



NAMINews

NATIONALLY RECOGNIZED AFFILIATE OF THE YEAR 2004

This issue: Mental Health Crises: Getting Treatment

Handling Mental Health Crises

WHO WE ARE
 NAMI-
**METROPOLITAN
 BALTIMORE, INC. IS A
 GRASSROOTS
 ORGANIZATION
 DEDICATED TO
 HELPING FAMILIES
 ALLEVIATE THE
 SUFFERING AND
 COMBAT THE STIGMA
 THAT SURROUNDS
 BIOLOGICALLY BASED
 BRAIN
 DISORDERS
 (MENTAL ILLNESS).**

**NAMI SERVES
 BALTIMORE CITY AND
 BALTIMORE COUNTY AND
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 NATIONAL ALLIANCE ON
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 UNITED STATES.**

WHAT WE DO
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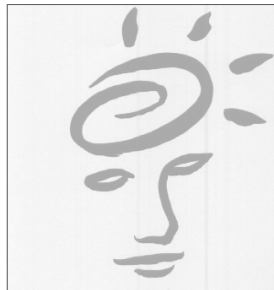
**EMPOWER
 FAMILIES THROUGH
 EDUCATION & SUPPORT;
 INFORMATION; AND
 ADVOCACY.**

**EDUCATE THE PUBLIC
 THROUGH PERSONAL
 EXPERIENCE AND
 CONFRONT STIGMA.**

**EVALUATE MENTAL
 HEALTH PROGRAMS AND
 PARTNER IN
 BETTER MENTAL HEALTH
 SYSTEM DESIGN.**

**SUPPORT RESEARCH
 WITHIN BASIC ETHICAL
 GUIDELINES
 RESEARCH.**

Sooner or later, if someone is afflicted with a major mental illness, a serious crisis will occur. When this happens, there are some actions that family members/friends can take to help diminish or avoid harm to the ill person, to others and to property. In the midst of crisis there are three requisites: 1. to reverse any escalation of the psychotic symptoms, 2. to provide immediate protection and to support the individual with mental illness and 3. to protect and support others in the vicinity.



When experiencing a crisis, a person can lose total control of thoughts, feelings and behavior. This lack of self control seldom occurs suddenly. A variety of behaviors may give rise to concern: sleeplessness, ritualistic preoccupation with certain activities, suspiciousness, unpredictable outbursts, and so on. If you suspect a person has ceased taking medications, encourage a visit to the physician. Awareness of these early symptoms of relapse may avert a serious mental health crisis. The more psychotic the person becomes, the less likely you are

to succeed.

Recognize that the ill person is in an "altered reality state". You do not want to threaten, frighten or otherwise agitate the ill person, who is probably terrified by the experience of losing control over their thoughts and feelings. Also, "voices" may be giving life-threatening commands; messages may be coming from light fixtures; snakes may be crawling on the window. If the person is not too agitated, you may ask what the voices are saying. In extreme situations the person may "act out" the hallucination, e.g., shatter the window to destroy the snakes.

Your primary goal is to help the person regain control. Therefore, you must remain calm. If you are alone, contact someone to stay with you until professional help arrives. If you feel in danger, leave and then seek immediate help for the ill person. Despite other efforts, the person may need to be hospitalized. If you need professional help, seek it— call the physician, a mental health crisis center, or the police.

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What is a Psychiatric Crisis?

In most situations, a psychiatric crisis is characterized by at least one of the following:

- Active danger to self or others like:
 - * suicidal thinking or behavior,
 - * high risk behavior, thinking about or harming others
 - * violence toward property
- Passive danger to self or others (this includes serious neglect of self or of others in one's care)
- Sudden change in mental status
- Acute psychotic symptoms

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Personal Experiences with Involuntary Treatment

Having an involuntary evaluation or an involuntary admission is not always the wrong decision. I wish the only thing that happened to me was that I was admitted to a hospital. I was never EP'd, although I probably should have been.

In May 2001, I was manic and psychotic. I broke into someone's home and destroyed property because I thought I was a lead character on a movie set. Two days before this, my family had called my psychiatrist hoping to get immediate help for my clearly psychotic behavioral symptoms. The doctor said that she was unavailable and, I would have to wait

for my appointment in 3 days.

I wish now that the doctor had recommended that my family "EP" me or take me to an ER. Instead, I broke into someone's house, was *arrested* the next day and taken to a detention center where I stayed for 2 weeks. I had a competency hearing and was found competent. I never went to a hospital, but I was lucky to get medication and support from a counselor at the detention center. During my stay at the detention center I was in solitary confinement for a week. I cleared up mentally only to find myself locked in a cell with no caring person to talk to.

I was lucky and was referred to a new psychiatrist and given intense outpatient treatment. I have been with the same psychiatrist since 2001. I have only been hospitalized once since, for a weekend!

I have looked back on my experience and wish sometimes I had been taken to a hospital. I think it is critical for families and friends to know there is a system in place to have their friends and loved ones seen on an emergency basis.

Karen A. Mann, RN BSN, NAMI Maryland Board member, NAMI - Metropolitan Baltimore volunteer.

My Involuntary Admission to the Hospital

Approximately 20 years ago, I was diagnosed with recurrent major depression, psychosis, and post-traumatic stress disorder (PTSD). My additional diagnosis of lupus led to a deep depression. I began to seriously neglect myself. In addition to refusing medical treatment for somatic illnesses and not taking medications, I stopped eating and sleeping. Eventually I became severely underweight. The emotional boundaries between my family and I were crossed on numerous occasions. My family had to find a means of intervention. Frustrated and heart broken, my mother obtained an emergency petition.

The police arrived at my door early one morning and told me that they were taking me to the hospital. I was placed in isolation upon arrival and was medicated without ever talking to a doctor or nurse. At first I was horrified, then angry with the doctors and my family. After a few hours, the doctors transferred me to a psychiatric facility without saying why or where I was going. The doctor immediately placed me on "one to one" observation.

For months, I was in a state of shock,

unable to talk, or participate in individual or group therapy. I developed a fear of not having control over life. This fear derived from the highly structured hospital environment. Obsessed with thoughts of permanent hospitalization, I paced the halls still unable to eat or sleep. During the first few months of hospitalization, I struggled daily with suicidal thoughts. I felt violated, ashamed, and unimportant.

After being medicated for a few months, I was able to participate in groups. My fears and obsessions subsided, and I was able to sleep, eat and maintain a normal weight.

After the hospitalization, I was extremely inept in social situations. There was also the daily fear of imminent hospitalization, or that my family would take out another emergency petition. I chose NAMI to reintroduce myself to a social environment. By coming to NAMI-Metro Baltimore informational meetings, I heard the love and dedication of others' family members. Now I understand that my parents had acted completely out of love. I gradually began the journey of forgiveness with humility.

By letting go of anger, bitterness and resentment, it was possible to work through the pain into healing. In the Peer-to-Peer Recovery Education Course and by attending the NAMI-CARE peer support groups, I learned not to engage in frustration, anger, judgment or blame. Instead, I learned to forgive myself, and in doing so, to forgive my family for doing the only thing they could do to save my life. I am currently in the process of recovery and the prospect of hospitalization is not as frightening. Seeking medical attention for somatic illnesses is not as traumatic.

I have begun to reinvest in life. I survived and I have grown from the experience. I have learned that protecting my recovery means that developing new coping skills and changing my normal patterns of reacting will be lifelong work if I am to enjoy a higher quality of life. Now, I expect a better future.

Deneice Valentine, NAMI - Metropolitan Baltimore In Our Own Voice: Living with Mental Illness presenter, NAMI-CARE peer support group facilitator and Peer to Peer Recovery Course mentor.

NAMI Support and Education Programs

NAMI-Metropolitan Baltimore, Inc., a family-oriented grassroots organization, offers many free programs and services including:

- **Peer Support Groups for relatives and significant others** of persons with a mental illness. All of our peer groups meet on weeknights or Saturdays. You are welcome to attend more than one group. *These groups use the NAMI National support group model.* Call 410-435-2600 for more info.
- **Peer Support Groups for Consumers** of mental health services. All of our groups meet on weeknights or Saturdays. Call 410-435-2600 for more info.
- **Informational Meetings and Workshops.** Lectures & workshops on topics of interest to mental health providers, persons dealing with mental illness and their families. Meetings are held every 3rd Wednesday from 7pm-9pm September through May. Call 410-435-2600 for more info.
- **Family-to-Family Education Program, a Free,** intensive, 12-session peer-led education and support curriculum for family members & significant others of persons with a mental illness. *The 2½ hour classes are held once a week for 12 weeks.* Call 410-435-2600 to reserve a space.
- **Peer-to-Peer Education Course, a Free,** 9 consecutive sessions, peer-led education and support curriculum for consumers of mental health services focusing on recovery and relapse prevention. *The 2 hour classes are held once a week for 9 weeks.* Call 410-435-2600 to reserve a space for yourself.
- **“In Our Own Voice: Living with Mental Illness,”** a 1 1/2 hour to 2 hour workshop about coping with mental illness led by consumers of mental health services, adapted for various audiences, including mental health staff, the faith community, and the public.
- **Public Policy Advocacy** to improve the lives of persons with mental illness and their families.
- **Information & Resource Materials** concerning the treatment of mental illness, coping strategies, and the mental health system.

**NAMI-
Metropolitan
Baltimore, Inc.
serving
Baltimore City
& Baltimore County**

*a local affiliate of the
National Alliance on
Mental Illness (NAMI)
and
NAMI Maryland*

5210 York Road (Rear 2d Fl)
Baltimore, MD 21212

Phone: (410) 435-2600
Fax: (410) 435-0355

Email:
namimetrobalti-
more@yahoo.com

Website:
[www.nami.org/sites/
namimetrobaltimore](http://www.nami.org/sites/namimetrobaltimore)

Editor/Executive Director
Kathryn S. Farinholt

**Many thanks to the volunteers
who help get our newsletter out
to our members and others!**

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volunteers !
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Positive Principles for Family and Friends to Remember in a Crisis

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

GET HELP. You must get help! No one can handle these devastating crises alone. Your plan should always involve other family members, public authorities, crisis workers, and professional assistance— notified **ahead** of time, if possible. Call the local Crisis Hotline. (*See p. 5*)

TRUST YOUR INSTINCTS. If you are worried about violence or suicide, you can bet something is building up and that events are overwhelming your relative.

VOCALIZE YOUR CONCERNS. You can't keep your head in the sand about violence and suicide. You have to speak about these fears directly and openly to your relative/friend. You must show

your reaction to these dangers. Tell him his behavior is making you feel afraid; ask point blank if he is contemplating suicide. In a crisis, candor is **essential**. It reduces tension, "detoxifies" secret plans, and lets a lot of air into a sealed off, turbulent mind.

SHOW RESPECT. Even though your relative/friend is "scaring you to death" or making you angry, you need to approach him with respect. All good crisis intervention is calm, purposeful, and respectful.

ACT TO PROTECT YOUR LOVED ONE. This is the highest form of caring for them, even if it involves forced or involuntary commitment. And it is a difficult paradox to deal with: To keep them safe, we must let them go; even if they hate us for "locking them up," even if they break off with us, we must move decisively to insure their well-being. We cannot hang back because we think they

will no longer love us. Mental illness can put people in mortal danger. In this situation, love **acts!**

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

PROVIDE INFO TO 911 OPERATOR. If indicated, call the police, but explain that your relative or friend is in need of a psychiatric assessment and that you have called them for help. *See p.6.* In short, try to prepare the officers for what to expect.

Remember, things always go better if you speak softly and in simple sentences.

Handling Mental Health Crises

(Continued from page 1)

What NOT to Do in a Crisis

The following are guidelines on what to avoid in the midst of a crisis:

Don't threaten. This may be interpreted as a power play, increase fear or prompt assaultive behavior.

Don't shout. If the person [in crisis] seems not to be listening, it isn't because they are hard of hearing. Other "voices" are probably interfering or predominating.

Don't criticize. It only makes matters worse; it can't possibly make things better.

Don't squabble with other family members over "best strategies" or allocations of blame. This is no time to prove a point.

Don't bait the person into acting out wild threats; the consequences could be tragic.

Don't make direct, continuous eye contact or touch the person. Comply with requests that are neither endangering nor beyond reason. This allows the person to feel somewhat "in control."

Don't block the doorway. But do keep yourself between the person in crisis and an exit.

Don't be patronizing or authoritative if encouraging the person to go to the hospital. Explain that the hospital will provide relief from the symptoms, and that the person will not be kept if treatment can be continued at home or in some other protected environment.

Don't make ultimatums such as "Either go to the hospital or leave the house." This invariably intensifies the crisis.

What to Do in a Psychiatric Crisis in Maryland: Voluntary & Involuntary Treatment

NAMI member E. Burton's workshop on psychiatric crisis in Maryland is the basis for this article. Laws vary from state to state. Crisis service availability varies from county to county. We have added editor's comments and local resources in Baltimore City and County.

Psychiatric Crisis Definition

In most situations, a psychiatric crisis is characterized by at least one of the following:

- Active danger to self or others (this includes suicidal thinking or behavior, high risk behavior, thinking about or doing harm to others and violence toward property)
- Passive danger to self or others (this includes serious neglect of self or of others in one's care)
- Sudden change in mental status
- Acute psychotic symptoms

Sometimes it is difficult to assess whether or not a person will become violent toward self or others. Some signs of possible impending agitated violence include*:

- Speech that is loud, threatening and profane
- Increased muscle tension, such as sitting on the edge of the chair or gripping the arms; clenched fists and teeth
- Rapid breathing, flushed face; eyes widen, nostrils flare
- Hyperactivity – restless and repetitive movements, pacing
- Slamming doors or knocking over furniture

(*Adapted from: Hyman, SE and Tesar, GE (1994) Manual of Psychiatric Emergencies, 3rd Ed., p. 29, Boston: Little Brown)

First Choice: Voluntary Treatment

The first choice in dealing with a person in a psychiatric emergency is for that person to seek treatment voluntarily. If he or she has a mental health care provider, contact that provider for advice. If the person has insurance, Maryland law requires that the insurance company cover emergency hospitalization or residential crisis services. If the person has no mental health provider, encourage him or her to go to an urgent care center like Psychiatric Urgent Care Unit at the University of Maryland Hospital, a psychiatric hospital (such as Sheppard Pratt

Hospital), or an emergency room at a hospital that has a psychiatric unit.

If possible, accompany the person in crisis to the hospital or crisis center so you can provide information about his or her illness and current behavior.

In Baltimore City, the Baltimore Crisis Response System (BCRI) handles crisis phone calls 24 hours a day, and can provide intervention, support and resources. The BCRI mobile crisis team can be called to the home from 8am to 8pm, depending on availability. To access the Mobile Crisis Team (consisting of doctors, nurses, therapists, and others) call the Crisis Hotline at 410-752-2272 (or 410-433-5175).

In Baltimore County, the Baltimore County Crisis System handles crisis phone calls 24 hours a day, countywide at 410-931-2214. The Baltimore County mobile crisis team currently serves specific (expanding) parts of the County, from 10am to midnight. To access the Mobile Crisis Team (and other services, including the possibility of an appointment within the next few days) call the Crisis Hotline at 410-931-2214. In-home intervention services to help link people with services are available countywide.

Involuntary Treatment in Maryland

If the individual will not seek treatment voluntarily, one can petition the court for an involuntary mental health evaluation. Currently Maryland law does not allow for outpatient civil commitment, only involuntary evaluation and involuntary hospitalization. *[Outpatient civil commitment means that a judge has ordered a person to comply with psychiatric treatment and if s/he fails to do so, s/he will be hospitalized involuntarily. Such a law is in place in other states, most notably in New York where the law is called "Kendra's Law."]* Maryland criminal law provides for involuntary outpatient treatment through the parole and probation system. If a person fails to comply with treatment, he or she will be sent back to jail.

In order to obtain an involuntary psychiatric evaluation of an individual, you must petition the court. As of October 1, 2003, the petitioner must have reason to believe that the individual has a mental disorder and presents a danger to the life

or safety of the individual or of others. (The law no longer requires that there be imminent danger of bodily harm).

Definition of "Mental Disorder"

"Mental disorder" means the behavioral or other symptoms indicate

- to a lay person: a clear disturbance in the mental functioning of another individual; or
- to a physician, psychologist, clinical social worker or licensed clinical professional counselor doing an examination: at least one mental disorder that is described in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM). *Md. Code §10-620.*

Definition of "Dangerousness"

"The individual presents a danger to the life or safety of the individual or of others" has been interpreted by administrative law judges as:

- *Active dangerousness:* Overt acts such as threats of violence or acts of violence.
- *Passive Dangerousness:* Inability to care for self or others in your care, such that the individual's life or safety are at risk. Examples include endangering oneself by not eating or drinking, neglect of serious medical conditions, or an inability resulting from the mental disorder to recognize actions with serious harmful consequences (e.g., not calling 911 if a child in their care attempts suicide, dangerously inadequate clothing/shelter in cold weather, unable to cross street safely).

After October 1, 2003, the "danger" need not be imminent in order to be considered by the judge.

Definition of "Reason to Believe"

"Reason to believe" is a standard somewhat less than "probable cause." Certainty is not required. The facts should "warrant the belief of a prudent person." "Reason to believe" may be based on an examination by a health care professional or observation. If a police officer observes the individual, s/he does not necessarily have to observe the behavior that indicates a mental disorder or dangerousness. "Reason to believe" may also be based on information obtained from family members concerning the

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Psychiatric Crisis in Maryland: Voluntary and Involuntary Treatment

(Continued from page 5)

mental disorder or dangerousness.

Provider Recommends Hospital; Consumer Refuses

If the Emergency Petition form is completed by a health care professional, the professional must give the form directly to a law enforcement officer. The individual in crisis should be picked up and taken to the nearest hospital. The provider must have personally examined the ill individual, although the law does not specify the time frame within which this examination must have been performed.

No Provider: Consumer Refuses Treatment

If the individual has no provider and it is an emergency, there are several options.

First Choice: Mobile Crisis Team on site evaluation, if the situation allows for response time. Provide the team with detailed information on psychiatric history and dangerousness.

Other Choices:

- File a petition for emergency evaluation if danger is not imminent. (May take several hours. *See below.*)
- Call 911 if the situation requires immediate intervention. A police officer can observe the individual and complete the Emergency Petition form. Request a specially trained officer (request BEST/CIT officer in Baltimore City) if response will not be delayed. Provide information.

Emergency Petition by Lay Person

The Emergency Petition form can be completed by any interested lay person, but it must be reviewed and approved by an administrative law judge. [Remember, it need not be reviewed if done by a peace {police} officer or a qualified health professional.] The form can be obtained on the internet (<http://www.courts.state.md.us/courtforms/joint/ccdc13.pdf>), at any District Court, and at some Circuit Courts. The forms can be filed at any district court. It may take several hours before the judge reviews the petition. After 4:30pm, in Baltimore County, you cannot submit an emergency petition to a judge. You should probably call the Crisis hotline to

consult and, if an emergency petition is necessary, you will have to call 911.

After hours, in Baltimore City, the Court Commissioners at 501 East Fayette Street or 1400 East North Avenue, can accept a petition 24 hours a day. Bring the individual's medical records including hospital records, doctor reports, diagnoses and a list of his/her prescribed medications. Be prepared to talk to the judge to justify your petition. (See p.7 *Weighing Your Concerns*)

The judge will only grant the petition if the court finds probable cause to believe the individual has shown symptoms of a mental disorder and meets the dangerousness criteria. The petitioner's job is to draw a vivid portrait of a person in mental distress that is so serious that he/she meets the dangerousness standard and should be evaluated. Describe the current situation, giving as many details as possible. **Details matter.** Attach detailed answers. Concentrate on the current situation but, if appropriate, you can also provide information about dangerousness in similar situations that occurred in the past.

Emergency Petition Form:

Describing Current Behavior

EP Item 9: "The evaluatee is demonstrating the following behavior that leads me to conclude that he/she currently has a mental disorder." Include specific statements, behavior, showing clear disturbance of mental functioning.

EP Item 10: "The evaluatee presents a danger to the life or safety of the evaluatee or others because..." Include statements they have made and specific behaviors.

Some examples of how to provide details about the person's mental status and dangerousness are as follows:

- Evidence of potential for assaulting others (e.g. throwing dishes)
- Makes clearly threatening statements-list the statements verbatim
- Victims show injury, premises show recent signs of struggle or destruction (e.g., large hole in wall)
- Self-harm: suicidal statements, self inflicted wounds.
- Gross self neglect or neglect of those in care (e.g., failure to eat)

- Poor judgment, inability to recognize dangerous situations (e.g., acts on delusions or hallucinations, takes great risks without thinking, grossly overestimates or underestimates own abilities, does not anticipate serious adverse consequences of own actions, etc.)
- Similar situations in the past that resulted in dangerous acts or harm.

Specific examples:

Item 9: Subject paces for hours at a time. He can no longer concentrate long enough to read, work or watch TV. He said, "My thoughts are racing." His speech jumps from one topic to another without any connection. He said, "I must shower. My favorite color is green."

Item 10: Subject threw dishes against walls with me in the room. His father reports that the subject kicked a hole in the wall. Subject drives 20 miles per hour over the speed limit on dangerous curves and cuts off other cars. Two years ago, in a similar condition, he threatened to kill his father.

After an EP is Granted

If the judge grants the Emergency Petition, the petition will be given to the police department to be served, or in some cases, the petitioner may need to take the petition to the Sheriff's office to be interviewed. The police or sheriff will find the person in crisis and will transport him/her (often in handcuffs) to the hospital. [*Editor's Note:* It helps to give information concerning where and when the person in crisis can be found since action may not be taken right away. It helps to follow up with the police district in the area where the petition will be served to make sure that they have received it. You should also follow up to be sure the documents are forwarded to the next shift if the person is not found during the prior shift.]

The petitioner need not be on hand when the law enforcement officers pick up the individual. If the situation is dangerous, leave the scene or call 911. The law requires that the person be taken to the nearest hospital, but the petitioner may be able to request that the ill person be taken to another hospital.

What to Tell 911 and Police Officers Responding to a Mental Health Crisis

Remember: Call the mental health treatment provider or the local crisis hotline first, if you are not concerned for your or another's immediate safety. Have a crisis plan in place.

911 Calls: 911 workers usually input the caller's information (sometimes asking questions); the basic information is sent to the area dispatcher who will read what is typed to the officer answering the call. *It is important to quickly and concisely provide useful information that will ensure the safety of all involved.*

What to tell the 911 operator:

- * Ask if an officer trained about mental illness is available
- * Your relationship
- * Current problematic behavior
- * The diagnosis
- * Tell if they in treatment NOW?

- * What medications?
- * History of alcohol or street drugs? Currently? Which?
- * Any history of self-harm?
- * Any history of violence toward others? Specific people or types?
- * Any known triggers to avoid
- * Access to weapons or history of use (knives, broken glass, etc.)
- * Age, height, weight
- * Weight training?
- * Preference of hospital (this can *sometimes* be accommodated)

At the scene: If more than 1 person is available, it is important that one stay with the symptomatic person and the other meet the officer(s) away from the symptomatic person (if at all possible, outdoors).

Explain what is happening RIGHT NOW, repeat the information given to dispatch

(see checklist) and anything that has changed since you called 911. Explain how the symptomatic person reacts to multiple officers. *Always expect 2 or more officers as this is police procedure to protect officers and the public.*

Once the primary officer is given the call, the dispatcher will ask if additional officers are available. If indicated, the primary officer may say no additional officers are needed.

If your friend/relative is missing:

- Clothes last seen wearing.
- Locations your relative frequents
- Any accessible weapons?
- *See also* NAMI's Locating Homeless or Missing Relatives fact sheet at www.nami.org, or call NAMI to ask for a copy.

Emergency Petitions : Weighing Your Concerns

The key word to remember about emergency petitions for psychiatric evaluation is EMERGENCY. Emergency petitions are legal tools that may be used when your relative/friend is in crisis or the situation is emergent, and you are otherwise unable to get your relative/friend the necessary medical attention. The petition does not guarantee that your relative/friend will be hospitalized, it only helps get the individual to an emergency room for a psychiatric evaluation.

Sometimes this is the only way our relative/friends can get the medical help they need. Their inability to see they are becoming psychiatrically unstable may be a symptom of their illness. If the ill person is not willing to seek professional help, it may be necessary for the family/friend to intervene.

The process can be difficult, long, confusing, stressful, and frustrating.... You must detail many behaviors that are distressful on the form and for the judge. *Even if the petition is granted, it only remains valid for five days. If your relative/friend is not located within that time, the petition becomes obsolete and you must begin the process again.* If your relative/friend is found and taken to the hospital, the doctor may still not decide

to commit them. If an individual is committed to a hospital, he/she still has the right to sign-in voluntarily, which also allows him/her to *sign-out* voluntarily after submitting a 72-hour notice of intent to leave the facility. The health care provider may re-certify them, but they will have a hearing before an administrative law judge within 10 days of admission, and the judge will determine if the individual continues to meet the legal criteria for involuntary commitment. If you believe your relative/friend is still a danger to self or others, you may repeat the EP process. [It is complicated and confusing— and it is still not going to provide a cure.]

What are the risks and benefits of taking out an emergency petition? One risk is that the ill person will become extremely angry at you for “trying to get him locked up.” Another is that the person seeking the evaluation will feel guilty and forever remember the look on the ill person's face as the officer takes him into custody. Many officers don't understand mental illness, which can add to the seemingly “punitive” nature of the EP. And what will the neighbors think when the police take our relative/friend out of the house in handcuffs?

You may be asking yourself—Can't I just take a vacation and deal with this whole issue another time or couldn't somebody else take over for me? You would not be alone in these thoughts. But for many people, after the process is completed and the individual is in the hospital, it is the first chance they have to let go and relax. They do not have to keep “walking on egg shells.” It may be the first time they can honestly report they know the whereabouts of their relative/friend and that their relative/friend is safe.

REMEMBER, Emergency Petitions address a crisis or emergency situation. They are not a solution for long-term care.

*Bette Stewart, NAMI-MD
Family to Family Coordinator*

[Editor: Sometimes you have to take actions to keep your friend/relative or those around them safe. This may anger them when they are in crisis and is difficult and traumatic for everyone concerned. But sometimes when your relative or friend is doing better, they MAY thank you. Forgive yourself, but if necessary, “love acts.” See p.2]

Involuntary Hospital Treatment: for a Psychiatric Crisis in Maryland

NAMI member E. Burton's workshop on psychiatric crisis in Maryland is the basis for this article. We have added editor's comments and local resources in Baltimore City and County.

When an individual is in a psychiatric crisis, s/he may be in need of hospitalization, but may be unwilling to go to the hospital voluntarily. Maryland law allows for a family member, a mental health professional, or another person to petition the court to have a person hospitalized involuntarily for a psychiatric evaluation. The article on p.5-6 discussed the process of completing the petition. This section will discuss what happens in the hospital after a person has been transported involuntarily.

Emergency Room ("ER") Evaluation

Once a person arrives in the emergency room (usually accompanied by a sheriff's deputy), the law requires that s/he receive a psychiatric evaluation by two physicians or a physician and a psychologist within six hours.

Family members or those accompanying the individual should give the emergency room examiners information relating to the five criteria for involuntary hospitalization, including current symptoms, dangerousness (past and present), history of mental illness, hospitalizations, medications, recent refusals or attempts at outpatient treatment. This is best done with a one-page written summary.

If the family member is not present in the emergency room, the summary may be faxed, and receipt of the fax should be confirmed by telephone.

If possible, arrange for the individ-

ual's outpatient mental health provider (psychiatrist or therapist) to speak to the ER personnel. Tell the ER examiners if you are unwilling to accept the person back in your home or if the person would be homeless if released from the ER.

Involuntary Hospital Admission

The criteria for involuntary hospital admission are:

- Has a mental disorder AND
- Needs inpatient care or treatment AND
Presents a danger to the life or safety of the person or others AND
- Is unable or unwilling to be admitted voluntarily AND
- There is no available less restrictive form of intervention that is consistent with the person's welfare and safety.

Not Certified in ER for Admission

If the person does not meet the above criteria, s/he will not be "certified" for hospital admission. If not certified, the person is immediately free to go. *A family member may request that the ER staff discuss with the individual a referral to a residential crisis bed or other appropriate services.* The individual may be "re-petitioned" at any time under new circumstances.

Involuntary Hospital Admission Issues

A person may not be held in an ER for more than 30 hours. If a person is certified for admission but the hospital does not have a bed available, the hospital must notify the Maryland Department of Health and Mental Hygiene (DHMH) within 24 hours. DHMH is required to provide hospital admission within 6 hours of notification.

One may request admission to a specific hospital, but the request may not necessarily be honored.

Hearing Within 10 Days

Once an individual has been admitted to a hospital, a hearing before an administrative law judge **MUST** take place within 10 days of admission.

The individual's parent, guardian or next of kin must receive notice of the hearing and may testify in person or by speaker phone. Others may notify the hospital of their wish to testify as well.

Change to Voluntary Status

Any time before the hearing decision, a patient may request a change in status to "voluntary admission" IF the hospital physician finds the patient able to understand and agree to treatment. Voluntary status allows the patient to sign out of the hospital at any time unless physicians determine that the patient meets the criteria for involuntary admission and is re-certified. **Let the hospital staff know if the patient has previously refused treatment after conversion to voluntary status.**

Commitment Hearing

The commitment hearing should take place *in the hospital* within ten days of admission. The original petition, hospital certifications, and records may be reviewed. Witnesses are usually called but may not speak spontaneously; they can only answer the judge's questions. **Family members should primarily address issues of dangerousness.** Before the hearing advise the hospital presenter of a family member's wish to present so s/he can ask appropriate questions.

(Continued on page 9)

Involuntary Hospital Treatment...

(Continued from page 8)

Write out and practice your comments. Try to work them in even if not totally responsive to the question. Be sure to say whether the person will be homeless if they are released at the hearing.

If a person does not meet the criteria for involuntary admission, s/he may leave or request voluntary admission. As noted above, s/he may be re-petitioned for evaluation under new circumstances.

Errors in the emergency petition can lead to discharge from the hearing. If the petition is vaguely worded, and does not document dangerous behavior or is not completely filled out, the judge may decide that the person should be released.

Does Meet Criteria

If a person meets the criteria for involuntary admission, s/he may be

held in the hospital for up to six months without a new hearing. Note however, that currently the average stay in a general hospital is about five days, and about 7-14 days for a psychiatric hospital.

Discharge Criteria for Involuntary Patients

The criteria for discharge after a person is involuntarily admitted are:

- Inpatient care is not needed to protect the individual or others;
- Discharge would not endanger the individual or the person or property of others; and
- The person can care for him/herself or will be cared for properly by a responsible person who is able and willing to care for the individual.

In summary, involuntary hospitalization is needed in situations where hospitalization may help avoid a tragic outcome. It may be the best

chance for a person to begin to stabilize, but is not a long-term solution and may put significant stress on the relationship between the petitioner and the ill person.

NAMI recommends “I Am Not Sick, I Don’t Need Help” by Xavier Amador, for family members of consumers who are non-compliant with treatment. This provides information on mending your relationship after you have petitioned and testified for involuntary hospitalization.

Basic information about how to file a petition and the phone numbers for local district courts in Maryland can be found in the brochure, “What to do in a Psychiatric Crisis in Maryland.” Please contact NAMI-Metropolitan Baltimore (410-435-2600) or NAMI-Maryland (410-863-0470) if you would like a copy of this brochure.

Advice on Taking Care of the Caregiver —Author Unknown

1. Be gentle with yourself.
2. Remind yourself that you are a loving helper, not a magician. None of us can change anyone else—we can only change the way that we relate to others.
3. Find a place where you can be peaceful —use it every day—or when you need to.
4. Learn to give support, praise, and encouragement to those about you—and learn to accept it in return.
5. Remember that in light of all the pain you see around you, you are bound to feel helpless at times. You need to be able to admit this without shame. Just in caring and in being there, you are doing something important.
6. Learn to vary your routine often and to change your tasks whenever possible.
7. Learn to know the difference between complaining that relieves tension and the complaining that reinforces it.
8. Focus on one good thing that happened during the day.
9. Become a resource to yourself! Be creative and open to new approaches to old things.
10. Create and use a support system. Use a “buddy” system, your local support group, your friends, regularly as a support, for reassurance and to redirect yourself.
11. Learn to use the expression “I choose to...” rather than expressions like “I have to...,” “I ought to...,” or “I should...”
12. Learn to say “I won’t...” rather than “I can’t...”
13. Learn to say “no” and mean it. If you can’t say “no,” what is your “yes” worth?
14. Aloofness and indifference are far more harmful to the ill person—and to yourself—than admitting to an inability to do more.
15. Above all else—learn to laugh and to play.

Tips for Getting the Hospital to Retain Your Ill Friend or Family Member

Many families complain that after they've gone through a great deal of trouble to get their very ill relative hospitalized, the patient is released within a few days. Often this is before medications have had time to significantly improve their condition. One family member has the following recommendations on obtaining longer hospitalizations when needed. These may or may not work for you as every case is different, but trying them is empowering and could result in the desired outcome.

1. Hospital Choice: Average lengths of stay are generally longer in Psychiatric Hospitals than in General Hospitals. (The general hospitals we checked averaged about 5 days, and the psychiatric hospitals averaged between 7 and 14 days depending on the type of unit.) Maryland Health Services Cost Review Commission penalizes general hospitals whose overall average patient stay is more than a few days. *This policy does not apply to private and public psychiatric hospitals.* Therefore, before hospitalization is needed, find out the average length of stay from each hospital under consideration, by calling the hospital, insurance company or the local mental health system.

2. Obtain a copy of your insurance carrier's exact medical necessity criteria for psychiatric hospital admission and continuing stay authorizations. If there is no insurance coverage, obtain the hospital authorization criteria for the Maryland state psychiatric hospitals from the MAPS website at <http://www.maps-md.com>. Click on "For Providers", then "Provider manual", then "Chapter 6: Medical Necessity Criteria". If you do not have computer access, ask the NAMI MD office to fax or mail you a printout. Preferably have this available before the hospitalization or as soon as possible after admission. Use this as indicated below.

3. Immediately after admission to a private hospital, fax or give a copy of the authorization criteria to the attend-

ing doctor for use in requesting authorizations and inclusion in the medical record. Also, submit in writing a brief (no more than one page) explanation of why you believe your relative meets the specific criteria for admission and continued stay, why short hospitalizations have been unsuccessful in the past, and why your relative might benefit from a longer hospitalization. State this clearly, *especially* if you believe your relative still presents a danger to self or others. Give specific reasons, including recent phone conversations, visits, and past history. Tell the psychiatrist and case manager that if the insurance company refuses authorization, you would like the hospital to do all possible appeals. Follow up with a phone call to the attending psychiatrist to discuss all of this. (The psychiatrist is the one who must convince the insurance company).

4. Fax the one page information sheet (see #3 above) to the medical director of your insurance company and call him to discuss it. If you believe that your relative still presents a danger to self or others, you may wish to say that you will hold the insurance company liable if they release him against the recommendation of the attending physician. Hospitals may be reluctant to accept your family member in the future if you say this to them, however, if you are desperate you might wish to contact the risk management/legal section of the hospital and explain to them why you think your relative is still dangerous.

5. If the insurance company or MAPS denies authorization, call the medical director of the hospital and ask for his assistance with an appeal. Also, call back the Medical Director of the Insurance Company or MAPS and say you wish to join the hospital's appeal or at least submit information for them to consider. Fax a letter stating this and giving specific reasons why you believe your relative meets the medical necessity criteria. (You may not have standing to join the appeal unless you are your relative's Health Care Agent

or guardian, or the policy subscriber.)

6. If the attending physician recommends a discharge and you believe that the person still meets "medical necessity" criteria or is a "danger to self or others", discuss it with the Hospital Medical Director. If he is not helpful, request that he arrange for an outside consultation. (Your insurance company may not pay for this or the additional days involved.)

7. Clearly tell the hospital case manager and doctor if you are unwilling to accept your relative back home if you believe they present a danger to self or others, or if you are unable to properly care for them. (Private hospitals sometimes will try to keep a homeless patient a little longer, but not always. Local hospitals do discharge people to homelessness, but state hospitals rarely do unless the patient wants it.)

8. If all appeals for continued hospitalization fail, ask the hospital to request insurance authorization for discharge to a Crisis House. A recently passed Maryland law requires that all mental health insurance now include this as a covered benefit, although there may be substantial co-pay. Request the medical necessity criteria for this service from your insurance company or MAPS and proceed as in 3, 4, and 5 above.

9. Assume hospital staff has permission from your relative to talk to you unless told otherwise. If they say that your relative has not given such permission, remind them that under the law they are still permitted to receive oral and written information from anyone. In this case do NOT pressure them to give you specific information about your relative, if you are not the guardian. They are often willing to answer questions about their "general policies and procedures" regarding patients in similar "theoretical" circumstances.

*Excerpted with permission-
Evelyn Burton.*

Glossary

Baltimore Area Crisis Services: Hotlines & Mobile Crisis Teams

Baltimore City: Baltimore Crisis Response System (BCRI) handles crisis phone calls 24 hours a day. The BCRI mobile crisis team can sometimes be called to the home from 9am to 8pm. To access the Mobile Crisis Team, call the Crisis Hotline at 410-752-2272.

Baltimore County: the Baltimore County Crisis System handles crisis phone calls 24 hours a day, county-wide at 410-931-2214. The Baltimore County mobile crisis team serves certain parts of the County, from 10am to midnight. To access the Mobile Crisis Team (and other services, including the possibility of an appointment within the next few days), call the Crisis Hotline at 410-931-2214. In-home intervention services to help link people with services are available countywide.

Critical Periods. (Crisis period)

1. **Crucial.** Extremely important because of being a time or happening at a time of special difficulty, trouble, or danger, when matters could quickly get either worse or better.

2. **Life-threatening** as a medical condition, or in danger from such a condition

Dangerousness. “The individual presents a danger to the life or safety of the individual or of others” has been interpreted by administrative law judges as:

Active dangerousness: Overt acts such as threats of violence or acts of violence.

Passive Dangerousness: Inability to care for self or others in one’s care, such that the individual’s life or safety are at risk. Examples include endangering oneself by not eating or drinking, neglect of serious medical conditions, or an inability resulting from the mental disorder to recognize actions with serious harmful consequences (e.g., not calling 911 if a

child in their care attempts suicide, dangerously inadequate clothing/shelter in cold weather, unable to cross street safely).

Emergency Petition for a Psychiatric Evaluation

Legal petition to court to order law enforcement to transport the individual to an emergency room for a psychiatric evaluation.

Escalation. Escalate: To increase. To become or cause something to become greater, more serious, or more intense

Hallucination. False sense perception. The perception of somebody or something that is not really there, often as a symptom of a number of psychiatric disorders or as a response to certain drugs.

Involuntary (as in evaluation or hospitalization). Compelled. Required or exacted against somebody’s will or wishes

Involuntary Hospital Admission Criteria:

- Has a mental disorder AND
- Needs inpatient care or treatment AND
- Presents a danger to the life or safety of the person or others AND
- Is unable or unwilling to be admitted voluntarily AND
- There is no available less restrictive form of intervention that is consistent with the person’s welfare and safety.

Mental Disorder - statutory definition in *Md. Code §10-620*.

- The behavioral or other symptoms which indicate
- to a lay person: a clear disturbance in the mental functioning of another individual; or
- to a physician, psychologist, clinical social worker or licensed clinical professional counselor doing an examination: at least one mental disorder that is described in the American Psychiatric Association’s Diagnostic

and Statistical Manual of Mental Disorders (DSM).

Outpatient civil commitment.

Where a judge has ordered a person to comply with psychiatric treatment and if s/he fails to do so, s/he will be hospitalized involuntarily. Such a law is in place in other states, most notably in New York where the law is called “Kendra’s Law.”

Psychiatric Crisis. In most situations, a psychiatric crisis is characterized by at least one of the following:

- Active danger to self or others (this includes suicidal thinking or behavior, high risk behavior, thinking about or doing harm to others and violence toward property)
- Passive danger to self or others (this includes serious neglect of self or of others in one’s care)
- Sudden change in mental status
- Acute psychotic symptoms

Psychosis. Loss of contact with reality. A psychiatric disorder such as schizophrenia or mania that is marked by delusions, hallucinations, incoherence, and distorted perceptions of reality

Reason to Believe. A standard somewhat less than “probable cause”; certainty is not required. The facts should “warrant the belief of a prudent person.” “Reason to believe” may be based on an examination by a health care professional or observation. If a police officer observes the individual, s/he does not necessarily have to observe the behavior that indicates a mental disorder or dangerousness. “Reason to believe” may also be based on information obtained from family members concerning the mental disorder or dangerousness.

Ultimatum. Final demand. A demand accompanied by a threat to inflict some penalty if the demand is not met.



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I would consider going with other NAMI volunteers to educate the community, health or criminal justice professionals and/or policymakers about our issues (training offered)

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Documents and information submitted to the State of Maryland are available from the Secretary of State for the cost of copying and postage.