive functions – activities related to the ability to think – take in and process information, reason, memorize, learn, and communicate.

Community Residence – Person living in an apt where they entered into an agreement that is not covered by Ohio tenant landlord law. Rules in program or service agreement attached to housing. Refers to financial sponsorship and/or provision of some degree of onsite supervision for residents.

comorbidity: (coe – more – bid – ditty) The occurrence of two or more disorders at the same time. The disorders may occur independently of each other, or one may occur as a consequence of the other.

confidentiality: (con – fid – den – she – al – ity) The ethical principle that a physician may not reveal any information disclosed in the course of medical attendance.

Conservatorship/Guardianship: In some cases, a person who is suicidal refuses to seek or accept treatment. They may engage in self-harm, risky behaviors and multiple suicide attempts. Oftentimes a person in this condition has a serious underlying mental illness that they refuse treatment for. Unfortunately, because they present such a significant danger to themselves, they may need someone else to make these decisions for them.
A conservatorship/guardianship is a legal relationship granted by a court that allows one person (the conservator) to make personal decisions for another (the ward), who has shown themselves to be unable to fulfill the basic requirements needed to protect their own health and safety. Unless otherwise specified, the conservator has all of the powers that a parent has over a minor, which would allow the conservator to direct the ward's mental health treatment and suicide prevention measures.

Controlled substances – classes of compounds categorized by the US Drug Enforcement Administration as potentially addictive (i.e. opiates, narcotics, etc.)

Correctional Facility – Refers to any facility operated by city, county, state or federal law enforcement providers. Examples: Jail, Workhouse, Prison.

Crisis Care – Provision of short-term care to stabilize person experiencing psychiatric emergency. Offered as an alternative to inpatient psychiatric unit. Staff 24 hours per day/7 days a week. Treatment services are billed separately.

deinstitutionalization: (de – insta – toosh – in – nal – lye – zay – shun) Change in locus of mental health care from traditional, institutional settings to community-based services. Sometimes called trans-institutionalization because it often merely shifts the patients from one institution (the hospital) to another (such as a prison).

delusion: (dee – lose – yun) A belief that is clearly implausible but compelling and central to an individual's life.

depersonalization: (dee – person – nal – eye – zay – shun) Feelings of unreality or strangeness concerning the environment, the self, or both. This is characteristic of depersonalization disorder and may also occur in schizotypal personality disorder, schizophrenia, and in those persons experiencing overwhelming anxiety, stress, or fatigue.

derealization: (dee – ree – al – eye – zay – shun) A feeling of estrangement or detachment from one's environment. May be accompanied by *depersonalization.*

detoxification: (dee – tox – see – fih – cay – shun) The process of providing medical care during the removal of dependence-producing substances from the body so that withdrawal symptoms are minimized and hysiological function is safely restored. Treatment includes medication, rest, diet, fluids, and nursing care.

differential diagnosis: The consideration of which of two or more diseases with similar symptoms the patient suffers from.

dopamine: (dope – pah – meen) A neurotransmitter which regulates movement, mood and motivation. There are 3 major pathways in the brain's dopamine system: 1) *mesocortical:* emotion, motivation, cognition; 2) *mesolimbic*: feelings, emotions, psychosis; 3) *nigostriatal*: planned and voluntary coordination of movement.

DSM-IV: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, 1994. The American Psychiatric Association's official classification of mental disorders.

dual diagnosis: The co-occurrence within one's lifetime of a psychiatric disorder and a substance use disorder.

dyskinesia: (disc – kin – nees – yah) Any disturbance of movement. It may also be induced by medication.

dystonia: (diss – tony – yah) Abnormal positioning or spasm of the muscles of the head, neck, limbs, or trunk; the dystonia develops within a few days of starting or raising the dose of a neuroleptic medication, because of dysfunction of the *extrapyramidal system.*

efficacy: (effi – ka – see) Effectiveness of a drug as a therapeutic agent, particularly over long term use.

electroconvulsive therapy (ECT): Use of electric currents, with anesthetics and muscle relaxants, applied briefly to one or both sides of the brain. Most effective in severe depression.

endocrine disorders: (end – doe – crin) Disturbances of the function of the ductless glands that may be metabolic in origin and may be associated with or aggravated by emotional factors, producing mental and behavioral disturbances in addition to physical signs. Of particular significance in psychiatry is the

*hypothalamic-pituitary-adrena*l (HPA) axis, consisting of a self regulating circle of neurohormones released from the hypothalamus and stimulating the release of hormones from the pituitary. These in turn stimulate hormone secretion in target organs (thyroid, adrenal, and gonads.) The HPA axis is involved in the regulation of sexual activity, thirst and hunger behaviors, sleep, learning and memory, and perhaps in antidepressant activity.

epilepsy: (ep – pih – lep – see) A neurologic disorder characterized by periodic motor and sensory seizures, sometimes accompanied by alterations of consciousness.

Executive function deficits – disturbances in the sequence of mental processes that relate to the ability to plan, initiate, organize, and follow through on an activity. Includes problems with time management, organization, and prioritizing.

Family Psycho-Education: Offered as part of an overall clinical treatment plan for individuals with mental illness to achieve the best possible outcome through the active involvement of family members in treatment and management and to alleviate the suffering of family members by supporting them in their efforts to aid the recovery of their loved ones. Family Psycho-education programs may be either multi-family or single-family focused. Core characteristics of family Psycho-education programs include the provision of emotional support, education, re-sources during periods of crisis, and problem-solving skills.

Forensic Legal Status – Client is involved in the criminal or juvenile justice system and is al-so served or eligible to be served by the mental health system. Forensic clients can be **adults or youth** who get arrested, detained, or diverted who have a mental illness. They can also be individuals in the hospital or on conditional release who have a forensic legal status or people coming out of prison/jail who have serious mental illness.

Foster Care – Living situations in which the client resides with a non-related family or person in that person's home for purpose of receiving care, supervision, assistance, and accommodations. Treatment services are billed separately. Licensed through the state.

Functional Family Therapy (FFT): FFT is a phased program where each step builds on one another to enhance protective factors and reduce risk by working with both the youth and their family.

grandiosity: (gran – dee – oss – city) Exaggerated belief or claims of one's importance of identity, often manifested by delusions of great wealth, power, or fame.

Grievance – formal process of filing a complaint with the mental health system, requires a hearing process.

hallucinations: (hah – loo – sin – nay – shuns) False perceptions that are heard, seen, tasted, smelled or felt.

Homeless – Refers to those who have no fixed address and/or those who reside in shelters that provide overnight lodging for homeless persons. Examples: Homeless shelter; Mission; Street or Outdoors.

Hospital – Refers to any non-state operated hospital, including a private psychiatric hospital or the psychiatric division of a general medical facility. Examples: General Hospital; Community Hospital; Private Psychiatric Hospital.

hypertensive crisis: Sudden and sometimes fatal rise in blood pressure; it may occur as a result of combining *monoamine oxidase inhibitors* and *tyramine* in food, or over-the-counter medications (e.g., cough remedies and nose drops).

hypothalamus: (hype – poe – thall - uh – muss) The complex brain structure composed of many nuclei with various functions. It is the head ganglion of the *autonomic nervous system* and is involved in the control of heat regulation; heart rate, blood pressure, and respiration; sexual activity; water, fat, and carbohydrate metabolism; digestion, appetite, and body weight; wakefulness; fight or flight response; and rage.

Illness Self-Management/Wellness Management & Recovery: These are broad set of re-habilitation methods aimed at teaching individuals with a mental illness strategies for collaborating actively in their treatment with professionals, for reducing their risk of relapses and re-hospitalizations, for reducing severity and distress related to symptoms, and for improving their social support. Specific evidence-based practices that are incorporated under the broad rubric of illness self-management are psycho-education about the nature of mental illness and its treatment, "behavioral tailoring" to help individuals incorporate the taking of medication in-to their daily routines, relapse prevention planning, teaching coping strategies to managing distressing persistent symptoms, cognitive-behavior therapy for psychosis, and social skills training. The goal of illness self-management is to help individuals develop effective strategies for managing their illness in collaboration with professionals and significant others, thereby freeing up their time to pursue their personal recovery goals.

illusion: A misperception of a real external stimulus.

Independent Living (Own Home) – a house, apartment, or a home that the client rents or owns, which is not sponsored, licensed, supervised, or otherwise connected to mental health or AOD providers. Includes children living with parents, adult living with parent, or an adult who has a roommate where they share household expenses.

insight: The extent of a person's understanding of the origins, nature and mechanisms of his or her mental illness.

insomnia: Inability to fall asleep (also called *initial insomnia*); or stay asleep (also called *middle insomnia*) or waking up too early (also called *terminal insomnia* or *early morning wakening*).

Integrated Dual Disorder Treatment (IDDT): Dual diagnosis treatments combine or integrate mental health and substance abuse interventions at the level of the clinical encounter. Hence, integrated treatment means that the same clinicians or teams of clinicians, working in one setting, provide appropriate mental health and substance abuse interventions in a coordinated fashion. In other words, the caregivers take responsibility for combining the interventions into one coherent package. For the individual with a dual diagnosis, the services appear seamless, with a consistent approach, philosophy, and set of recommendations. The need to negotiate with separate clinical teams, programs, or systems disappears. The goal of dual diagnosis interventions is recovery from two serious illnesses**.**

Intensive Home-based Treatment (IHBT): Intensive Home-Based Treatment is a time-limited mental health service for youth with serious emotional disabilities and their families, pro-vided in the home, school and community where the youth lives, with the goal of stabilizing mental health concerns, and safely maintaining the youth in the least restrictive, most normative environment. IHBT provides a comprehensive set of services (CPST, Behavioral Health Counseling and Therapy; Crisis Response; mental health assessment, supportive services) integrated by a team of providers into a seamless set of services delivered to the family. The main purposes are out-of-home placement prevention, reunification, and stabilization & safety.

Interpersonal therapy (IPT) – a contemporary approach to the treatment of mood disorders that focuses on current problems, important social relationships, self-evaluation by the patient with assessment of his own current situation and clarification and modification of maladaptive perceptions and current interpersonal relationships; this therapy strengthens the person's communication and problem solving skills

kindling: (kin – dling) The creation of seizures in an area of the brain by subjecting it to repeated, low level electrical stimulation; eventually the area becomes so sensitive that seizures will occur spontaneously, with no electrical stimulus.

labile: (lay – bile) Rapidly shifting mood; unstable.

Licensed MR Facility – Refers to any ODMR-DD licensed group home or community facility (that is not an ICF-MR) where supervision, services and/or accommodations are provided. Examples: Group Home for persons with MR; Residential Facility for persons with MR.

lithium: Used in the treatment of acute mania and as a maintenance medication to help reduce the duration, intensity and frequency of bipolar disorder. There is a narrow band of effective dosage above which toxicity occurs and below which there is no effect; can also cause fetal damage.
maintenance drug therapy: Continuing a therapeutic drug after it has reached its maximum *efficacy*, and at a minimum effective level to prevent an early relapse or a later recurrence of illness.

Medication Management: In the toolkit on medication management there does not appear to be any explicit definition of medication management. However, the critical elements identified for evidence-based medication management approaches are the following: Utilization of a systematic plan for medication management; Objective measures of outcome are produced; Documentation is thorough and clear; Consumers and practitioners share in the decision-making.

Mental Retardation/Developmental Disability – Can be used to indicate client has a DD diagnosis without entering a specific Axis II diagnosis.

Military Family – Client is the child, spouse or other dependent of active or inactive soldier. Military includes National Guard, Army, Navy, Marines, Coast Guard.

Multi-Systemic Therapy (MST): MST views the individual as nestled within a complex network of interconnected systems (family, school, peers). The goal is to facilitate change in this natural environment to promote individual change. The caregiver is viewed as the key to long-term outcomes
.
nervous system: specifically a drug whose principal effect is on psychomotor activity.

norepinephrine: (nor – reppin – nef – frin) A type of neurotransmitter secreted by the adrenal glands in response to arousal-provoking events such as stress. It influences mood, emotional behavior, alertness, anxiety and tension.

Nursing Facility – Refers to a nursing facility licensed by the Ohio Department of Health for the provision of various levels of nursing care. Examples: Skilled Nursing Facility; Intermediate Care Facility; Nursing Home.

orthostatic hypotension: (or – thoe – stat – tic high – poe – ten – shun) A drop in blood pressure resulting in a dizzy or faint feeling that is produced after suddenly sitting up or standing up. Many psychiatric drugs cause orthostatic hypotension. It can be a serious side effect in elderly patients.

Other's Home – House, apt, or other living situation in which the client lives with a relative or friend who is head of the household. Includes Kinship Care: Children living with a relative who is also the legal foster parent should be reported in this category.

paranoia: (parra – noy – yah) A feeling or state in which someone believes others are trying to harm them when this is absolutely untrue.

Parkinsonian effects: (park – in - so – nee – an) Drug-induced effects resulting from an antipsychotic medications that mirror classical Parkinson's disease symptoms, such as reduction in motor abilities and coordination, shuffling gait, drooling, muscle rigidity, and tremors. Ordinarily the effect occurs within 5 to 90 days of drug initiation.

Peer Supporters: Peer Supporters actively work within an organization's collaborative support structure as a defined part of the recovery team. Specifically, part of the CPSs job description is to utilize the lived experience as a tool to help others move forward on their recovery journey.

prodromal phase: (pro – dro - mull) The phase during which a deteriorating state of health is recognized that later culminates in full-blown illness. During the deterioration phase, there are subtle warning signs of the impending illness, such as withdrawal, bizarre thoughts, or other behaviors recognized as precursors of a psychotic episode.

prophylactic: A treatment or medication used to protect against the onset, or recurrence of a disease or disorder.

Psychiatric Advance Directives: You may also want to ask about a Psychiatric Advance Directive (PAD), which is a legal document that allows a second party to act on your loved one's behalf if he becomes acutely ill and unable to make decisions about treatment. The PAD is written by your loved one when they are currently 'competent.' It details the individual's preferences for treatment should they become unable to make such decisions due to their mental health condition. Planning ahead can make a huge difference in your loved one's treatment experience in the future.

psychomotor agitation: (adge – jih – tay – shun) Excessive motor activity, usually nonpurposeful and associated with internal tension. Examples include inability to sit still, fidgeting, pacing, wringing of hands, and pulling of clothes.

psychopathic: (sy – co – path – ic) An anti-social personality disorder characterized by aggressive, criminal or amoral behavior and lack of remorse.

psychopharmacology: (sy– coe – far – muh – coll – oh – gee) The study of the action of drugs that affect thinking, emotion and behavior; the branch of medicine that specializes in medications to treat mental illnesses.

psychosis: (sy– coe – siss) A mental state characterized by extreme impairment of the sufferer's perception of reality, including hallucinations, delusions, incoherence and bizarre behavior.

psychotropic drugs: (sy – co – trope – pic) Drugs that alter psychological functioning and / or mood, thoughts, motor abilities, balance, movement, and coordination.

refractory: (ree – fract – tree) Non-response to the known therapeutic effect of a drug or course of drug treatment; or non-response due to increased tolerance to a drug over time. See *treatment resistant*.

rehabilitation: In psychiatry, the methods and techniques used to achieve maximum functioning and optimum adjustment for the patient and to prevent relapses or recurrences of illness; sometimes termed *tertiary prevention*.

Residential Care – short-term living environment (or longer term for some adults), it may or may not be 24-hour care. Reasons for this type of care are more environmental in nature. May provide supervision, services, and accommodations. Treatment services are billed separately. This category includes: **Child**

Respite Care – short-term living environment, it may or may not be 24-hour care. Reasons for this type of care are more environmental in nature. May provide supervision, services and accommodations. Treatment services are billed separately.

Serotonin: (sair – ah – tone – in) A type of neurotransmitter that impacts sensory processes, muscular activity, and cognition, It is a factor in states of consciousness, basic bodily functions, complex sensory and motor activities, and mood. Serotonin is thought to be implicated in mood disorders, aggression, and schizophrenia. Fluoxetine (Prozac) and clozapine (Clozaril) are thought to be significant effects of the serotonergic systems (those that produce serotonin).

Severely Mentally Disabled (SMD) or **Seriously Emotionally Disturbed** (SED) – **Adults:** The client has a long-standing, persistent disability due to a psychiatric condition. The client will have a history of multiple psychiatric hospitalizations and/or placements as well as substantial engagement with community mental health providers. **Child/Adolescent:** The client has substantial behavioral or emotional problems at school, home, or in the community that have a negative impact on development and functioning. The client has a history of disrupted living environment, school suspensions/expulsions, and or juvenile justice involvement. For more details, see SMD/SED Operational Definition.

Sexual Offender – Client is a registered offender and/or someone with a history of referral and treatment for sexual aggression.

side effect: A drug response that accompanies the principal response for which a medication is taken. Most side effects are undesirable yet cause only minor disturbances; others may cause serious problems.

sign: Objective evidence of disease or disorder. See also *symptom.*

Social Security Disability Insurance (SSDI) – disability insurance payments to individuals who have retired prematurely due to a disability, but who have contributed to the disability fund through their employment; the children of these retirees; or people who became disabled before age 18 years.

Social Security Income (SSI) – program of income support for low-income adults or children who are aged, blind or disabled as established by the Title XVI of the Social Security Act

stable: Not subject to episodes of recurring illness or decompensation; cessation of neurondegenerative disease progression in chronic schizophrenia.

State MH/MR Institution – Refers to any state-operated institution under the jurisdiction of the ODMH or ODMR-DD. Examples: State Psychiatric Hospital; State Developmental Center; Behavioral Healthcare Organization.

Stigma – the labeling of a person or group to indicate that something is abnormal; the stigma of mental illness is still strong enough that many individuals are reluctant or refuse to seek treatment.

Stimulants – a class of medications that increase or enhance central nervous system activity (i.e. Ritalin, Dexedrine, Adderall, Cylert, etc.)

substance abuse: A maladaptive pattern of psychoactive substance use indicated by either: 1) continued use despite knowing that it causes or exacerbates a persistent or recurrent social, occupational, psychological, or physical problem, or 2) recurrent use in situations in which it creates a physical hazard (such as driving when intoxicated). Abuse refers to relatively mild, transient symptoms. Compare *substance dependence.*

substance dependence: Impaired control over use of a psychoactive substance and continued use of the substance despite adverse consequences. Dependence can include physiological tolerance to a substance and is more serious and persistent than substance abuse.

Suicidal – Includes clients with a history of multiple episodes of suicidality or low lethality suicidal behavior. Also refers to history of intentional self-injury (e.g., cutting).

Suicidal ideation – the presence of a suicidal thought or plan

Supported Employment: Supported Employment (SE) is an evidence-based service to pro-mote rehabilitation and return to productive employment for persons with serious mental illness' rehabilitation and their return to productive employment. SE programs use a team approach for treatment, with employment specialists responsible for carrying out all vocational services from intake through follow-along. Job placements are: community-based (i.e., not sheltered workshops, not onsite at SE or other treatment agency offices), competitive (i.e., jobs are not exclusively reserved for SE clients, but open to public), in normalized settings, and utilize multiple employers. The SE team has a small client to staff ratio. SE contacts occur in the home, at the job site, or in the community. The SE team is assertive in engaging and retaining clients in treatment, especially utilizing face-to-face community visits, rather than phone or mail contacts. The SE team consults/works with family and significant others when appropriate. SE services are frequently coordinated with Vocational Rehabilitation benefits.

Supportive Housing: Supported Housing is a specific program model in which a consumer lives in a house, apartment or similar setting, alone or with others, and has considerable responsibility for residential maintenance but receives periodic visits from mental health staff or family for the purpose of monitoring and/or assisting with residential responsibilities, criteria identified for supported housing programs include: housing choice, functional separation of housing from service provision, affordability, integration (with persons who do not have mental illness), right to tenure, service choice, service individualization and service availability.

supportive psychotherapy: A treatment technique that helps a patient reduce stress and cope with his or her disorder without probing disturbing thoughts or emotions.

symptom: A specific manifestation of a patient's condition indicative of an abnormal physical or mental state; a subjective perception of illness.

syndrome: (sin – drome) A configuration of symptoms that occur together and constitute a recognizable condition.

tachycardia: (tack – ah – card – ee – ah) Unusually rapid heartbeat (greater than 100 beats per system. It is a form of heart arrhythmia.

tapering: The process of slowly decreasing the dose of medication over several days or weeks until the medication is completely discontinued. This is done to reduce or avoid withdrawal symptoms.

tardive dyskinesia: (tar – div – disk – kin – nees – ya) A side-effect of traditional antipsychotic drugs.This side-effect, which involved abnormal involuntary movements of the face, tongue, mouth, fingers, upper and lower limbs, and occasionally the entire body, usually appears after taking the drug for some time and occurs in at least a mild form in 25 to 40 percent of patient on antipsychotic agents. Tardive dyskinesia may be severe or irreversible in 5 to 10 percent of cases.

Temporary Housing – Non-hospital, time limited residential program with an expected length of occupancy and goals to transition to permanent housing. Includes room and board, with referral and access to treatment services that are billed separately.

Therapeutic Foster Care: Children are placed with foster parents who are trained to work with children with special needs. Usually, each foster home takes one child at a time, and caseloads of supervisors in agencies overseeing the program remain small. In addition, therapeutic foster parents are given a higher stipend than to traditional foster parents, and they receive extensive pre-service training and in-service supervision and support. Frequent contact between case managers or care coordinators and the treatment family is expected, and additional re-sources and traditional mental health services may be provided as needed. A key difference between TFC and traditional foster care is the TFC family receives an extensive pre-service training and in-service supervision and support.

tolerance: The reduced responsiveness of the body to a drug as a function of reduced sensitivity of the nerve receptors over time.

toxicity: (tox – sis - city) The capacity of a drug to damage body tissue or seriously impair body functions.

tranquilizer: A drug that decreases anxiety and agitation. Preferred terms are anti-anxiety and antipsychotic drugs.

Transgendered – Client expresses a gender identity that differs from the one corresponding to his/her sex at birth.

treatment resistant: Lack of response to a specific therapy that would ordinarily be expected to be effective. The patient who does not respond to the usual dosage of a drug but does respond to a higher dosage is often termed a “relative resister.” Absolute resistance refers to the patient who fails to respond to any dosage of the drug. See *refractory.*

tremor: (trem – mur) A trembling or shaking of the body or any of its parts. It may be induced by medication.

Type 1 Residential Treatment– —Provides room and board, personal care, and certified mental health services to one or more adults, or children or adolescents. Provider is licensed and certified by ODMH as a Type 1 Residential facility. Reasons for this placement level of care are more psychiatric or behavioral in nature than environmental.

withdrawal: A pathological retreat from people or the world of reality, often seen in schizophrenia.

withdrawal symptoms: New symptoms that arise because a drug is discontinued. These almost always go away within two weeks of drug discontinuation. Tapering a drug rather than abruptly discontinuing it reduces and sometimes even eliminates withdrawal symptoms.

WRAP: A Wellness Recovery Action Plan can also be very helpful for your loved one to plan his overall care, and how to avoid a crisis. If he will not work with you on a plan, you can make one on your own. Be sure to include the following information:

- Phone numbers for your loved one’s therapist, psychiatrist and other healthcare providers
- Family members and friends who would be helpful, and local crisis line number
- Phone numbers of family members or friends who would be helpful in a crisis
- Local crisis line number (you can usually find this by contacting your NAMI Affiliate, or by doing an internet search for “mental health crisis services” and the name of your county)
- Addresses of walk-in crisis centers or emergency rooms
- The National Suicide Prevention Lifeline: 1-800-273-TALK (8255)

- Your address and phone number(s)
- Your loved one's diagnosis and medications
- Previous psychosis or suicide attempts
- History of drug use
- Triggers
- Things that have helped in the past
- Mobile Crisis Unit phone number in the area (if there is one)
- Determine if police officers in the community have Crisis Intervention Training (CIT)

Go over the plan with your loved one, and if he is comfortable doing so, with his doctor. Keep copies in several places. Store a copy in a drawer in your kitchen, your glove compartment, on your smartphone, your bedside table, or in your wallet. Also, keep a copy in a room in your home that has a lock and a phone.

WrapAround Services A process where the strengths, culture and challenges of a youth and their family are identified, and a plan is developed that provides both formal and informal supports to assist the youth and their family to have safety, stability, and success.

STARK COUNTY
Mental Health & Addiction Recovery
StarkMHAR.org

FUNDED & PARTNER PROVIDERS | JULY 1, 2023 - JUNE 30, 2024

(F) Funded Providers: Treatment, Prevention, and Recovery Providers that receive funding for the current year from StarkMHAR. (Information here reflects current StarkMHAR funded services; other services may be available.)

(P) Partner Providers: Treatment Providers that did not apply for funding for the current year from StarkMHAR and were approved to be part of the Provider network. (Other services may be available.)

Alliance Family Health Center (P)
330-249-7011
1401 S. Arch Ave., Suite A
Alliance, Ohio 44601
AllianceFamilyHealth.org
Ages Served: 14+

ASCEND (F)
330-454-2888
116 Cleveland Ave. NW Suite 200
Canton, Ohio 44702
ASCENDservices.org
Ages Served: 18+

AVO Behavioral Health, LLC (F)
330-331-7506
3745 Whipple Ave. NW
Canton, Ohio 44718
AVORecovery.com
Ages Served: 18+

Barbara Fordyce & Associates (P)
330-492-2006
4319 Hills & Dales Rd NW
Canton, Ohio 44708
BFordyce.com
Ages Served: All

The Blick Center (F)
330-762-5425
6657 Frank Ave. NW
North Canton, Ohio 44720
BlickCenter.org
Ages Served: Birth-18

Canton Community KidSummit Against Drugs (F)
330-453-1155
1227 Gross Ave. NE
Canton, Ohio 44705
Ages Served: 8 - Adolescence

Child & Adolescent Behavioral Health (F)
330-454-7917
919 Second St. NE
Canton, Ohio 44704
ChildandAdolescent.org
Ages Served: Birth-24

Children's Network of Stark County (F)
330-451-1700
213 Market Ave. N, Suite 200
Canton, Ohio 44702
StarkChildrensNetwork.org
Ages Served: Birth-22

Coleman Crisis Services (F)
330-452-6000
2421 13th St. NW
Canton, Ohio 44708
ColemanServices.org
Ages Served: All

Coleman Health Services (F)
330-438-2400
400 Tuscarawas St. W, Suite 200
Canton, Ohio 44702
ColemanServices.org
Ages Served: All

CommQuest Services (F)
330-455-0374
625 Cleveland Ave. NW
Canton, Ohio 44702
CommQuest.org
Ages Served: All

Emerald Pine Grief & Trauma Services (P)
330-546-0199
4111 Bradley Circle NW Suite 150
Canton, Ohio 44718
EmeraldPine.net
Ages Served: All

Continued on back ››

- AoD (Alcohol and Other Drug) Services
- Community Outreach
- Consultation Services
- Crisis Services/Mobile Response
- Crisis Stabilization Unit
- Detox Services
- Group Counseling
- Housing Services
- Mental Health Services
- Multiple Locations
- Peer Support
- Prevention Programs
- Residential AoD Services
- Respite
- Social Clubs
- Support Groups
- System/Peer Navigation
- Wrap Around Services

Printed July 2023

HWS Best Health Counseling (P)
330-442-2664
1303 West Maple Street Suite 102
North Canton, Ohio 44720
HWSBestHealth.com
Ages Served: All

ICAN Housing (F)
330-455-9100
1214 Market Ave. N
Canton, Ohio 44714
ican-inc.org
Ages Served: 18+

Lifecare Family Health & Dental Center (P)
330-454-2000
408 Ninth St. SW
Canton, Ohio 44646
LifecareFHDC.org
Ages Served: 10+

Make-A-Way (F)
330-837-0650
227 3rd St. SE
Massillon, Ohio 44648
MakeaWay.org
Ages Served: 18+

NAMI Stark County (F)
(National Alliance on Mental Illness)
330-455-6264
121 Cleveland Ave. SW
Canton, Ohio 44702
NamiStarkCounty.org
Ages Served: 14+

Pathway Caring For Children (F)
330-493-0083
4895 Dressler Rd. NW, Suite A
Canton, Ohio 44718
PathwayCFC.org
Ages Served: 5+

Phoenix Rising Behavioral Healthcare and Recovery Inc. (F)
330-493-4553
624 N. Market St.
Canton, Ohio 44702
PhoenixrisingBHR.org
Ages Served: 18+

Stark Community Support Network (F)
330-455-2260
1221 Harrisburg Rd. NE
Canton, Ohio 44705
StarkCommunitySupportNetwork.com
Ages Served: All

Stark County TASC (F)
330-479-1912
624 N. Market St.
Canton, Ohio 44702
StarkTASC.org
Ages Served: 14+

Summit Psychological Associates (F)
330-493-2554
832 McKinley Ave. NW
Canton, Ohio 44703
Summit-Psychological.org
Ages Served: 18+

W.A.T.O.E.S. (F)
330-806-6323
1225 Gross Ave. NE
Canton, Ohio 44705
watoes.com
Ages Served: All

STARK COUNTY
Mental Health & Addiction Recovery
StarkMHAR.org

Ability to Pay Guidelines: Stark County residents can access behavioral health services regardless of their ability to pay through a Stark County Mental Health & Addiction Recovery (StarkMHAR) Funded Provider. StarkMHAR Funded Providers accept various insurance programs, Medicare and Medicaid. Stark residents that are not covered by one of those options can receive services. Their ability to pay for those services will be determined by their income and could be fully subsidized by StarkMHAR.

988 SUICIDE & CRISIS LIFELINE
Dial "988"
24/7/365

StarkHelpCentral.com
Basic needs & more

- AoD (Alcohol and Other Drug) Services
- Community Outreach
- Consultation Services
- Crisis Services/Mobile Response
- Crisis Stabilization Unit
- Detox Services
- Group Counseling
- Housing Services
- Mental Health Services
- Multiple Locations
- Peer Support
- Prevention Programs
- Residential AoD Services
- Respite
- Social Clubs
- Support Groups
- System Navigation
- Wrap Around Services

Local Support Contact Information By County		
County	**NAMI Contact Info**	**Mental Health Board**
Ashland	NAMI Richland County 420 Stewart Lane Mansfield,OH 44907 Aubrie Hall 419-522-6264 families@manirc.org	1605 CR 1095 Ashland, OH 44805 419-281-3139 Ashlandmhrb@ashlandmhrb.org https://www.ashlandmhrb.org/ Crisis Line: 419-289-6111 or 888-400-8500
Ashtabula	NAMI Ashtabula 4817 State Rd. Suite 203 Ashtabula, OH 44004 ashtabulanami@gmail.com https://namiashtabula.org/about-nami-ashtabula/ Phone: (440) 606-6264	4817 State Road Suite 203 Ashtabula, OH 44004 440-992-3121 ashtabadmew@suite224.net http://www.ashtabulamhrsboard.org/ Help Line: 1-800-577-7849
Columbiana	NAMI Columbiana County 27 Vista Dr. Lisbon, OH 44432 (330) 424-0195 mwaybright@ccmhrsb.org	27 Vista Drive Lisbon, OH 44432 330-424-0195 bdmail@ccmhrsb.org http://ccmhrsb.org/contactus.html Crisis Hotline: 330-424-7767 or 800-427-3606
Cuyahoga	NAMI Greater Cleveland Katie Jenkins 2012 W. 25th Street Suite 705 Cleveland, OH 44113 216-875-7776 helpline@namicleveland.org www.namigreatercleveland.org	2012 W. 25th Street 6th Floor Cleveland, OH 44113 216-241-3400 http://cccmhb.org/ Hotline (216) 623-6888
Mahoning	NAMI Mahoning Valley Hope Haney 201 Wick Ave. Youngstown, OH 44503 (330) 727-9268 info@namimahoningvalley.org https://www.namimahoningvalley.org/	222 West Federal St. Suite 201 Youngstown, OH 44503 330-746-2696 http://www.mahoningmhrb.org/ Emergency call 330-747-2696
Medina	NAMI Medina County Katie Jenkins katie@namicleveland.org www.namimedinacounty.org	246 Northland Drive Suite 100 Medina, OH 44256 330-723-9642 office@adamhmedina.org https://www.medinamentalhealth.com/ Help Line: 330-725-9195

Portage	**NAMI Portage County** **155 E. Main St.** **Kent, OH 44240** **(330) 673-1756** **namiportage@gmail.com** **https://namiportage.org**	**155 East Main St.** **Kent, OH 44240** **330-673-1756** **Crisis Hotlines 330-296-3555 or 330-678-4357** **mhrbpc@mental-health-recovery.org** **https://www.mental-health-recovery.org/**
Richland	**NAMI Richland County** **420 Stewart Lane** **Mansfield, OH 44907** **Aubrie Hall** **419-522-6264** **families@manirc.org** **http://www.namirc.org**	**87 E. First St.** **Suite L** **Mansfield, OH 44902** **419-774-5811** **https://www.richlandmentalhealth.com/** **Crisis Helpline: 419-522-HELP (4357)**
Stark	**NAMI Stark County** **Kay Raga** **121 Cleveland Ave., S.W.** **Canton, OH 44702** **330-455-NAMI (6264)** **namistark@namistarkcounty.org** **www.namistarkcounty.org**	**121 Cleveland Ave, S.W.** **Canton, OH 44702** **330-455-6644** **info@starkmhar.org** **www.starkmhar.org** **Hotline: 330-452-6000**
Trumbull	**NAMI Mahoning Valley** **Hope Haney** **201 Wick Ave.** **Youngstown, OH 44503** **(330) 727-9268** **info@namimahoningvalley.org** **https://www.namimahoningvalley.org/**	**4076 Youngstown Road S.E.** **Suite 201** **Warren, Ohio 44484** **330-675-2765** **http://www.trumbullmhrb.org/** **Hotline: 1-877-796-3555 or 330-296-3555**
Tuscarawas **Carroll**	**NAMI Tuscarawas-Carroll Co.** **PO Box 621** **New Philadelphia, OH 44663-0621** **330-440-4742** **namituscarawascarroll@gmail.com** **http://www.nami.org/sites/tusc-carroll**	**119 Garland Dr. S.W.** **New Philadelphia, OH 44663** **Tuscarawas: 330-364-6488** **Carroll: 330-627-7912** **http://adamhtc.org/** **Crisis Hotline: Tuscarawas - 330-343-1811** **Carroll - 330-627-5240**
Wayne/ **Holmes**	**NAMI Wayne Holmes** **Jenn Grimm** **2525 Back Orville Rd.** **Wooster, OH 44691** **Vicki Slater 330-264-1590** **info@namiwayneholmes.org** **http://www.namiwayneholmes.org/**	**1985 Eagle Pass Drive** **Wooster, OH 44691** **330-264-2527** **https://www.whmhrb.org/** **Crisis Hotline: Wayne 330-264-2527** **Holmes 330-264-9029** **https://www.whmhrb.org/**

If you are experiencing a behavioral health crisis, please call:

HOMELESS HOTLINE

330-452-4363

CRISIS NUMBERS

***Call 330-452-6000, the Stark County Crisis Hotline anytime**

***Text 4hope to 741-741, the Crisis Text Line anytime**

***Call the Domestic Violence Help Line anytime at 330-453-SAFE (7233)**

***Call 9-1-1 if emergency services are needed. If requesting law enforcement, you can ask for a CIT Crisis Intvention Team trained officer**

***Opiate Helpline 330-454-HELP (4357)**

***Trevor Lifeline for LGBTQ Youth 866-488-7386**

***Military & Veterans Crisis Line 800-273-8255, press 1 anytime**

***Military & Veterans Crisis Text Line 838255 to get help now**

***Alcohol Hotline 800-331-2900**

***Al-Anon 800-344-2666**

***Alcohol and Durg Helpline 800-821-4357**

***National Domestic Violence Hotline 800-799-7233**

***National US Child Abuse Hotline 800-422-4453**

***National Domestic Violence Hotline 800-799-7233**

***National US Child Abuse Hotline 800-422-4453**

With You Here https://www.withyouhere.org/shop

AAKOMA Project https://aakomaproject.org/

National Human Trafficking Hotline 1-888-373-7888
SMS: 233733 (Text "HELP" or "INFO")

Additional Resources

CIT – Crisis Intervention Team
https://starkmhar.org/programs/crisis-intervention-team/

Stark County Mental Health and Addiction Recovery
https://starkmhar.org/

Care Teams
https://starkmhar.org/programs/care-teams/

Opiate Talk Force Stark County
https://starkmhar.org/programs/coalitions/opiate-task-force/

Stark County Suicide Prevention Coalition
https://starkmhar.org/prevention-resources/suicide-prevention/
https://www.facebook.com/StarkSuicidePrevention

Suicide Response
https://starkmhar.org/programs/critical-incident-stress-management-team/

Stark Help Central
https://www.starkhelpcentral.com

Stark County Critical Incident Stress Management (CISM) Team
https://starkmhar.org/programs/critical-incident-stress-management-team/

Zero Suicide
https://zerosuicide.edc.org/

QPR Question Persuade Refer Trainings
https://www.kent.edu/stark/qpr-training

Mental Health First Aid Trainings
https://starkmhar.org/trainings-and-events/mental-health-first-aid/

Vetaran Suicide Prevention
https://www.va.gov/health-care/health-needs-conditions/mental-health/suicide-prevention/

Light After Loss
https://lightafterlossstark.org/

Ohio Department of Mental Health and Addiction Services
http://mha.ohio.gov/

NAMI Ohio
http://www.namiohio.org/

NAMI National
http://www.nami.org/

Ohio Department of Alcohol and Drug Addiction Services
http://www.odadas.ohio.gov/public/

Ohio Department of Jobs & Family Services
http://jfs.ohio.gov/

Ohio Department of Aging
http://aging.ohio.gov/home/

National Institute of Mental Health
http://www.nimh.nih.gov/index.shtml

National Institute of Alcohol Abuse and Alcoholism
http://www.niaaa.nih.gov/

National Institute on Drug Abuse
http://www.drugabuse.gov/

Disability Rights Ohio
614-466-7264 800-282-9181
http://disabilityrightsohio.org

Consumer Advocacy and Protection Specialist ODMHA
614-466-7228 877-275-6364

Heartland Behavioral Health
330-833-3135
https://mha.ohio.gov/about-us/regional-psychiatric-hospitals/healthcare-facilities/heartland/heartland

Sunrise Vista Behavioral Health
https://www.sunrisevistahealth.com/treatment-program-admissions-oh/

Akron's Children's Hospital
https://www.akronchildrens.org/

NAMI Ohio Parent Advocacy Program
https://namiohio.org/parent-advocacy-connection-pac/

Funding provided by:

STARK COUNTY Mental Health & Addiction Recovery
StarkMHAR.org

PEGS FOUNDATION

NAMI Ohio
National Alliance on Mental Illness The State's Voice on Mental Illness

NAMI Stark County
121 Cleveland Ave, S.W.
Canton, OH 44702
330-455-NAMI [6264]

NAMI Stark County
Heartland Behavioral Healthcare
3000 Erie St South
Massillon, OH 44646
330-833-3135 x. 2170

E-mail: namistark@namistarkcounty.org **Website: www.namistarkcounty.org**