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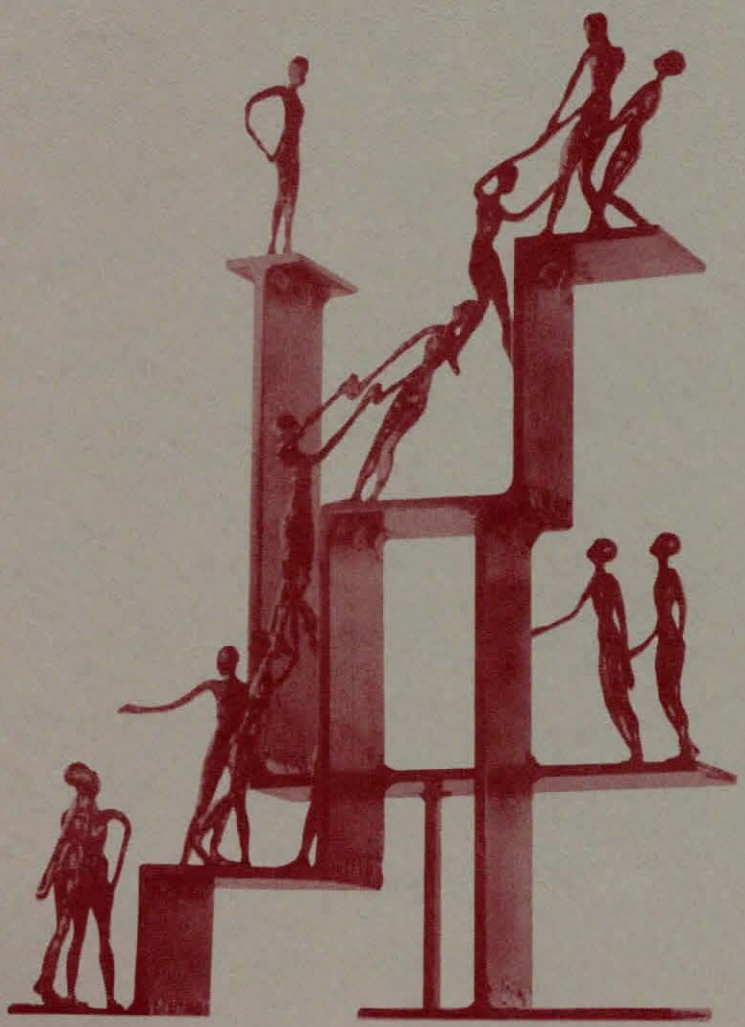
Help is within

REACH



A guide to forming self-help support groups for families of the mentally ill.

by
Barbara H. Muse
Assistant Director
Mental Health Association
in Forsyth County

Help is within REACH

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Additional copies may be purchased from:
Mental Health Association in Forsyth County
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(919) 723-9678

I dedicate this book as a
Tribute to my Dad,
Who unknowingly inspired much of my work
and helped to make this program a success.

Throughout his lifetime, Clyde Henderson had a mission. To make the world a better place to live, and to help those who were down and out, no matter what the reason. This remained constant, in his sane times and in his times of illness. Even when he became irrational about ways to accomplish this, the purpose was still the same.

What my Dad did not know was that his illness was the catalyst for forming family support groups in North Carolina. His illness helped identify the need for some changes in our laws, including the new outpatient committment law; and it was his illness that created an awareness of the need and developement of a large psychiatric unit in one North Carolina County.

Clyde passed away the week of Father's Day, 1984.

During his lifetime, I could not say in print that he was mentally ill, although when in his well mind he would have wanted it known if it could help someone else. The first step toward that help is the family's willingness to admit there is a problem.

One out of three families has a seriously disturbed loved one. When we families join together to bring mental illness out of the closet and promote research into the causes of mental illness, Dad's mission can be accomplished.

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SUPPORT GROUPS
A New "Front Porch Swing"

Being human carries with it many burdens of everyday living. For ordinary, everyday living, most people have coping skills that keep them funcitioning at an adequate level.

However, when life's major crises come along, few people can handle them alone. In the early days, every family or neighborhood had at least one large front porch with a swing or two where family and friends gathered in the evening or on Sunday afternoon. If someone were experiencing a major crisis, there was much support from those who had known you since you were "this high".

In today's world, things are different. Few persons have front porches and a swing any more, and even fewer have family and friends nearby who have known you for any appreciable length of time. If you are having a particularly hard time, there may be no one who you know who would understand what you are experiencing. With the apathy of many neighbors, you're afraid to open up and talk about your difficult time.

It is the absence of such support that has created a need for a new type of "front porch" setting. Self-help support groups are composed of persons who've experienced similar types of problems, sharing the knowledge they've gained, searching together for ways to survive. These self-help groups provide an avenue for participation . . . a place where the alienated feel their voices are heard and their experience counts. Within the past ten years self-help groups have spread from coast to coast, touched virtually every field, ballooned to a total of 500,000, and now involve 15,000,000 Americans.

Any number of persons sharing a common bond may develop a group for the purpose of support. In the case of REACH (REAssurance to eaCH), it is the common bond of having a mentally disturbed family member or close friend.

The first sense of relief comes when a person is willing to discuss his problems and discovers others have experienced similar situations. The discovery of other "inhabitants on the island with you" is very comforting. Together, sharing situations, the basic problem may be identified and solutions sought and accomplished.

A professional perspective

"I firmly believe that when a member of the family hurts, is sick, the whole family suffers and is affected. And I'm concerned for the family, particularly when that family is faced with a catastrophic illness."

Because of these feelings, says Dr. Arnold Nelson, he has become involved with REACH (REAssurance to eaCH), one of the programs of the Forsyth Mental Health Association, a United Way agency.

Dr. Nelson and his wife, Dr. Rosemary Smith Nelson, are both volunteer consultants for REACH. "Dr. Arnie," of course, is the hospital's Chief of Psychological Services, and both Drs Nelson (she is in private psychological practice) have been involved with the Mental Health Association program for several years. They are the only psychologists, in fact volunteering their professional services with the program.

The group, comprised mostly of people who are children or parents of psychologically disturbed family members, meets each week and provides a base from which these family members can help each other. Dr. Nelson applauds the participants' efforts to help themselves, to interact.

"My role is not therapeutic, but supportive," he emphasizes. "As a volunteer consultant I'm there to answer questions and sometimes provide information regarding selective topics. My wife and I, both professionally trained in psychology, have a deep interest in family concerns which are not often met through traditional treatment procedures. So we recognize a need for such support."

As for his personal interest in the agency as a volunteer, Dr. Nelson explains, "I'm 'need' oriented. I see a need out there for psychological consultants. To be sure, there are plenty of others who could do it, and I'm just flattered that the Mental Health Association sought us out to the involved. We're grateful that we have certain skills to meet some of these needs."

Obviously, Dr. Nelson supports this United Way agency. He says he applaudes all of its efforts, and that "some of the things it is doing are fantastic." He is especially appreciative of the Association's educational activities and its consultant relationship with other agencies.

Reprinted courtesy of:
VITAL SIGNS
Carolina Medicorp, Inc.
Special, August, 1984

"I'm just flattered that the Mental Health Association sought us out to be involved," says Dr. Arnie Nelson and his wife Dr. Rosemary Nelson. The couple counsels a support group for families of psychiatric patients.

Friends are Good Medicine

Recent medical research evidence indicates that supportive relationships are critical for the maintenance of health and the prevention of disease. Especially in times of crisis, social support helps buffer a person from the dangerious effects of stress. It has been determined that 50-80/% of **all** illness in this country is stress-related. Studies have proven that supportive relationships are particularly important in moderating excessive stress.

Most people think the growth of support groups is a phenomenon of the past twenty years. It is true that many support groups have been established in recent years, but the fundamental nature of support groups has been around since the dawn of civilization - people helping people - coping with problems and overcoming the difficulties of life's crises. Medical investigators call it "social support", health professionals may call it "natural helping networks", social scientists may call it "supportive networks" - whatever the name, the importance remains unchanged. It is the positive interactions between people; exchanges that provide a person the information that they are cared for and loved, esteemed and valued, and that they are part of a group or network of communication and mutual obligation.

Support groups are useful for sharing concerns and releasing pent-up stress and frustration. Support groups provide positive reinforcement to maintain change, role models for effective coping strategies, identification with fellow-sufferers, and an oppurtunity to give and receive concrete assistance. Perhaps most importantly, the support groups assure members that they are not alone in dealing with their problem and that there is hope for resolving the crisis successfully.

In many ways, support groups are the best examples of social support at work. What may begin as a group of strangers transforms into a network of supportive friends - and many times, friends are indeed the best medicine.

Steve Catron, Founder and Director
The Center for Social Support
Winston-Salem, N. C.

HELP IS WITHIN REACH IN FORSYTH COUNTY

REACH (REAssurance to eaCH) began in Minneapolis, Minnesota in the late 1970's when Bobbie Glaze approached the Mental Health Association about such a support group, out of her need as the wife of an Alzheimers victim. Karen Peterson was the sympathetic staff person who said, "Let's do something about this need."

In June 1978, at the National Summer Institute in Mobile, Alabama, I talked with Karen and came back to Winston-Salem excited about the possibilities of such a group. I had several interested persons who began doing a community survey, talking and planning. The committee persons were interested, but did not have an ill loved one and just did not have the "driving need" to get going. My personal time was very limited. Perhaps because I was not in a crisis and was seen more as the professional than a family member, the idea was put on hold for a few months. It was not until Lynn (last name confidential), the father of a young woman with schizophrenia, came in. that we were able to get going.

In September 1979, the MHA's Introspect Series began with a public forum about the mental patient from various perspectives, described elsewhere in this booklet. At that meeting, it was announced that the group would begin on the following Monday. From this meeting, we have grown from the original twenty-six members to over one hundred families. The average attendance at meetings is fifteen. There have been as many as sixty at some educational meetings.

A lending library of books such as: *Surviving Schizophrenia*, by E. Fuller Torrey, *Irregular People*, by Joyce Landorf, and others has been very valuable to our participants as educational resources. As needs have surfaced, flyers have been developed to try to meet some of these needs. (See Appendix.)

This booklet attempts to describe in detail how such a program may be established in your county. If you already have a family support program, hopefully you can find helpful hints for improving. The principals in this booklet may be used in the formation of any other kind of Support Group, (i.e., Widowed Persons, Parenting, etc., etc.)

SUPPORT GROUP DEVELOPMENT

Community Readiness - Laying the Foundation

For some special support groups, a survey may need to be done to see if there is really a need. You may already have identified the need and some persons who will be participating. In the case of families of the mentally disturbed, there ***is*** a need in ***every*** community. There probably are persons who are already asking for such a group.

Even though you know people could be helped by such a group, do "they" want it? Identify a few persons who do ***need and want*** this group. They will become your key persons in developing an ongoing system of support.

Gather a few interested persons as a committee to begin working out plans. The committee should be composed of at least one or two (preferably three or four) persons who've experienced the situation for which the group exists. (In the case of REACH, the common bond is living with or being closely associated with a mentally disturbed person.) Professionals and other interested citizens should be included on this committee. Persons with skills such as public relations, leadership skills, someone with clout among the counselors, psychologists, psychiatrists, physicians, etc. would be helpful. Planning should include answers to such questions as: When would we like to begin? What are the costs? Who will do the publicity, and how? Who will seek an appropriate location? What should we consider when looking for a place? Who will be the facilitator(s)? What should be the name of the group? Etc., etc., etc. the design and name of the group is up to your committee. However, I strongly believe that continuity of the name (REACH) and even design of the brochure will help spread our message across the country as citizens move from one community to another. The photograph on the front of the Winston-Salem brochure is available for loan if you desire to use it.

As you begin, it is very important to seek the support of professionals in the community. (See our letter of Introduction to Professionals under Public Introductions.) Explain the purpose of the group (in a letter, through phone calls and visits) to the physicians, psychiatrists, counselors, psychologists, ministers, and other professionals who may know families with disturbed members (or for another type of support group, those who know potential clients). Make it clear to them that this is not a therapy group. The support the members receive is very therapeutic, but is not to be confused with therapy. Solicit their willingness to refer persons who need such a group. When introducing it to professionals, assure them that it will not take their clients, just the reverse has been the case. Many persons in support groups recognize a need for more intensive help and are encouraged by others who have received such assistance.

It is most important to have two-way referrals. Professional support is a must.

Location Planning

When looking for a place, be sure to consider such things as: cost; safety, remembering that some females may need to come alone; lighting (inside and out); easy accessibility for persons not familiar with the area and/or handicapped; and comfortableness of the facility.

Churches, community centers, or many other public facilities may be available at no cost. It has been our experience that many persons wish to meet away from the community Mental Health Centers for various reasons. This might work in your community but get a feel of the opinion of potential members. The area for the ongoing support group must be casual, basically circular seating, "living room style".

A room with movable chairs and permission to move them is adequate. "Board meeting" types of rooms just do ***not*** lend themselves to support. There is something about having a hard table between participants which prohibits the closeness and warmth necessary for giving and receiving of support. Auditorium style is adequate for panel discussions and other information-type meetings, but ***not*** for the support group itself. The proper setting is a crucial factor in maintaining a warm supportive atmosphere. Church parlors are usually excellent. Doctor's office waiting rooms "after hours" are another good resource.

Brochure

Prepare a brochure which will be easy to read and eye-appealing. The brochure should include the basic purpose of the group, emphasizing confidentiality, the right to remain anonymous, and perhaps the basic rules of the group. A telephone number or address where one may get complete information is an essential. Home telephone numbers may not be a wise choice unless the person is willing to be called at all hours of the day and night. There are a few in almost every community who cannot make discreet decisions about when it is important enough to call at any hour. There will also be times the patient will see the brochure and will call, even collect, from "who knows where". Answering machines are very disturbing to a family in crisis. Hopefully there is a Mental Health Association or Crisis Hot Line in your community that can provide live coverages of a telephone at least during normal office hours.

Before the printing of a brochure, it is helpful if the frequency of beginning meetings has been determined by the committee. Leave room for flexibility according to need. Once your group begins, time, place, and frequency of meetings may need to be changed. A careful choice of wording, such as, "frequent meetings will be arranged to meet the need, "and" for information on exact time and places, call your Mental Health Association at ..... This will eliminate the need to reprint the brochure immediately.

Publicity

After all plans have been made, the brochure printed, the time and place chosen, and before the group begins, there should be a big "publicity splash". The identified professionals who will be a referral source should be given a few brochures with an accompanying letter or visit. Radio, TV and newspapers should be approached for the maximum possible exposure.

For personal appearances of TV or radio, you may wish to get a family member (in the case of REACH) from some other area of the state. It is very difficult because of safety as well as confidentiality for families to say publicly that they have a mentally disturbed loved one. Many times the disturbed persons refuse to admit or are unaware that they have problems. Newspaper articles may use aliases and hide the identity of a person being interviewed. They may change sex and other identifying facts.

Public Introduction

Public introduction to the group needs to be well planned. Perhaps you begin with a panel discussion, a dynamic speaker or whatever your imagination and resources may include. Our original introduction to the community was a panel discussion of the effects on the family from living with a mentally disturbed person. The discussion included perspectives of a family member, a pastoral counselor, a school special education instructor, and a family physician. At the closing of this meeting , regular support meeting plans were announced to begin the following week. The letter below was sent to all mental health professionals, school guidance councelors and family physicians in Forsyth County.

Mental Health Association in Forsyth County

An affiliate of the North Carolina and National Associations for Mental Health

409 Summit Street

919-723-9678

Winston-Salem, N.C. 27101

Anne M. Compere
Executive Director

August 30, 1979

Dear Friend of Mental Health,

The Mental Health Association in Forsyth County is introducing a new service to our community we will call REACH. This is an acronym for REAssurance to eaCH and provides much the same support for the families of the mentally ill and emotionally disturbed as Al-Anon does for families of alcoholics. It is designed to help those who are experiencing guilt, frustration, financial burdens or new family responsibilities because they are emotionally involved with a family member suffering from mental illness. REACH will provide support and information in an informal atmosphere where problems can be shared with others who have had similar experiences.

REACH has a three-fold purpose:

- to make available information and education about mental illness.
- to provide a resource group of professionals; psychiatrists, clergy, attorneys, bankers, social workers, as well as non-professionals whose expertise would benefit the group.
- to offer a supportive community for people who feel cut off from the mainstream of social activity due to their emotional commitment to the mentally ill person.

As a part of Introspect, our educational series, a panel discussion entitled The family of the mentally disturbed needs help too! Help is within Reach!, will be presented at Highland Presbyterian Church Activities Building on September 25, 7:30-9:00 p.m. Panel members will be Lee Dukes, Pastoral Counselor at North Carolina Baptist Hospital; Carolyn Lee, Coordinator of Family and Marriage Therapy at the Forsyth County Mental Health Clinic; Jane Matteson-Whistler, Director of Special Education, Winston-Salem/Forsyth County Schools; and a family member dealing with these concerns. The panel discussion is free and open to all.

Future meetings of REACH will be held weekly at a convenient Winston-Salem location. This will be announced at the above meeting. For information regarding REACH, call Barbara Muse (919)723-9678.

Please distribute the enclosed brochures to those in need of this support. The Mental Health Association and I hope you will include these two brief announcements in your next bulletin or circular. Everyone will benefit.

Sincerely,

Lynn
Chairman, REACH Committee

LJ:bhm
Enclosures

Meeting Preparation

When introduction to community, date, place, format, and publicity are being arranged, appoint a hostess who will take care of the "nitty-gritty" details such as the key, refreshments, seating, microphones, chalk boards, etc., as needs dictate. If refreshments are planned, I believe it is important to keep them simple. You do not want to set a precident that will be difficult to continue. The purpose is support not food.

Basic guidelines should be adopted prior to the printing of the brochure and the first meeting. These are subject to change by the group once the group is established. Guidelines used by the REACH group in Winston-Salem, developed over a period of time, are as follows:

* We are a group of people with a common bond sharing our troubles, understanding, strength, and wisdom.

* We listen, explore options, and express our feelings. We do not prescribe, diagnose, judge, or give advice; we suggest.

* We know what we share is confidential and that we have the right to remain anonymous if we choose.

* We have the right to take part or remain silent in any discussion.

* It is important that we actively listen when someone is talking and avoid having side conversations.

* We encourage "I" statements, so that everyone speaks in the first person.

* Having benefitted from the help of others, we recognize the need for offering our help to others in support groups.

* We have the opportunity to participate in advocacy with the Mental Health Association.

* We ask that you do not smoke inside the meeting room. If you must smoke please sit near the door or step outside. (Rooms with adequate ventillation may not need this rule).

When meetings are begun with the reading of these guidelines, the facilitator has a much easier task of keeping the participants "on track".

WHEN THE SUPPORT GROUP BEGINS

Basics

Some do's and don'ts for the introductory and future meetings:

DO welcome each person warmly. Make him feel at ease.

DON'T ask last names. Introduce yourself and welcome them. When they want to share their identity, they will offer their names.

DO give **the right to remain anonymous.**

After the group begins, emphasize the confidentiality. reiterate your welcome, the right to remain anonymous, and the right to refrain from discussion or to participate.

It is good to give the participants a chance to sign their name and address for a confidential mailing list used for notification of future events. Make certain that it is used only for this purpose and that those signing know that it is for that purpose only and will remain confidential.

Facilitating the Group

The facilitator should be "one of the group," not a professional, unless it is a professional with a mentally ill family member. The groups that have failed were led by professionals who have not experienced the common problem.

At the beginning of support meetings, you will need to:

- Read the proposed guidelines. Stating guidelines at the beginning helps the facilitator keep the discussions appropriate. Without guidelines, it can become a gossip session, intellectual discussion, or utter chaos as everyone tries to get into the act simultaneously.

- Get to know each other; share a little about yourselves. The facilitator may wish to tell something about her/himself first as sort of a pacesetter. When you reveal things about yourself and the struggles you've faced, others' hesitancy begins to dissappear.

- Establish frequency of meetings. We have found that with weekly meetings, no one gets confused about which week the meeting is being held.

Initially, we met weekly and this was very beneficial. We devoted two meetings per month to education, and two totally to sharing and support. At one point we tried bi-weekly meetings and found this not to be enough. If someone missed one meeting then it was a month before he could be back and if this happened to be the educational meeting, it could be two months without the sharing supportive meeting. We have discovered our best schedule to be weekly meetings with one educational program monthly. Once each month we have a psychologist as a resource person, the psychologist, helps to validate out feelings and beliefs. We also have an attorney who occaisionally comes to answer questions on legal concerns. (We make sure it is not free legal advise - just information type help - i.e. power of attorney, guardianship or competency type information.)

- Provide a few printed materials on relevant subjects, if available. (See Appendix for samples of materials we have developed to meet the needs as they have become evident.)

- Encourage a relaxed atmosphere. A cup of coffee, or glass of tea, helps set the scene. Do not let it become a competition of who can prepare the most elaborate refreshments.

- Dismiss **ON TIME.** Some persons need to leave, but hate to leave during the meeting. Encourage all who can, to stay around and get to know each other. Much of your support actually occurs here in groups of two or three, especially when the group becomes large.

- **DO** emphasize confidentiality. Remind participants when they leave **not** to take shared information out to others.

- **DON'T** allow anyone to impose his solutions, religion or theories on someone else. He may state his own beliefs, ideas and solutions, but must claim them as his own without "you should" or "you ought." They may be expressed by saying "have you considered..," or "have you tried..," or "this worked or did not work for me." "Shoulds" and "oughts" will wreck a support group quickly.

- **DO** try to keep away from religious beliefs, as some persons may be non-religious or of various faiths. Recognize everyone's belief system as valid for him/her. Closing with a moment of silence encouraging thoughts of love would be good. Try to avoid prayer as such as this could be offensive to some.

- When discussions become theoretical or hypothetical, bring them back to focus on "what is going on with you?", "how are you coping?", "what can we as a group do to help you?", "what are some things you do to deal with your stress?", "tell me about...", "would you like to share more about that?". Lead with some open-ended questions.

- **DO** focus on the persons present - - their feelings, frustrations, shared solutions and perhaps most of all, what they might do for themselves for pleasure, relaxation, to feel good about themselves. (The family cannot help the patient if it falls apart.)

- Do **NOT** allow anyone to talk about someone not present, except in such cases as that a regular member is in crisis and needs our support. The details of the crisis probably do not need to be given unless that member has asked that you share the information.

May I reiterate the facilitator must see that no one person monopolizes the conversations, that others listen when someone is talking and that no one be allowed to give "shoulds" and "oughts". the only "should" allowed is that everyone should be allowed to make his own decisions.

It is best not to make a habit of collecting money at the meetings for **any** reason. Some persons are financially devastated after paying major medical bills and are not able to contribute money. Do not embarrass them by asking for money. If persons offer to buy coffee, ice, cups, etc., they may be allowed to, but **do not ask.** Ask for their time as a volunteer sometimes; most want to help once they have been helped. From the members, you will identify the greatest group of volunteers as they begin to cope better with their situations.

An ideal support group will have from three to twelve persons. Too large a group is difficult to handle; however, there are some ways to deal with larger groups. If the small core-group grows slowly to a larger group, they do not want to divide their "family" so care must be taken to see that everyone has time to receive the support he needs.

One way we have accomplished this is to allow everyone a brief time to state what is going on with their family member and how they are coping right now. After everyone has had this brief time, we close and encourage everyone to stay and talk. People then automatically gravitate to persons with situations similar to their own. There are then several groups of two or three helping each other. Light refreshments help at this time, but are not necessary. We allow, or sometimes even encourage, members to bring light refreshments when they desire, but do not feel compelled to provide them each time. On cool days we do provide instant coffee and a pot of hot water, or an occasional bag of ice and some cold drinks in the summer (tea, Coke, etc.) but we never make this a high priority.

The facilitator needs to help the members look for humor in their situations. Emphasize the importance of laughter and help them to relearn how to laugh. Most families have forgotten. Try to close most meetings with a pleasant thought, poem, or appropriate joke.

Characteristics of Groups

As a group progresses, you will find three basic groups of persons. Each needs a different type of on-going help. The first group are **those in crisis**, perhaps for the first, second, or third time and who have never been able to discuss their situation with anyone; they are hurting and need lots of T.L.C. and encouragement. The second group are **those who have been dealing with the illness and have learned to cope**, but want to learn all they can about mental illness (or other problems). These families are beginning to accept the fact that the loved one will probably never recover. This also is a very difficult stage and the family needs much support. They are needing answers and a feeling of being needed. With a little training, or if they have had group experiences or group training, they may become great facilitators. Thirdly, **persons who have accepted the fact there is nothing that can be done for their patient**, but they are **commited** to identifying the problems and **changing "the system"**. The needs of all these persons may be met with careful planning.

Members at any stage of progress need information on a wide variety of subjects. As the group begins to identify problems which they cannot answer, they will need to invite speakers who can answer (i.e., the person who signs commitment petitions, someone from the treatment facilities in the area, a psychiatrist, a lawyer, a social worker and many more). Care must be taken, however, that all meetings do not become speaker meetings. Even at speaker meetings, a brief time should be allowed after the speaker has adequate time for questions and answers, to give support for those in crisis. A major characteristic of every group is, there is usually someone in a crisis.

Some groups open their informational meetings to any interested persons, but open their support sessions only to persons who are very close to a mentally ill person.

A Group Observer

We have from time to time had reporters, nursing students, law students, and others request to observe the group. We soon realized the members felt a real need to go back and repeat their entire history to these persons. The members came away feeling empty; it did not meet their need as a group when this occurred. Now we limit such visitors to one every "now and then." When one does come, I ask that he come just as a new family member, not ready to talk about the sick one. At the close of the meeting I will introduce him and remind this person again in the presence of the members of the confidentiality of all that has been shared. This has worked adequately most of the time. On two occaisions I introduced the visitors, had them sit back a little behind the members and asked the members not to feel the need for past history, but rather to go ahead as though the visitors were not present. This worked, but not as well as the "newcomer" approach.

The Disruptive Participant

From time to time a disruptive person may attend. For example, there may be a manic depressive personality type who believes it is his/her spouse who has the problem. The facilitator must be strong enough to remind this person to share time with others, draw the line if the disruptive person starts giving shoulds and oughts. We sometimes remind this person that this group is supportive and not therapy and perhaps his/her problem is so severe or deep or complicated that we do not feel adequate to help. We have on occasion suggested a professional who might be able to help with his/her type situation. We never say, "I believe it is you who has the problem." We go along with the concept that it is the spouse. These persons rarely come more than once or twice as their needs do not get met here. They find the group will not make "it" go away and will not solve the problem for them. We do suggest as we would for any other. On a few occasions, I have personally called someone confidentially after the group and suggested professional help because of "our feelings of inadequacy," not because "he is sick." In such cases the use of "I" or "we" statements of taking blame cannot offend too much.

In the case of a person who came for several weeks but never shared, it finally came out that she was of a religious sect that believed our mentally ill persons are possessed of demons. She wanted us to get her into the hospitals to "cast out the demons" when a family member became hospitalized. This is when our stand on not discussing religious matters became very important. We used that stand to say we did not impose our beliefs, or allow anyone to discuss or impose theirs upon the patients. It was suggested that she could offer proayer or whatever she chose for the families and patients in the privacy of her home or church as long as it was done silently. We reminded her of the confidentiality of patients and families. She began coming less frequently as she discovered she could not accomplish her mission.

Each difficult, disruptive person must be handled individually, but with the group guidelines, in most cases this can be done tactfully., However, for the sake of the group as a whole, I would not hesitate to just bluntly say, "You do not quite fit into this group," if it became necessary. Preserving one person's feelings at the expense of the group is too high a price to pay. If you deliberately hurt feelings, you have a problem. However, if you do what has to be done, for the sake of the group, and the disruptive person's feelings are hurt, he has a problem.

THE ONGOING SUPPORT GROUP

Advisory Council

The committee which was formed at the beginning may continue to serve as an advisory council or such a council could be appointed. Always include at least two active members of the group in a council. In the early months, frequent times of evaluating the meetings, looking at its strengths and weeknesses, should be planned. Such a council should be an ongoing adjunct to the support group. A primary purpose of this council would be to reaffirm and offer guidance to the facilitator. A close watch for needs and ways of meeting these needs of the group and resource and referral are other purposes of this council. Council members probably should be persons who attend occasionally and have a "real feel" for the families' needs. The council should always keep in mind the primary purpose is ***SUPPORT***. Do ***not*** let it get away from that. Bring in as many extra's as you need or want, but always focus on support. This is a must if the members are to develop the closeness and rapport needed for an ongoing group. In Forsyth County, we have two psychologists (a husband-wife team), who attend once each month as a volunteer resource. They stay somewhat in the background during meetings, being primarily a resource and sounding board. They are very careful not to become "therapists" leading a therapy session. Occasionally we or they will identify a specific recurring type of problem. We ask them to lead an entire session on that specific problem as part of our education program. By staying so closely in touch with the group, they make excellent council members and advisors. A member of your Board of Directors would be a valuable asset to this council as a liason between the group and board, keeping the Board apprised of progress and needs. If you have a board member who has experienced illness in the family, that person could be a real asset.

Evaluation

Frequent meetings of the planning committee following the initiation of the group are needed to evaluate the process, needs and effectiveness. This will help to keep the group running smoothly before problems develop and become part of the pattern.

Do not judge the **success** of the group **by the attendance.** Some of the best, most successful groups I've attended have had only three or four persons . If you can get three or four regulars to learn to lay their feelings "on the line" and develop trust and a good, solid "family feeling," then the group will grow when they reach out one by one as new persons come in.

When groups begin very large, it is very difficult for members to have enough trust in each other to really open up and become close-knit. It can be done, but trusting and openness has a better chance if the large group is broken into smaller ones.

The council should be constantly aware of the members needs and be alert to when needs are not being met. Ask the members from time to time if there are topics that need to be discussed. Introduce a fresh approach occasionally and observe the response. Give feedback to the facilitator on how to keep the group open and helpful. This can only be done by frequent evaluation.

COSTS AND FUNDING

Basic Costs

The printing of a brochure and perhaps letters, postage, and initial supplies are all that are absolute necessities. A business donation or small grant could be sought if no funds are available. The rewards to both the family and the community are significant.

An occasional mailing to members with a schedule of special events may be desired. Printing and postage should be considered. (See sample letters in Appendix)

If not otherwise available, the group may wish to purchase its own coffee pot, cups, etc., but most of these items may be donated by interested persons.

A staff person devoting at least 20 hours per week can be extremely helpful to such a group but is not required. A very interested volunteer could at least begin the process. In the event staff is desired, I shall include tips on funding from foundations and other sources.

Funding Proposals to Foundations or Other Sources

State clearly in the first paragraph the amount of funds being requested. The proposal should contain:

1. A concise description of the project
2. What the project hopes to accomplish
3. Total cost of the project
4. Funds on hand or pledged and from what sources
5. Other sources being approached.
6. How future funding will be obtained if the project is a continuing one.

Attachments should include:

1. A complete line-item budget.
2. A list of the governing board of the petitioning organization.
3. A copy of the federal tax exemption certification under Code Section 501 (c) (3), except in the case of a governmental agency.
4. Supplementary materials in support of the proposal may also be sent.

The following pages are a sample of our grant proposal for **REACH** and the **Court Assistance Program** funding

Mental Health Association in Forsyth County

An affiliate of the North Carolina and National
Associations for Mental Health

392 S. Stratford Road
Winston-Salem, N.C. 27103

Thruway Shopping Center
919-723-9678

Anne M. Compere
Executive Director

Barbara H. Muse
Assistant Director

April 30, 1982

Kate B. Reynolds Poor and Needy Trust
Charitable Funds Management
Wachovia Bank and Trust Company, N.A.
P. O. Box 3099
Winston-Salem, NC 27102

Dear Committee:

We deeply appreciate the opportunity of submitting the enclosed application for program funding from the Kate B. Reynolds Poor and Needy Trust.

The Mental Health Association in Forsyth County is a non-profit, non-governmental agency whose objectives include the promotion of good mental health and the care, both short and long term, of those who suffer the debilitation of a mental illness.

One of our programs called REACH is described in the enclosed material. It is a direct service to both the patients and the families of those who are mentally ill. It often involves direct crisis intervention and/or personal support from one of our staff members. It is becoming increasingly apparent that much more time and attention should be paid to this population. With additional staff time and financial resources, we could begin to more adequately serve these dire needs.

We estimate that sixty percent of the daily work load of our Assistant Director, Ms. Barbara Muse, could be spent on this program and its related individual cases. Enclosed is the write-up of a typical case that grew out of her present involvement in the courts. Ms.Muse will also be involved in the training of volunteers who assist weekly in our community outreach.

A breakdown of the $12,237.81 we request from you is indicated. $7,874 would be used to pay the salary of Ms. Muse. The use of the remainder of the grant is shown under F., Budget Requested, in our stated proposal.

We are including for your information a very few samples of the types of materials we need in considerable quantity for free distribution to families dealing with mental and emotional illness.

If further information or clarification is needed or desired, please call us at 723-9678.

Sincerely,

Lena C. Godwin

(Mrs.) Lena C. Godwin, President

LCG/jc

Enclosures

Title: REACH

Program Director: Barbara Muse, Staff

J. T. (last name confidential), Chairman

Need Established:

Knowing that more than one person in every four families in America suffers from some form of mental illness, and that during psychotic, manic, depressed or other severe episodes, the entire family suffers through extremely stressful situations, **REACH** (REAssurance to eaCH) was formed in Forsyth County to offer assistance to these families.

Type of Program:

Support system for families and friends of the mentally ill, emotionally disturbed, and/or substance abusive persons (hereinafter referred to as MIP).

Purposes:

A. Reduce tension and stress in homes of MIP, minimizing possible additional breakdowns of the other family members.
B. Reduce tension in neighborhoods that could and frequently does erupt into violence.
C. Increase coping skills.
D. Identify sources of stress.
E. Seek solutions to problems causing these stresses.

Goal:

To be available to all families and friends of MIP s in times of crises.

Audience:

A. Families who believe that a member has an emotional disturbance, mental illness, alcohol or other substance abusive behaviours.
B. Families whose MIP voluntarily seeks help for problems.
C. Families who successfully persuade their disturbed person to seek help.
D. Families who have to pursue legal enforcement to get help for a loved one. (This group is the one with the greatest risk of violence and additional breakdowns.)
E. Neighbors and friends of MIP's.
F. Students and professionals who wish the opportunity of learning more about and working with this particular population.

How Audience is Reached:

A. "Help is within **REACH**", a public forum dealing with issues surrounding the family of the mentally ill.
B. Referrals from physicians and therapists.
C. Clerk of Court who handles involuntary civil commitments.
D. Volunteers in court at commitment hearings.
E. Word of mouth of current members.
F. Newspaper calendar of events.

How Purposes are Met:

A. Educational **REACH** meetings held once each month, open to all families and friends of MIP's.
   1. This meeting is led by visiting professionals from community agencies, police department, attorneys, psychiatrists, etc., as a means of supplying answers and resources for the numerous problems faced.
   2. Small amount of time is allocated for support with one-on-one interaction following this meeting.

B. Support meeting, held every Monday:
   1. Two volunteer psychologists are meeting with this group to lend guidance as members seek to support each other. Sharing of experiences and solutions is the primary method used in this meeting.
   2. Stress reduction upon family members is achieved by:
      a. Identification of sources of stress. Key sources are:
         1. High costs of long term treatment and continued medication
         2. Legal problems due to inappropriate behaviour of the MIP
         3. Constant hassles due to living closely with one not capable of making appropriate choices, including repeated destruction of personal property.
         4. Inadequate housing for the "adult children".
      b. Sharing ideas of "what has helped me" in similar situations.
      c. Sharing information on sourches of help.
      d. Talking with people "who understand".
      e. Learning to laugh when crying would do no good.
      f. Seeking to solve problems which may have possible solutions.
      g. Recognition and acceptance of things which cannot be changed.
      h. A telephone network - numbers to call when **REACH** members need someone who cares.

C. Commitment Assistance:
   1. Offer support and information prior to judicial hospitalization hearing. Patient has court appointed attorney. Family has **no** one. Effective March 10, 1982, the Assistant District Attorney who had been representing the families legal interests, was removed from the court room. The family is now left to flounder through an involuntary commitment with no one to assist except a **REACH** volunteer, unless they can afford a private attorney. It has been the experience of the volunteers that most attorneys do not fully understand mental illness, do not have a thourough understanding of the mental health laws, and have no idea of what other options are available.
   2. A volunteer is present in the courtroom, observing hearing proceedings. Follows petitioner from courtroom if they seem not to understand what actually happened or if they disagree with decision.
   3. Helps to clarify "what happened". Helps to answer "now what?" "What If?" "When he or she returns, what . . . ?" Also a resource of other options in cases where patient is released.
   4. Resource on housing, community programs and financial assistance.
   5. Resource of patient and family "rights."
   6. Clarification of mental health laws.

D. Other Assistance:

1. Being supportive by attending court with family member when MIP is involved in criminal acts.
2. Hold community meetings to discuss problems and work on solutions.
3. A community resources directory has been requested by the National Center for State Courts and several attorneys. This directory is being compiled and will be published and provided to commitment attorneys as soon as money becomes available.

E. Hope For the Future:

1. Families and friends are getting active on legislative committee, trying to improve laws, seek funding for residential care and establish needed facilities.
2. Through learning experiences in the support group and one-on-one contacts, it is hoped that our response to the patient when he/she returns home will be more positive and healing.
3. Meetings with legislative persons, police officers, judges, mental health authorities (state and local) lets families know their concerns are being heard. Solutions are being found for many of the problems.

F. Budget Requested:

Salaries and Benefits:	
Program Director (60% of full-time salary)	$7,875.00
Secretary (5% of full-time salary of Administrative Asst.)	550.00
Medical and Life Insurance (60% and 5% respectively)	448.25
FICA and Unemployment Tax (60% and 5% respectively)	724.56
Transportation	240.00
Continuing Education, workshops, & Staff Development	400.00
Literature:	
Pamphlets for distribution to clients and potential clients	500.00
REACH Brochures for potential clients - reprinting	300.00
New Mental Health Resources Directory to be used by clients as well as by all professionals involved in civil commitments (recommended by the national Center for State Courts)	
Postage and Mailings:	500.00
Brochure mailing	50.00
Printing of routine mailings	100.00
Postage for routine mailings	200.00
Emergency Assistance:	
Transportation, medication, etc. for poor and needy clients and families	200.00
Refreshments for Support Meetings and Miscellaneous:	150.00
Grand Total	$12,237.81

SAMPLE CASE

A typical example of additional assistance to a family and patient was a case held in District Criminal Court on April 27, 1982. I shall begin at the first of my involvement with this case.

In mid-March of this year, a 20-year-old man appeared in commitment court. The psychiatrist at the Mental Health Clinic In-Service Unit had said he was not commitable as defined by the law and he planned to dismiss the case. The young man said that though they had helped him in the few days he'd been there, he knew if he went home that day, he would hurt someone. He pleaded to be held. The judge thought he needed additional help and commited him for "up to 30 days". The family took him to Forsyth Hospital and had him admitted to the psychiatric unit. He spent about 10 days in therapy and was released. The day of release, he became violent. At this point, a brother-in-law took out a warrant and had him arrested.

After lengthy discussions with his therapist at the In-Service Unit and Forsyth Hospital, I was able to evaluate the situation and work with the district attorney who was to represent the family and with the attorney representing the patient. I assisted and supported the family in seeking the route which seemed to be in the best interest of the patient. Testing had proven he was capable of decision-making and knew right from wrong.

The 20-year-old male is mildly mentally retarded and is at a 12 to 15-year level emotionally. In the past he had not been willing to go for therapy. The aunt who had raised him is a caring, loving but uneducated person and does not know how to handle the behavior problems of a 20-year-old adolescent with mental difficulties.

Result of today's court actions:

- Guilty verdict.
- Time already spent in jail accepted as enough to let him know that violent outbursts are not acceptable behavior.
- A sixty-day jail sentence was given - suspended for 3 years on the condition that he go for all the therapy deemed necessary by the Mental Health Center and follow their instructed medical regimen and that he not run away or move without consent, knowledge and approval of his therapist and the court.
- Received commitment on the part of the aunt to attend therapy with him as needed.

Through this procedure, hopefully we will have a productive citizen in the future, not a mentally ill hardened criminal. This is a typical court case where family assistance is offered. Without this assistance the case is usually either dismissed, with the patient returning to additional violence, in a non-therapy home situation or to an active jail sentence with hardened criminals.

Barbara H. Muse,
Assistant Director

APPENDIX

INVOLUNTARY (FORCED) HOSPITALIZATION PROCEDURE IN FORSYTH COUNTY, N.C.

for persons who are: mentally ill - emotionally disturbed - inebriate

A person is Commitable IF mentally ill, inebriate or emotionally disturbed AND dangerous to self

OR

others

From time to time a caller needs information about involuntary hospitalization for someone. Time is of extreme importance in some of these cases. Your ability to relay accurate information could be very helpful.

WHO IS COMMITABLE?

First, let me define who can be hospitalized against his wishes. A person may act extremely weird, displaying very abnormal behavior or any number of strange things and still not be commitable. In order to take away a person's freedom, he or she must be mentally ill or inebriate and dangerous to self or others. By N.C. law, dangerous is defined as follows:

A. "A person is dangerous to himself if:

1. He has acted in such a manner as to evidence that
   a. He would be unable without care, supervision, and the continued assistance of other people not otherwise available to exercise self-control, judgment, and discretion in conducting his daily responsibilities and social relations or to satisfy his need for nourishment, personal or medical care, shelter, protection and safety; and
   b. There is a 'reasonable probability' of 'serious physical debilitation' to him within the 'near future' unless 'adequate treatment' is given to him pursuant to the involuntary commitment laws.

   If there is evidence that he has engaged in behavior that is grossly irrational, 'taken actions that he is unable to control,' acted in a way 'grossly inappropriate to the situation,' or has in any other way given evidence of 'severely impaired insight and judgment,' a prima facie "inference" is thereby created that he is unable to care for himself.

2. He has attempted suicide or threatened suicide, and there is a 'reasonable probability' of suicide unless he is given 'adequate treatment' under the involuntary commitment laws.

3. He has mutilated himself or attempted to mutilate himself and there is 'reasonable probability' that he will seriously mutilate himself unless he is given 'adequate treatment' pursuant to the involuntary commitment laws.

B. A person is dangerous to others if, within the recent past he has inflicted, attempted to inflict, or threatened to inflict serious bodily harm on another or if he has acted in such a way as to create a 'substantial risk' of serious bodily harm to another and there is a reasonable probability that he will repeat his conduct."[1]

If the caller believes a person meets this criteria, then he or she may request to sign a commitment petition. Anyone who has first-hand knowledge of the person's "dangerousness to self or others" as described above may sign the petition requesting hospitalization against the person's wishes. It does not have to be a family member! It must be someone with first-hand knowledge. It cannot be "Sister Susie told me" of the dangerousness; Sister Susie would have to sign the petition herself.

From time to time there has been some confusion surrounding who may sign a commitment petition. It is most important that the caller understand that it is whoever has the personal knowledge of the dangerousness.

PROCEDURE

9-5 o'clock weekdays, or if

Violent

During routine office hours (Monday - Friday) the petitioner would go to the Hall of Justice, 200 S. Main Street, Main Street Level (2nd floor if entering from Liberty Street) to the office marked "Judicial Hospitalization" and see Larry Councilman. If he (or his assistant in his absence) agrees the person meets the commitment criteria, he will complete the necessary papers and explain the process to the petitioner.

However, there are times when the patient is too violent or too out-of-touch with reality, or the petitioner has no transportation and it is not possible to go to the Hall of Justice. At this time the police (if inside the city) or sheriff's department (outside the city) may be called in to evaluate and/or assist. It may be necessary to fully explain the dangerousness of the situation to the officer when called. The officer probably will inform the caller that he must go to the Hall of Justice to sign a petition. If this happens, the caller must explain the details preventing him from taking this action and urge the officer to assist in getting the petition signed.

---

[1] H. Rutherford Turnbull, III, *The Law and the Mentally Handicapped in North Carolina*, 2nd ed. (Chapel Hill: Institute of Government of the University of North Carolina, 1979), pp. 5-2, 5-3.

weekends
nights
holidays

In the event the petition must be signed during the night, weekend, or holiday, the proper law enforcement (sheriff if patient is located outside city limits, city police if inside city limits) is to be called first. He is to first assist in controlling the dangerous person, if needed, asking another officer to take the petitioner to the home of the magistrate-on-call to complete the necessary papers. The first officer may transport the petitioner if restraint or supervision of the potential patient is not required.

After proper papers are completed, the patient will be transported to a medical facility to be evaluated. In Forsyth County this could be Forsyth Memorial Hospital or Charter Mandala Center if the patient has financial means to pay and the petitioner has made certain that a bed is available prior to signing the petition. Otherwise, the petitioner will require the officer to take this person to the Mental Health Center Inpatient Unit.

In other counties the officer will inform the petitioner of the choices for placement.

What next?

POSSIBLE RESULTS OF PETITION: OPTIONS

Upon arrival at a medical facility, a physician must evaluate and determine whether this person is commitable. It is always helpful if the petitioner will go to the hospital when the person is picked up to be available to the doctor if he has questions.

Very important

The physician, after examination, will have several choices. The family member (or other petitioner) needs to be made aware of the physician's possible responses, which are:

1. Person is mentally ill and dangerous and hospitalization is recommended.
2. Person is mentally ill and potentially dangerous, but capable of functioning in the community with care and supervision. The physician is to be sure supervision and living arrangements are available, probably give medication, make an appointment with some outpatient facility, and release the person back to the community, pending court order for outpatient commitment. At this point, it is vital that the petitioner know that should this person again become dangerous to self or others, a new petition should be signed so doctors may re-evaluate and possibly order inpatient care.
3. Physician may say he does not find the person meeting both criteria needed for commitment. If physician says the person is mentally ill but, from his perspective, not dangerous, the patient will be released. The petitioner will need to petition again as soon as the person does something else that would qualify as dangerous.
   If the physician says the person is dangerous but not mentally ill (still his judgment decision but one must legally accept it at that time) the petitioner should take out a warrant for his/her arrest, if he/she has committed any illegal acts, including definite threats. Perhaps through negotiations with the district attorney via MHA Court Assistance Program, they may get psychiatric help through the judicial system. (Psychiatrists state that psychiatric therapy primarily is to teach people to function within our society and in some cases, the judicial system has more impact on recovery than the hospital.) The family or petitioner may need a lot of support in accepting this as an option and needs very much to come to REACH meetings to help them deal with their feelings surrounding this.
4. The physician may say that he is neither mentally ill nor dangerous and release the person then and there with no follow-up. Should this happen, the family should watch for additional signs and be ready to try again. They may wish to consider contacting another facility and seek evaluation by a different physician.

family needs
encouragement
& much T L C

Should the doctor believe the patient does not meet the criteria for involuntary hospitalization, he may try to convince the patient to stay voluntarily or he may release said person at that time.

In any event, suggest to the caller that he contact the Mental Health Association office and talk with a REACH member on the next working day. REACH members will assist the person in finding "where to go from here." They will offer assistance in the courtroom during the commitment hearing which will be held within 10 days after the individual has been picked up and examined by the first physician.

Prepared by MHA/Forsyth County
723-9678

1985

"But The Doctor Won't Talk To Me!"

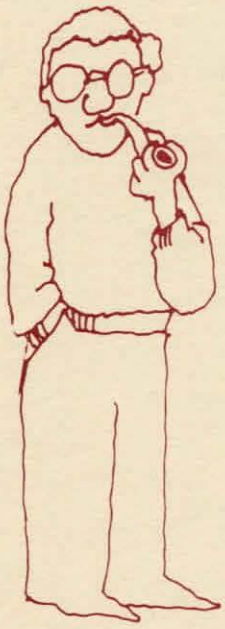
(For the parents of mentally disturbed sons or daughters)

The family of the mentally disturbed frequently feel the need to talk with the treating physician. However, calls or visits seem to stop at the switchboard or secretary. Fear of violation of the patient's confidentiality puts many physicians in a very defensive position.

The family may have information the doctor really needs to know. They may only want to know "How can we help the patient to recover? What should we do or not do? When should we? Should we tell?" and many other legitimate questions.

The doctor may interpret their attempts at communication as being nosy, or they won't let go of the apron strings. What "he's" told me is none of their business. Any of these interpretations may be right.

However, it has been my experience that most of the time the parents do not want to know "what he said". The parents, most of the time, would love to not only cut the apron strings, but destroy the apron altogether. When the disturbed person is tossed back into their lap to be caregiver, the apron must be the net that breaks the fall.



Parents: When you have information the doctor needs to know, write it down and mail it. He cannot possibly violate a confidentiality by reading his mail.

If you want his help on how you should treat this person, let the secretary know this is what you want, or again write and ask your specific concerns.

Let the doctor know upfront that you do not want confidential information - you want advice on how to help.

Let him know you are available to learn. Be willing to consider changes in family behavior patterns - willing to hear new options. Don't try to "tell" the doctor how to treat "him".

Physicians, psychologists, social workers, and other therapists:

Please help the family know how to change their response to the member if this is what's needed. Give them affirmation if their response is good. Families are not trained therapists and have lots of feelings of inadequacy.

If it truly is "tight apron strings", help the family to learn to untie them. Please don't treat us as aliens from a foreign planet with a new communicable disease.

Please listen when we feel we must share something with you. You may get new insight into some problems. You obviously do not have to use this information - unless perhaps it would help the patient. If it only helps the family to feel better, the end result will help the patient.

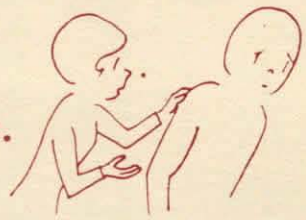
THE FAMILY WANTS TO HELP. PLEASE HELP THEM TO KNOW HOW. OPEN COMMUNICATION BETWEEN THE TREATMENT TEAM AND THE PRIMARY CAREGIVERS IS THE FIRST PRIORITY IF PROGRESS IS TO CONTINUE FOLLOWING TREATMENT.

United Way

Mental Health is... Every Body's Business

Barbara H. Muse
Assistant Director
Mental Health Association
390-C S. Stratford Road
Winston-Salem, NC 27103-1820
(919) 723-9678

Your concern can help



RELATING TO MENTALLY DISTURBED FAMILY MEMBERS WITH T.L.C.

Mentally disturbed persons probably will respond to adults who:

* respect their ideas, wishes, likes and dislikes, and let them have opinions and help them find options.
* allow them to learn by doing, even though the choices and methods may be different from yours.
* provide them with clear, reasonable limits.
* understand that they often have changes in feelings.
* can admit that even as well adults we don't have all the answers.

But,

Most mentally disturbed persons will react by pulling in or striking out when adults:

* do not allow them their privacy. "What are you doing with your door locked?"
* tell them how they should feel. "You know you shouldn't feel that way."
* push them for decisions they are not ready to make. "What do you mean, you don't know what you want to do?"
* set too many "petty" limits.

TRY TO CHANGE THE SITUATION

You Can Help by:

* feeling with them their joy when they are happy, and their sorrow when they are sad. Respond as much to their feelings as to their words.
* being "on call" but not totally possessed to answer questions, to give information, and for companionship. Be yourself with them.
* knowing where your skin ends and theirs begins; by not intruding or telling them how they feel, and not allowing them to intrude on you.
* listening and being open to their views, even if you disagree.
* being aware that our world seems different to this person.
* setting reasonable behavior expectations.

Remember:

* most mentally disturbed persons are raw nerve endings all over; underneath their sometimes cool exteriors they are extraordinarily sensitive to all behavior and feelings that affect them. Their behavior fluctuates like the wind; they change their minds frequently, and try many different things at the same time.
* the message you give them may not always be the message that they receive, as in all communications between people.
* this person may tend to view things in distorted ways, but they are real to him/her, so arguing won't help.
* friends are important to this person though they may be few. Encourage them to develop friendships.
* give disturbed persons options.
* if you need help, ask for it; there are many skilled persons who can help you.

Barbara Muse, Asst. Dir.
Mental Health Association
in Forsyth County, 1982

United Way

LOSS

During periods of personal loss, the painful feelings involved may create thoughts that one is "going crazy". Mental and emotional balance can be severely tested. Often others react in ways which can fasten or retard recovery from loss. Helpful responses include:

1. Accepting a wide range of feelings as human and normal for the stressful circumstances without becoming "shocked"
2. Not being embarrassed by tears.
3. Not giving unwanted advice.
4. Being warm and affectionate.
5. Reminding the person of their strengths and abilities, especially the ability to grow.
6. Trusting the person to come through the difficult time.
7. Treating the person as an adult capable of making decisions.
8. Acknowledging your own humaness and sharing it.
9. Being unafraid to question the person directly concerning feelings of loss.
10. Respecting the person's courage and sense of determination.
11. Understanding grief is not a disease.
12. Trying to understand what the feelings mean to the person even if one is uncomfortable when those feelings are expressed.
13. Honestly telling the person when one is unable to be with him or her because of problems or needs of one's own.
14. Being faithful to commitments and promises.
15. Respecting the need for privacy without ignoring the need for human contact.
16. Aiding when practical problems arise.
17. Discouraging self-destructive behavior.
18. Keeping shared personal information confidential.

Harmful responses include:

1. Telling others information shared in confidence.
2. Responding in ways that are poorly timed or unsettling.
3. Telling stories of tragedy and catastrophe when the person is feeling vulnerable.
4. Not taking seriously what is meaningful or sacred to the person.
5. Continually questioning the person his or her decisions.
6. Making a point of disapproving of other's behavior that resembles that person's own behavior.
7. Continuing behavior that the person clearly indicates is harmful or upsetting to him or her.
8. Failing to keep promises.
9. Labeling the person's feelings or behavior as "sick", "neurotic", "hysterical", "stupid", "feeling sorry for yourself", "selfish" or "weird".

"You tell me your diagnosis, then I'll tell you mine."

Mental Health Association in Forsyth County
390-C S. Stratford Road
Winston-Salem, NC 27103-1820 (919) 723-9678

A therapist by any other name . . .

When it comes to providing mental health treatment and services, there's a lot of confusion about who does what and for whom.

Here's a quick rundown of various mental health professions to give you a better idea of what the differences and similarities are. This guide should prove handy if you're not sure where to turn with a particular problem or question on mental health or if you're in a position to refer a friend or relative in need of professional help.

First, the **clinical psychologist.** Concerned primarily with diagnosing and treating emotional and mental problems, the clinical psychologist works with individuals or groups in inpatient, office or community settings. He or she may specialize in areas such as behavior therapy, marriage counseling, or family therapy.

The clinical psychologist develops expertise in psychotherapy, research, consultation and teaching; often he or she works in teams with members of other mental health professions, such as psychiatrists, social workers or nurses.

The principal difference between a **psychiatrist** and a clinical psychologist is that the psychiatrist is a medical doctor, having been through four years of medical school, a year's internship and three years of psychiatric residency. The psychiatrist, unlike his or her counterparts in the mental health field, can administer and prescribe drugs to patients.

Like the psychologist, the psychiatrist works in a variety of clinical settings, such as in a private or group practice, a hospital, a community mental health facility or in an institutional setting such as a school or major corporation. Psychiatrists practice a variety of treatment forms, including psychoanalysis, group or individual psychotherapy, hypnosis, and others.

Social work is concerned with restoring, maintaining and enhancing social functioning. The **social worker** in mental health provides needed services to disturbed or mentally ill individuals, their families and their communities.

Working regularly with patients and their families, social workers play a key role in reorienting patients back into their families and communities.

A **registered psychiatric nurse** provides clinical nursing care, counseling, assistance to other mental health personnel, mental health education and a wide range of other services. He or she may be involved in individual or group psychotherapy, family therapy, consultation or research.

The **mental health technician** works with emotionally ill and mentally retarded patients. He or she may work with patients in a hospital, community or family setting, where the primary concern is with developing social relationships. The psychiatric technician usually works with the therapist who is ultimately responsible for patients' care. The technician is skilled at working in the community, mobilizing resources and improving services for clients.

The list of mental health therapists, professionals and non-professionals goes on and on. Whether you're looking to a psychiatric social worker, nurse, or technician, a clinical psychologist, psychiatrist or neuro-surgeon, they all share the same concern: helping find ways to make everyday living more effective and rewarding for everyone.

Contact your local MHA to locate the mental health professionals in your community.

Mental Health Association
of Forsyth County
390-C S. Stratford Road
Winston-Salem, North Carolina, 27103
(919) 723-9678

SELF-HELP/ SUPPORT GROUPS IN FORSYTH COUNTY

JULY 1984

LIST COMPILED BY:

FIRST LINE 727-8100

FORSYTH COUNTY
INFORMATION & REFERRAL SERVICE

660 WEST FIFTH STREET
WINSTON-SALEM, N.C. 27101

727-8100

MENTAL HEALTH RESOURCES IN FORSYTH COUNTY

JUNE 1984

LIST COMPILED BY:

FIRST LINE 727-8100

FORSYTH COUNTY
INFORMATION & REFERRAL SERVICE

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727-8100

Mental Health Association in Forsyth County

An Affiliate of the North Carolina and National Associations for Mental Health

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December 7, 1984

Dear Friends within REACH,

Many of our loved ones have been, or are in, crisis situations; some are doing great, and others are status-quo. Whatever your situation, I hope that REACH has provided some relief, support, encouragement, or knowledge during 1984.

On December 17, let us make a special effort to celebrate our love for each other, in the spirit of whomever you acknowledge as your higher power. To begin this celebration, a lovely person -- a second year seminary student, chaplain intern at Duke University -- will help us to see, through our loved ones' eyes, what it is like to hallucinate, be paranoid, and out of touch with reality. She is a beautifully recovered person who has suffered from schizophrenia. Knwoing her will help us celebrate our own wellness, and revitalize our love for a family member who sometimes tries our abilities to continue to love.

A second part of our celebration will be to bring a decoration or snack to create a festive atmosphere; it need not be elaborate -- when it's all put together, it will be elaborate.

Let's make this a true celebration of our love for each other. Bring a smile, a joke, an extra hug and let's enjoy some time together, just purely for fun.

The enclosed prayer rendered at a meeting I attended in October aptly expresses my prayer for you for the coming year.

Hoping to see you on December 17.

Always,
Your friend within REACH,

Barbara

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June 7, 1983

Dear Friends Within REACH:

From time to time we re-evaluate our needs and try to readjust REACH to meet these needs. As summer approaches, some have said that it is too long between meetings if they have to miss one. Also, some persons show up on the wrong night, when there is no meeting.

Therefore, for at least the summer months, we're going to try meeting each Monday evening at Knollwood Baptist Church at 7:30 p.m. We will begin once again having a speaker or educational focus once each month.

A program on major tranquilizers has been planned for July 18. Alvin Tyndall from the Mental Health Center will bring two video tapes on the family interactions with a patient on tranquilizers, followed by discussion. Please mark this date on your calendar now.

A suggestion has been made that we have a covered dish dinner, combining morning and evening groups on each 5th Monday evening. I would like to hear from you as to whether you would like to try this. The next month that has five Mondays would be August.

I am fully aware that many of you cannot get to many of the meetings. Some need it more frequently than others. If you are at a stable time in your family situation, others need you to reassure them that stable times do return. Come as frequently as you can, you're needed, whether or not you are in a crisis. Our next evening meeting will be Monday, June 13. Our morning meetings are continuing to be each Thursday morning at the Mental Health Center at 10:00 a.m.

REACHing out to you, I hope to see you soon.

Sincerely,

Barbara

Barbara H. Muse

P.S. Please let me know if you wish to plan "something extra" or not meet at all on Monday, July 4th.

BHM/sp