



**SERVING INDIVIDUALS
WITH
PSYCHIATRIC DISABILITIES
IN
CENTERS FOR INDEPENDENT LIVING**

A FACT SHEET

**From the
Temple University Collaborative on Community Inclusion
Of Individuals with Psychiatric Disabilities**

For more information on the topics discussed in this fact sheet, please contact Richard Baron at rcbaron@temple.edu (215.204.9664) at the Temple University Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities (tucollaborative.org).

The contents of this Informational Resource Guide were developed under a grant from the Department of Education, NIDRR grant number H133B080029 (Salzer, PI). However, those contents do not necessarily represent the policy of the Department of Education, and do not imply endorsement by the Federal Government.

Table of Contents

Introduction	2
1. What are psychiatric disabilities?	4
2. Do individuals with psychiatric disabilities recover? ..	4
3. What services and supports do individuals with psychiatric disabilities seek from their Center for Independent Living?	6
4. Should individuals with psychiatric disabilities be treated differently from other individuals who use CIL services and supports?	7
5. What diagnoses are associated with psychiatric disabilities?	8
6. Where can individuals with psychiatric disabilities turn for help?	9
7. What types of help are available to individuals with psychiatric disabilities?	10
8. What are the major trends re-shaping mental health care today?	14
9. How do these trends affect CIL personnel?	16
10. What should a CIL staff member do if someone he or she is working with becomes agitated or upset? ..	17
11. How can CIL staff handle psychiatric emergencies? ..	18
12. What can a CIL do to improve services and supports for individuals with psychiatric disabilities?	20
List of Local Mental Health Resources	21

Acknowledgements

The Temple University Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities would like to gratefully acknowledge the contributions to this document made by Loran Kundra, JD, LSW, CPS, a Research Specialist at the Collaborative; and Susan Rogers, Director of the National Mental Health Consumers' Self-Help Clearinghouse, a consumer-run national technical assistance center funded by the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. The Temple University Collaborative also gratefully acknowledges the help of the other individuals with lived experience who gave useful feedback on several drafts of the document.

Introduction

Centers for Independent Living (CILs) across the country are increasingly aware of the need to develop more effective ways of helping individuals who have psychiatric disabilities, or who have physical or sensory or intellectual *and* psychiatric disabilities, on their recovery journeys. This Fact Sheet responds to the need for very basic information about psychiatric disabilities. It was developed in cooperation with individuals with lived experience of psychiatric disabilities as well as leaders in the independent living movement and CIL staff. Designed to be a brief summary of the answers to the 12 most-frequently asked questions of CIL supervisors and staff, the Fact Sheet also provides more information on each topic by directing interested readers to suggested websites.

It is important to note that there are many similarities between the independent living movement and the movement for social justice of individuals with lived experience of psychiatric disabilities. Both are strong advocacy movements; both value the empowerment of individuals; both believe in the dignity of risk; both believe that individuals with psychiatric disabilities can and do recover; and both emphasize control, choice, and self-

determination by individuals with disabilities in regard to their treatment, services, and supports.

Individuals with psychiatric disabilities turn to their local Centers for Independent Living for the same types of services and supports – housing, jobs, friendships, life guidance, and advocacy – that are offered to those with physical, sensory, or intellectual disabilities. CIL staff are uniquely qualified to provide the assistance needed in a way that recognizes each person’s strengths, ambitions, and opportunities, as well as their specific challenges.

Those with psychiatric disabilities are “persons first.” In other words, not only do they have many talents, abilities and interests, just as anyone does, but even while someone is experiencing severe manifestations of their psychiatric disability, that person is often able to participate in, take satisfaction from, and contribute to community life, just like everyone else. Yet, when someone is known to have a psychiatric disability, he or she is often considered only in the light of his/her illness.

This Fact Sheet is designed to help change that. You may want to use it as a reference point, or to start a discussion within your CIL about psychiatric disability that includes individuals with lived experience of psychiatric disabilities, or to initiate connections between your CIL and local mental health providers about the values you share.

For more information on these shared values, you may also want to read “The Independent Living Movement and People with Psychiatric Disabilities: Searching for Common Ground,” by Darby Penney and Ronald Bassman at <http://www.community-consortium.org/pdfs/ILC.pdf>.

Finally, there are a number of different words and phrases that are used to describe individuals who have psychiatric histories, and some that individuals with psychiatric disabilities prefer to use to describe themselves. These include - but are not limited

to - "individuals with lived experience," "consumers," "survivors," "consumer/survivors," "ex-patients," "people with mental illnesses," "c/s/x (consumers/survivors/ex-patients)," "people in recovery," and "individuals with psychiatric diagnoses." However, while we recognize the variety of objections to some terms and the array of suggested alternatives, the language we use in this Fact Sheet is "individuals with psychiatric disabilities."

1. What are psychiatric disabilities?

Psychiatric disabilities may be described as a variety of thought patterns and behaviors that can disrupt an individual's ability to lead a happy and productive life. Although these characteristics vary in kind and severity from person to person and often vary as well for each individual over time, they may include depression and anxiety, fearfulness (which may include an unfounded or exaggerated suspiciousness or distrust of others), confused thinking, and the kinds of misperceptions that people often describe as "hearing things" and "seeing things." While the exact causes of psychiatric disabilities are unknown, they may result from some combination of genetics, environmental stressors and traumatic events.

For more information on psychiatric disabilities, please see: Center for Psychiatric Rehabilitation: What is Psychiatric Disability and Mental Illness?

<http://www.bu.edu/cpr/reasacom/whatis-psych.html>

2. Do individuals with psychiatric disabilities recover?

Individuals with psychiatric disabilities can and do recover and go on with their lives, often with the help of therapy, medications, and rehabilitative services, which may include traditional, alternative, and/or peer support services. Some individuals recover completely; others may need continued help in order to maintain their recovery.

Recovering from psychiatric disabilities has been defined by many different individuals in a variety of ways. Here are some definitions from the *Report from the Recovery Plank at the National Summit of Mental Health Consumers and Survivors, Portland, Oregon, August 26-29, 1999* (http://www.mhselfhelp.org/pubs/view.php?publication_id=63):

- "What does recovery mean to me? To have hope. To feel like a useful, needed person. To be able to utilize the abilities I have. To be able to help others and be a contributing member of society. To have a positive attitude. To be out of the victim mode and be able to transcend the experience I had. To feel connected to the Creator and other people. To take responsibility and take charge of my life. To lead a productive life. Inner healing. Enjoy living. Spiritual wholeness. Living effectively. It's giving back, forgiveness. Helping other people. Believing in yourself. Overcoming obstacles in achieving my goals." – *Sheilah Hill, Shining River Press*
- "Recovery is a person-centered process. It is a journey that an individual undertakes and designs as a step-by-step strategy toward their own idea of wellness. To be recovering is to be taking personal responsibility for the challenges that are associated with mental illness." – *Mark Duffy, Collaborative Support Programs of New Jersey*
- "Recovery means being able to lead a productive life. It means being able to take care of myself, to have hopes and dreams, to achieve these hopes and dreams. Recovery means that I am able to help myself and others, by sharing my experiences with others." – *Lisa Braswell*
- "Recovery does not mean that one is 'cured' nor does it mean that one is simply stabilized or maintained in the community. Recovery often involves a transformation of the self wherein one both accepts one's limitations and discovers a new world of possibility." – *Patricia Deegan, Ph.D., Boston University Institute for the Study of Human Resilience*

The National Empowerment Center offers *Seven Characteristics of a Person Who Has Recovered from Mental Illness*
<http://www.power2u.org/articles/recovery/characteristics.html>.

The Substance Abuse and Mental Health Services Administration's National Consensus Statement on Recovery, located at http://www.samhsa.gov/news/newsreleases/060215_consumer.htm, discusses 10 principles necessary to achieve recovery.

For personal stories of recovery by individuals with psychiatric disabilities, please see:
<http://www.allmentalhealth.samhsa.gov/publications/mystory/> or <http://akmhweb.org/recovery/rec.htm> ; and to purchase a compilation of stories of recovery, please see:
<http://www.vocalvirginia.org/#/about-firewalkers/4544567632> or <http://www.bu.edu/cpr/products/books/titles/voices.html>

3. What services and supports do individuals with psychiatric disabilities seek from their Center for Independent Living?

Like everyone else who turns to a CIL for support, individuals with psychiatric disabilities want to be seen as individuals, to be treated with respect and dignity, and to be able to direct the services and supports they receive. Many turn to CILs for advocacy – both to help ensure that they receive the services and supports to which they are entitled and to respond to the harmful or ineffective treatment they have received elsewhere. Others seek out CILs for assistance in finding a job, moving to a new home, or managing their lives, while others may also want their CIL's help in locating enlightened local mental health programs or alternatives to medical-model treatment, especially peer support services. In each case, the individual's own goals must be the starting point for providing services.

For more information on the services and supports provided by CILs, please see: <http://www2.ed.gov/programs/cil/index.html>
For CILs' Standards and Assurances, please see:

<http://www.mtstcil.org/skills/il-3-standards.html>

For a directory of CILs, please see:

<http://www.bcm.edu/ilru/html/publications/directory/index.html>

4. Should individuals with psychiatric disabilities be treated differently from other individuals who use CIL services and supports?

CILs should offer the same array of services and supports to someone with a psychiatric disability as they do to someone with a physical, sensory or intellectual disability, both by ensuring that the full range of CIL services are also available to individuals with psychiatric disabilities and by helping individuals access the mental health services in which they choose to participate. This is the same as the way in which CILs respond to the disability-specific needs of a person with hearing loss or limited mobility, both by providing targeted CIL services and locating assistive devices that respond to each individual's particular needs.

In the same way, CILs can recognize that the particular situation of each person with a psychiatric disability may create unique opportunities and challenges. Understanding psychiatric disabilities, helping individuals to make decisions about when and how to access treatment and rehabilitation services from both traditional and alternative mental health care providers and peers, and helping CIL clients with psychiatric disabilities to advocate for themselves are all part of the independent living philosophy.

CIL staff should be aware that it may take a while to build a relationship of trust with any particular CIL client with a psychiatric disability – just as it does with anyone. So it may be a while before CIL clients are willing to share their hopes and goals with staff so that staff can be most effective in helping them.

Learning more about psychiatric disabilities is an important first step, and helping individuals to access the private, public and/or

alternative mental health and support services available to them – if they have not already done so – can be critical. You may want to jot down (at the end of this Fact Sheet) the information you may need to obtain help for individuals with psychiatric disabilities. However, make sure you first ask consumers' permission before you seek services on their behalf.

5. What diagnoses are associated with psychiatric disabilities?

Mental health professionals use a wide range of diagnostic labels to describe certain prominent characteristics, or groups of characteristics, that affect the lives of the individuals they serve; and most public and private mental health funding systems require a psychiatric diagnosis in order to reimburse mental health service providers. CIL workers may want to know more about these general diagnostic categories used in the mental health system. It is important to note that many individuals with psychiatric disabilities have received many different diagnoses over the years, so that many people believe both the diagnostic process and the labeling of symptoms are often rejected as irrelevant and/or unhelpful. That said, examples of some general diagnostic categories are:

affective disorders – Also known as mood disorders, these disorders are characterized by dramatic changes or extremes in affect and emotion. Depression and bipolar disorder are two types of affective disorders.

schizophrenia – This diagnosis tends to include all or some of the following characteristics: misperceptions (which may be called hallucinations – such as “hearing things” or “seeing things” – or delusions), blunted or flat emotions, withdrawal from reality, and disorganized thinking.

anxiety disorders – These are characterized by extreme fear associated with certain objects or situations.

personality disorders – These tend to be long-lasting, deep-seated patterns of acting and thinking that often differ from the cultural norm and cause problems in social functioning.

substance abuse – These disorders involve the overuse and dependence on substances like alcohol and illegal drugs or the abuse of prescription medication.

For more information on some common psychiatric diagnoses, please see: [Center for Psychiatric Rehabilitation: What is Psychiatric Disability and Mental Illness?](http://www.bu.edu/cpr/reasacom/whatis-psych.html)
<http://www.bu.edu/cpr/reasacom/whatis-psych.html>

6. Where can individuals with psychiatric disabilities turn for help?

Centers for Independent Living can play an important role in helping individuals with psychiatric disabilities to recover. First, CILs can offer them the same services and supports they offer to everyone else. Second, CIL staff can play a key role in helping consumers find mental health assistance, including alternative services and peer support, when and if they want it. Individuals with private (e.g., employer) insurance can ask their insurers to refer them to psychiatrists and/or counselors; and for individuals with more limited incomes, the public mental health system provides a wide array of services. However, CIL staff may want to learn more about local services beforehand to ensure that either private or public resources share the CIL's perspective on the importance of consumer empowerment and the goals of community inclusion. In addition, CILs can play a role in helping traditional mental health services to adopt new and more effective approaches that emphasize empowerment and community inclusion.

7. What types of help are available to individuals with psychiatric disabilities?

Individuals with psychiatric disabilities may use a variety of mental health services, whether in public or private mental health systems, including alternative services and peer-run programs. Keeping in mind, as noted above, that CIL staff will want to know more about how the local providers of each service respond to the important issues of empowerment and community inclusion, CILs may want to develop some knowledge of the wide array of services and supports that individuals with psychiatric disabilities may already be involved with or may wish to take advantage of in the future. These include:

therapy – In either individual or group therapy, individuals are encouraged to talk about their problems and seek new ways of thinking or acting. Therapy may be able to help someone heal. Although the quality of therapeutic services varies widely and some therapeutic services may be counterproductive, individuals with psychiatric disabilities are often a good judge of what is working for them.

For information on different types of psychotherapy and what one can expect when they start psychotherapy, please see:
<http://www.mayoclinic.com/health/psychotherapy/MY00186/DSECTION=what-you-can-expect>

medication – Many individuals with psychiatric disabilities take medications to help control the most troubling manifestations of their disability. Finding the right medication at the right dosage is often a difficult process and, because medications can also have difficult and sometimes dangerous side effects, whether or not to take such medications must be a personal and informed choice. The National Coalition for Mental Health Recovery offers “Guidelines for Promoting Recovery Through Choice and Alternatives” <http://www.ncmhr.org/press-releases/4.28.11.htm> to help individuals evaluate mental health services and make decisions about medication and other treatments.

For more information on medications, how they work and the kinds of medications prescribed for different conditions, please see the National Institute of Mental Health's publication:
<http://www.nimh.nih.gov/health/publications/mental-health-medications/complete-index.shtml>

For more information on the negative aspects of psychiatric medications, please see:
<http://www.ncmhr.org/downloads/Anatomy-Of-An-Epidemic-Summary-Of-Findings-Whitaker.pdf>

rehabilitation – A wide range of mental health programs help those with psychiatric disabilities with housing, employment, relationships, education, finances, health care, etc. These services can be found in a variety of settings, including community mental health centers, psychiatric rehabilitation programs, and other specialized agencies that focus on the housing, employment, and/or social rehabilitation needs of those with psychiatric disabilities.

For more information about what psychiatric rehabilitation is and what psychiatric rehabilitation practitioners do, please see:
<http://www.uspra.org>

peer support – Peer support – the delivery of counseling, advocacy, and support to individuals with psychiatric disabilities by other individuals with psychiatric disabilities - is considered an indispensable component of recovery by the federal Substance Abuse and Mental Health Services Administration
<http://store.samhsa.gov/product/National-Consensus-Statement-on-Mental-Health-Recovery/SMA05-4129> . There are numerous peer support services available throughout the country that can help individuals with employment, housing, or advocacy issues. There are also peer-run crisis services, still few in number (<http://www.power2u.org/peer-run-crisis-alternatives.html>)

To find a peer-run service in your area, you can contact the National Mental Health Consumers' Self-Help Clearinghouse (at <http://www.mhselfhelp.org>). Another source of such information is the consumer/survivor organization in your state. Contact information for most of these organizations is available from the National Coalition for Mental Health Recovery at <http://www.ncmhr.org/members.htm>

peer-run services – Many state and county mental health authorities now support programs run by and for individuals with lived experience of psychiatric disability – programs where peers control the program's board of directors, its staff, and its budget.

For more information about peer-run services and some peer-operated programs in the United States, please see: The National Coalition for Mental Health Recovery <http://www.ncmhr.org> and "Consumer/Survivor-Operated Mental Health Services" <http://www.ilru.org/html/publications/newsletters/Briefs/Vol2Iss2.pdf>

alternative treatments – Such alternatives as yoga, emotional CPR (eCPR) <http://www.emotional-cpr.org/>, mindfulness medication, Reiki <http://www.reiki.org/faq/whatisreiki.html>, acupuncture, art therapy, music therapy, and others have been found effective in helping individuals with psychiatric disabilities work toward recovery.

inpatient care – Sometimes individuals with psychiatric disabilities seek to be hospitalized on a voluntary basis. Other times, when someone is adjudicated to be a danger to themselves or others, he or she may be committed to either a brief stay in a community hospital psychiatric unit or a state psychiatric hospital. It should be noted that treatment in the community is often considered to be less coercive and traumatic than treatment in a state hospital, and there is a continuing effort to deemphasize institutional care and improve the range and quality of community-based services.

outpatient care – This may consist of individual and/or group psychotherapy, medication, and/or psychiatric (also known as psychosocial) rehabilitation services. Many of these services – which may be traditional or alternative – now focus on the practical aspects of community inclusion: living in the community with a psychiatric disability.

partial hospitalization services/day treatment programs – an intensive program in a community setting, available for individuals who need less intensive services than are provided in inpatient settings and are ready to focus on community adjustment issues. Again, any such programs must be evaluated to ensure that they have a recovery orientation.

case management services – Case management helps individuals coordinate their mental health treatment, rehabilitation services, and practical aspects of life. While the term “case management” has been criticized as reducing people to “cases,” many mental health systems rely on one form of case management or another to help individuals with psychiatric disabilities access critically needed services.

supported housing programs – These programs offer individuals decent, affordable, permanent housing in the community, often linked to mental health and substance abuse treatment, employment, and health care supports. Many such programs are based on the acclaimed Housing First model http://www.pathwaystohousing.org/content/our_model, in which housing is offered first, and then supportive services in the areas of mental and physical health care, substance abuse treatment, education and employment are made available.

For more information on supported housing programs, see:
<http://drk.bu.edu/information-products/psychiatric-disabilities/supported-housing/>

and <http://drk.bu.edu/research-syntheses/psychiatric-disabilities/supported-housing>

trauma-informed care – The recognition that many people have experienced trauma – including trauma inflicted by mental

health services – has made many aware of the need for trauma-informed care <http://www.samhsa.gov/nctic/> .

For more information about how to access any of these mental health services, contact your county or state Office of Behavioral Health (which may have another but similar name) or your local mental health association (MHA). Local MHAs can be found through Mental Health America’s national website:

<http://www.nmha.org/> or <http://www.mentalhealthamerica.net> .

On the Mental Health America home page is a “Find an Affiliate” map, where CIL workers can identify their local MHA by zip code.

8. What are the major trends re-shaping mental health care today?

Mental health systems have been in the process of transformation over the past 20 years. As a result, today there is a much greater emphasis on self-determination, recovery, community inclusion and peer support.

self-determination – Mental health systems increasingly recognize the importance of individuals’ making decisions for themselves – about their goals, about the nature and pace of the treatments and rehabilitation services they receive, and about the policies that shape mental health service options. This approach is very similar to the fundamentals of the CIL philosophy.

recovery – Mental health systems today have left behind the notion that individuals with psychiatric disabilities are “chronic” or “cannot be helped” in favor of a more positive approach: that everyone with a serious psychiatric disability – whether or not they have persistent manifestations of their psychiatric disability – can recover and live a satisfying, productive life.

community inclusion – Mental health systems are increasingly aware that many individuals with psychiatric disabilities need to spend less time in mental health agencies and more time drawing upon the everyday resources of their communities: the recreation centers; schools and colleges; churches, synagogues, and mosques; job training programs; housing services; and social

opportunities available to anyone with or without a psychiatric disability. The goal is independence.

For more information on community inclusion, please see:
http://tucollaborative.org/comm_inclusion/community_integ_intr_o.html

peer support (including peer specialists) – Many mental health programs (including peer-run programs) employ peer specialists to offer those with psychiatric disabilities the one-to-one support of someone like themselves – someone who has “been there.” Peer specialists, who have received training and may be state-certified, often help individuals with psychiatric disabilities develop a *Wellness Recovery Action Plan* (WRAP) and help them set recovery-oriented goals.

For more information about peer specialists, please see the National Association of Peer Specialists: <http://www.naops.org>

For more information about WRAP, please see The Copeland Center:<http://copelandcenter.com/what-is-wrap/>

For a history of the consumer/survivor movement, please see:
http://en.wikipedia.org/wiki/Consumer/Survivor/Ex-Patient_Movement

psychiatric advance directives (PADs) are plans developed by individuals with psychiatric disabilities when they are less troubled by severe manifestations of their psychiatric disability. They are often completed in consultation with clinicians and counselors. PADS specify the kind of care that someone wishes to receive when and if they are in a psychiatric crisis, to ensure that their wishes are followed during those times when they are not in a position to make the best judgments about the care they need. They may designate a health care proxy to make sure that their wishes are carried out. Unfortunately, even where advance directives carry the weight of state law, psychiatrists may not follow them.

For more information about PADs, please see the National Resource Center on Psychiatric Advance Directives:
<http://www.nrc-pad.org/>

self-directed care allows individuals to control their own budgets and choose and pay for the goods and services they believe will help them in their recovery. For example, they may use their funds to pay for a college class or clothing to wear to a job interview rather than more time with a therapist.

integrating mental health care with primary care – Often the manifestations of psychiatric disabilities and the side effects of medications have detrimental physical effects. For example, weight gain and smoking are common for individuals with psychiatric disabilities, as are high blood pressure, high blood sugar, and high cholesterol. Many of these life-shortening physical problems are caused by psychiatric medications. As a result, individuals who have psychiatric disabilities have a life expectancy 20-25 years *shorter* than those who do not. The growing awareness of this disparity has led to many new programs' emphasizing basic physical health care; and efforts have been made to promote wellness programs such as smoking cessation, weight loss and personal fitness.

For more information about the integration of primary and behavioral health care, please see:

http://www.samhsa.gov/Matrix/MHST/Compendium_Mental%20Health.pdf and <http://www.ibhp.org/index.php>

9. How do these trends affect CIL personnel?

CIL workers should keep several issues in mind, including:

language – It is important to use “person first” language, which emphasizes that the individuals in question have talents, abilities, strengths and interests and that their psychiatric disabilities are just one aspect of who they are. CIL staff would want to refer to “a person with a psychiatric disability” or “a person with a psychiatric history,” and never to “a schizophrenic” or a “depressive,” for instance. (It would be much better still to avoid such labels entirely.)

privacy – Individuals with psychiatric disabilities – like anyone else – are entitled to privacy with regard to their psychiatric histories and current use of resources. HIPAA (Health Insurance Portability and Accountability Act) regulations apply, and it is also important to recognize the dignity of individuals and ensure that everyone respect and protect their privacy.

For more on person-centered language guidelines, please see:
<http://www.bu.edu/cpr/prj/langguidelines.pdf>

For more about appropriate terms for clinical conditions, please see the Substance Abuse and Mental Health Services Administration ADS Center's Guidance on Transformational Language:
<http://www.promoteacceptance.samhsa.gov/publications/TransformationalLanguage.aspx>

For more information on why person-centered language is important, please see Advocacy Unlimited: People First Language: Dignity, Not Semantics:
http://www.mindlink.org/people_first_language.html

10. What should a CIL staff member do if someone he or she is working with becomes agitated or upset?

The best way to respond to someone who has a psychiatric disability is the same way that you would to anyone else: treat that person with respect and dignity, be patient, listen to them, look for solutions to the problems presented, and acknowledge the legitimacy of that person's feelings. Remember that when someone who has a psychiatric disability becomes upset or agitated, it does not usually signal a psychiatric crisis. A poem (<http://acaciaward.Ocatch.com/leunig/youandme.htm>), by Debbie Sesula, "You and Me," sums up this situation: it begins, "If you're overly excited, you're happy / If I'm overly excited, I'm manic. / If you imagine the phone ringing, you're stressed out. / If I imagine the phone ringing, I'm psychotic. . . ."

If, however, a person does become agitated or upset and you feel that this is tied to manifestations of their psychiatric disability as opposed to being a reasonable response to the situation – such as, for example, if someone has been told that he is losing his housing or that she is not eligible for a service she needs – then it may be wise to seek assistance. Help that person to contact his treatment providers and/or peer crisis support and stay with him until he is able to obtain services.

CIL staff should familiarize themselves with Emotional CPR (eCPR), an educational program designed to teach anyone to assist another person through an emotional crisis by three simple steps of C=Connecting, P=emPowering, and R=Revitalizing. *For information about Emotional CPR, please see:* <http://www.ncmhcsso.org/emotional-cpr.htm>

For additional information on finding your local mental health association, please see the map on the home page of Mental Health America: www.mentalhealthamerica.net . Scroll down for information about how to find help in a crisis.

For information about peer crisis respite services, please see: <http://www.power2u.org/downloads/MH-PeerOperatedCrisisRespitePrograms.pdf>

For clinical information on how to work with someone who has a psychiatric disability who is agitated, please see: <http://www.ispub.com/ostia/index.php?xmlFilePath=journals/ijem/vol4n1/psycho.xml>

11. How can CIL staff handle psychiatric emergencies?

There are rare situations when individuals experience the kind of psychiatric crisis that leaves them, at that moment, “a danger to themselves or others,” in the oft-used legal terminology. Such rare situations may require a stronger intervention than usual to ensure that the individual’s own life or someone else’s life is not

at imminent risk. Even in these unusual circumstances, however, service providers should be aware of the person's treatment preferences, and then seek to help that person so that decision making is returned to him or her as quickly as possible.

Handling a psychiatric crisis of the sort described above, which is extremely rare, may be particularly challenging for CIL workers, who strongly believe that someone should always direct his or her own treatment and care. Here are some suggestions:

using psychiatric advance directives – Individuals with psychiatric disabilities who have talked to their CIL or service provider ahead of time about their treatment preferences in the event of an emergency can continue to direct their treatment even when they are not well. Increasingly, service recipients and providers rely on psychiatric advance directives, which give individuals – when they are well and able to make better judgments – opportunities to make decisions about the kind of care they would like when they are in the midst of a psychiatric crisis, although, as noted above, even in states where psychiatric advance directives have the weight of law, they may be ignored by treatment professionals.

handling severe psychiatric crises – In the rare psychiatric emergency where someone has not indicated their treatment preferences and where they may be an immediate danger to themselves or others, involuntary intervention may be needed in order to keep them and/or others safe. While such interventions appear to run counter to both the CIL philosophy as well as to the philosophy of most enlightened psychiatric treatment and rehabilitation service providers, they may be necessary on rare occasions. In the event of a crisis when you strongly believe someone is imminently a danger to themselves or to others, call 911 or a local emergency unit for help.

For information about peer-operated crisis respite services, please see: <http://www.power2u.org/downloads/MH-PeerOperatedCrisisRespitePrograms.pdf>

If the person you are working with says that they are thinking about suicide, please have them call the number listed at the National Suicide Prevention Lifeline as well as seeking additional support from peers or treatment providers:
<http://www.suicidepreventionlifeline.org/>

12. What can a CIL do to improve services and supports for individuals with psychiatric disabilities?

A CIL may want to develop stronger ties to local mental health systems, local mental health provider agencies, and local peer-run self-help groups, including your statewide peer-run organization <http://www.ncmhr.org/members.htm> .

mental health systems – Open a dialogue with your city, county, or state mental health office, and work to establish linkages so that CIL staff know whom to turn to for advice, support, and crisis assistance.

mental health providers – Get to know your local provider agencies. Find out how much they do (or do not) share your values of peer empowerment and self-direction, and consider joint training for staff.

peer-run self-help groups – Contact your local peer-run self-help groups, peer support specialists, or peer-run services to share information and ideas on coordinated care.

List of Local Mental Health Resources

Local Peer-run Services

Contact Person and Title:
Address:
Phone:E-mail:Website:
Notes:

Local Mental Health Association (www.mentalhealthamerica.net)

Contact Person and Title:
Address:
Phone:E-mail:Website:
Notes:

County or City Office of Mental Health

Contact Person and Title:
Address:
Phone:E-mail:Website:
Notes:

Emergency Contacts (Suicide Crisis Hotlines and Adult Crisis Response Centers)

Name of Center:
Address:
Phone:E-mail:Website:
Notes:

Other Key Contacts (including peer-run groups and services)

Name/Agency:
Contact person:
Services/Supports:
Phone:E-mail:Website: