

Lawyers and Stress, Depression, Substance Abuse, and Suicide **Scott A. Kaplan, Ph.D.**

Lawyers and Mental Health Issues: Stats and Facts

- Stress among law students is 96%, compared to 70% med students and 43% grad students.(1)
- Chronic stress can trigger the onset of clinical depression and substance abuse.
- Entering law school, law students have a psychological profile similar to that of the general public. After law school, 20-40% have a psychological dysfunction.(2)
- Before 1st year, depression rates among law students approximated that of the general population (about 9-10%). 32% by the end of the first year. 40% by the third year.(3)
- Lawyers are the most frequently depressed occupational group in the US.
- Lawyers are 3 times more likely than those in other professions to experience depression.(5, 6)
- 25% of US lawyers suffer from some form of depression.(4)
- 15% of individuals with clinical depression die by suicide.(7)
- Substance abuse among lawyers is as much as double the national average.(5)
- Alcoholism and/or Drug Dependency affect 10% of the US population.(8)
- 15% to 20% of lawyers suffer from alcoholism and substance abuse.(9)
- Substance abuse is a factor in 50% of the disciplinary cases that come before The Attorney Registration and Disciplinary Commission.(10)
- Just over 95% of Americans classified as needing substance use treatment because of the problems they experienced did not feel they needed treatment.(11)
- 94% percent of US primary care physicians in a study conducted in 2000 failed to diagnose substance use disorders properly.(12)
- Substance abusers are 10 times more likely to commit suicide.(5)
- Lawyers rank 5th in incidence of suicide by occupation.(2)
- Lawyers are 3.6 times more likely to commit suicide than people in the general population.(2)

What is Stress?

According to Dr. Hans Selye in *The Stress of Life*, stress is our mind and body's nonspecific response to any demand placed on it. This demand, or stressor, is beyond the person's perceived abilities to cope. Stressors are environmental triggers that evoke a biopsychosocial reaction. It is important to know the sources and signs of stress in order to cope adaptively.

Signs of Stress

Individual Sources of Stress

- Poor diet, sleep, or exercise;
- Decreased physical abilities and health;
- Lack of confidence in abilities;
- Limited training or coping skills;
- Pessimistic/cynical view of life or others;
- Lack of interests outside of job;
- Increased education;
- Unrealistic thoughts or expectations.

Interpersonal Sources of Stress

- Lack of friendships in/outside of profession;
- Too many friendships within profession;
- Negative relationships with others;
- Competition with other attorneys;
- Significant losses or deaths;
- Financial concerns;
- Family fears attorney being injured or killed;
- Family not understanding demands;
- Having young children;

Behavioral Symptoms

- Prolonged withdrawal;
- Changes in appetite;
- Changes in sleep patterns;
- Increased alcohol use;
- Increased sick leave;
- Restlessness or pacing;
- Aggressiveness or impatience.

Cognitive Symptoms

- Poor concentration, memory, or attention;
- Poor problem solving or decision-making;
- Hypervigilance or being easily startled;
- Decreased awareness of surroundings;
- Intrusive & disturbing thoughts or images;
- Racing thoughts & excessive worry;
- Distractibility, impulsivity, & mistakes

Internal Stressors

- Fear of failure;
- Need to appear confident and competent;
- Hostility/anger from & toward client(s)

External Stressors

- Client wanting quick resolution;
- Slow movement in case;
- Others not understanding role;
- Demands from client(s)

Job-Related Sources of Stress

- Changes in mission or duties
- Work-life conflict/Long hours - short deadlines;
- Challenging material/Fragmentation of work;
- Boredom alternating with crisis/trauma;
- Exposure to suffering and misery;
- Consequences of actions;
- Fears (safety, security, legal, financial);
- Repeat offenders & "difficult" clients;
- Stigma

Physical Symptoms

- Fatigue or weakness;
- Nausea or vomiting;
- Muscle tremors or twitches;
- Chest pain or difficulty breathing;
- Elevated blood pressure/heart rate;
- Profuse sweating or chills;
- Decreased libido.

Emotional Symptoms

- Irritability and agitation
- Depression, grief or anxiety
- Fear or apprehension
- Uncertainty or guilt
- Emotional outbursts/Intense anger
- Suicidal thoughts;
- Suspiciousness or paranoia.

What is Depression?

Depression is a mood disorder that changes how you think and feel, and also affects your social behavior and sense of physical well-being. The causes, symptoms, onset, duration, and extent that it interferes with your level of functioning depend on the type of depression.

Dysthymia – Sometimes referred to as mild, chronic depression. It is similar but less severe than major depression and does not disable a person from functioning. The depressive symptoms seem like a long-term depressed mood, two years or longer. 6% lifetime prevalence rate.

Adjustment-related Depression – Sometimes referred to as an acute or situational depression. It occurs within three months of an identifiable stressor or trigger event and lasts no longer than six months. Up to 50% lifetime prevalence rate.

Major Depression – It is characterized by a combination of symptoms that interfere with a person's ability to work, sleep, eat, and enjoy once-pleasurable activities. Major depression is disabling and prevents a person from functioning normally. 16.5% lifetime prevalence rate.

Bipolar Depression – Sometimes referred to as manic depression. It is characterized by alternating between periods of major depression and extreme elation or mania. Sometimes there are psychotic features. Two subtypes; bipolar I and bipolar II. Up to 2% lifetime prevalence rate.

Depression Due to General Medical Condition – It is a depression related to a medical condition or disability. Up to 60% lifetime prevalence rate.

Postpartum Depression (PPD) – It is a mix of physical, emotional, and behavioral changes that happen in a woman within four weeks after giving birth. Sometimes there are psychotic features. 10% lifetime prevalence rate without psychotic features and .1 % with psychotic features.

Seasonal Depression – Sometimes referred to as seasonal affective disorder (SAD). It emerges during the same time each year. The onset is usually during the winter months when there is less natural sunlight. Rates vary by region. 10% lifetime prevalence rate.

Signs of Depression

If someone experiences most of the symptoms below for more than two weeks, there is a good chance they are suffering from depression.

- Feeling sad, empty, stuck, worthless or unmotivated
- Feeling helpless, hopeless, ashamed or guilty
- Recurrent suicidal thoughts
- Inability to experience pleasure
- Decreased interest in things that one typically enjoys
- Fatigue or loss of energy
- Significant fluctuations in weight when not dieting
- Changes in appetite
- Changes in sleep patterns
- Explanations are in Global, Internal, & Chronic terms
- Self-critical thoughts
- Disturbing dreams/recollections
- Inability to concentrate
- Difficulty making decisions
- Irritability/anger outbursts
- Socially isolating oneself
- Increased alcohol or drug use
- Decrease in job performance
- Absenteeism/missing deadlines
- Attrition (work, relationships, health)

Signs of Mania, or Bipolar Depression

- Abnormally & persistently elevated or irritable mood
- Inflated self-esteem or grandiosity
- Recurrent suicidal thoughts, intent, or attempts
- Indiscretion/risky behavior (spending, sex, drugs, etc)
- Flight of ideas or racing thoughts
- Unusually talkative/fast, pressured speech
- Decreased need for sleep (days)
- Decreased need for food (days)
- Increase in goal-directed activity
- Psychomotor agitation
- Increased distractibility
- False, exaggerated beliefs

What is Suicide?

According to the Center for Disease Control and Prevention, **suicide** is defined as death caused by self-directed injurious behavior with any intent to die as a result of the behavior. A **suicide attempt** is a non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury. **Suicidal ideation** is when a person is thinking about, considering, or planning for suicide. It does not mean they will act on it.

Signs of Suicide

- Dramatic mood changes
- Striking changes in behavior
- Excessive drinking or drug abuse
- Anxiety or agitation
- Isolating and withdrawing from others
- Hopelessness/helplessness/“stuck”
- Uncontrollable anger/hostility
- Talking about death or dying
- Engaging in risky activities
- Negative self-evaluation

Commonalities of Suicidal People

- Stressors – frustrated needs
- Stimulus – unendurable pain
- Purpose – seek solution to pain
- Goal – relief of ambivalence
- Feelings – hopelessness, helplessness
- Feelings – alone, loss of control
- Thinking – constricted focus on pain
- Effect – manipulation/control of others
- History – coping through escape, low frustration tolerance

How to Help

- Ask about suicide. You're not planting the seed. It shows concern.
- Encourage your friend/colleague to talk. Isolation adds risk.
- Avoid advising, analyzing, distancing, judging, or persuading. It shuts people down.
- Offer hope, care, and understanding. (“You are not alone”; “The feeling will change”)
- If the threat of suicidal harm is imminent, call 911 and stay with your friend.
- See your own counselor. Helping others can be very stressful.
- Call the Lawyer Assistance Program or other resources for assistance.
- Encourage your friend/colleague to seek professional help. Normalize it. Destigmatize.
- Be confident. Build efficacy. Express knowledge about the referral and the process.

What you can expect when the person you're helping sees an emergency counselor:

- The counselor will assess the person's level of risk and level of safety.
- The counselor will create a plan to assure the person's safety over the next 24 to 72 hours.
- The safety plan could be voluntary or involuntary hospitalization
- The most common safety plan is for the person to go back to his/her “normal” routine
- The plan will provide a structure for how the person can best spend his/her time during the next day or so. Plans often include spending time with others, keeping closely to his/her typical responsibilities, going to work, and engaging in self-care behaviors. The plan will emphasize not using any alcohol or drugs.
- The plan will include an action strategy for the person to follow if s/he becomes suicidal again over the next day or so.
- Many times after a suicidal threat or attempt the person needs sleep, a time to emotionally recover, and needs structure to help him/her feel more connected to their daily life.

What is Substance Abuse?

According to the DSM-IV-TR, **substance abuse** is defined as a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. Individuals who abuse substances may experience such harmful consequences of substance use as repeated failure to fulfill roles for which they are responsible, legal difficulties, or social and interpersonal problems. **Substance dependence** is more serious than abuse. This maladaptive pattern of substance use includes such features as increased tolerance for the substance, resulting in the need for ever-greater amounts of the substance to achieve the intended effect; an obsession with securing the substance and with its use; or persistence in using the substance in the face of serious physical or mental health problems.

Signs of Substance Abuse – How Do You Know When It's a Problem? (WARM)

Look for signs related to Work performance, Appearance, Relationships, and Mood (WARM).

Work

- Decreased/poor productivity;
- Decreased/poor quality of work;
- Decreased/poor concentration;
- Decreased/poor problem solving
- Inability to make decisions/poor decisions
- Resistance to authority
- Misuse of equipment and frequent breaks
- Increased sick leave/tardiness;

Appearance

- Inappropriately dressed;
- Bloodshot eyes/dilated pupils;
- Slurred speech;
- Poor hygiene;
- Muscle/hand tremors;
- Unsteady stance/decreased coordination;
- Profuse sweating;
- Extreme changes in energy level or behavior;

Relationships

- Poor concentration, memory, or attention;
- Bad listening skills;
- Uncooperative;
- Over-confident;
- Loose boundaries;
- Argumentative/hostile;
- Accusative/unusually defensive;

Mood

- Irritability and agitation;
- Depression, grief or anxiety;
- Suspiciousness or paranoia;
- Fear or apprehension;
- Emotional outbursts/Intense anger;
- Withdrawn or excessively talkative;
- Instability/abrupt changes (after lunch/breaks);

Questions to ask yourself or others: CAGE Questionnaire - taken from IL LAP website.

- Have you ever felt you should Cut down on your drinking?
 - Have people Annoyed you by criticizing your drinking?
 - Have you ever felt bad or Guilty about your drinking?
 - Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (Eye opener)?
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- Are your associates, clients, secretary or family unjustly alleging that your drinking or drug use is interfering with your work or home life?
 - Have you failed to show up or showed up late at the office or court because of a hangover or showed up under the influence of alcohol or drugs?
 - Are you drinking or using drugs during the work day?
 - Have you commingled, borrowed, or otherwise misused client's trust or escrow funds?
 - Are you missing deadlines, neglecting to process mail, or failing to keep appointments or answer phone calls?
 - Do you ever really crave a drink or a fix to steady your nerves?
 - Have you lied to cover up your drinking or use of drugs?
 - Have you consumed alcohol or used drugs before a meeting or court appearance to calm your nerves, gain courage, or improve performance?
 - Have you experienced loss of memory (blackout) after drinking or use of drugs?
 - Have you ever had another attorney cover for you because of alcohol, drugs, or a hangover?

Mental Health Resources

- **Centers for Disease Control and Prevention**
Phone: 1-800-311-3435
URL: www.cdc.gov
- **National Institute of Mental Health**
Phone: 301-443-4513
URL: www.nimh.nih.gov
- **Substance Abuse and Mental Health Services Administration**
Phone: 1-800-487-4890
URL: www.samhsa.gov
- **Office of the Surgeon General
National Strategy for Suicide Prevention**
URL: www.mentalhealth.org/suicideprevention
- **American Association of Suicidology**
Phone: 202-237-2280
URL: www.suicidology.org
- **American Foundation for Suicide Prevention**
Phone: 1-888-333-AFSP
Phone: 215-363-3500
URL: www.afsp.org
- **National Alliance on Mental Illness (IL)**
Phone: 217-522-1403
URL: <http://il.nami.org/>
- **Psychology Today**
URL: www.psychologytoday.com
- **Dave Nee Foundation**
Phone: 646-801-7392
URL: www.daveneefoundation.com
- **CoLap Programs**
URL: www.americanbar.org/groups/lawyer_assistance.html
- **Lawyer Assistance Program (IL)**
Phone: 312-726-6607/800-LAP-1233
Downstate: 618-462-4397/ “ “ “
URL: <http://www.illinoislap.org/>
- **International Lawyers in Alcoholics Anonymous**
URL: <http://www.ilaa.org/home/>
- **Alcoholics Anonymous/AI-Anon**
URL: www.alcoholics-anonymous.org
URL: www.alateen.org
- **Suicide Hotlines**
1-800-SUICIDE/1-800-784-2433
1-800-273-TALK/1-800-273-8255
1-866-LAW-LAPS
- **Hellenic Foundation**
Phone: 773-631-5222
URL: www.hellenicfoundation.org
- **Insurance Co. Provider Listings**

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Suicide

Learn more, learn to help

Signs of depression and suicide risk:

- Change in personality-becoming sad, withdrawn, irritable, anxious, tired, indecisive, apathetic
- Change in behavior-can't concentrate on school, work, routine tasks
- Change in sleep pattern-oversleeping or insomnia, sometimes with early waking
- Change in eating habits-loss of appetite and weight, or overeating
- Loss of interest in friends, sex, hobbies, activities previously enjoyed
- Worry about money, illness (real or imaginary)
- Fear of losing control, "going crazy," harming self or others
- Feelings of overwhelming guilt, shame, self-hatred
- No hope for the future-"It will never get better, I will always feel this way."
- Drug or alcohol abuse
- Recent loss of a loved one through death, divorce, separation, broken relationship; or loss of job, money, status, self-confidence, self-esteem
- Loss of religious faith
- Nightmares
- Suicidal impulses, statements, plans; giving away favorite things; previous suicide attempts or gestures
- Agitation, hyperactivity, restlessness may indicate masked depression

Don't be afraid to ask: "Do you sometimes feel so bad you think of suicide?"

Just about everyone has considered suicide, however fleetingly, at one time or another. There is no danger of "giving someone the idea." In fact, it can be a great relief if you bring the question of suicide into the open, and discuss it freely, without showing shock or disapproval. Raising the question of suicide shows you are taking the person seriously and responding to the potential of his/her distress.

If the answer is "Yes, I do think of suicide," you must take it seriously.

Ask questions like: Have you thought about how you'd do it? Do you have the means? Have you decided when you'll do it? Have you ever tried suicide before? What happened then?

If the person has a defined plan, the means are easily available, the method is a lethal one, and the time is set, the risk of suicide is very high. Your response will be geared to the urgency of the situation as you see it. Therefore, it is vital not to underestimate the danger by not asking for details.

Common misconceptions about suicide:

- **"People who talk about suicide won't really do it."**

Almost everyone who commits suicide has given some clue or warning. Do not ignore suicide threats. Statements like "You'll be sorry when I'm dead," or "I can't see any way out"-no matter how casually or jokingly said-may indicate serious suicidal feelings.

- **"Anyone who tries to kill themselves must be crazy."**

Most suicidal people are not psychotic or insane. They must be upset, grief-stricken, depressed, or despairing, but extreme distress and emotional pain are not necessarily signs of mental illness.

- **"If a person is determined to kill themselves, nothing is going to stop them."**

Even the most severely depressed person has mixed feelings about death, wavering until the very last moment between wanting to live and wanting to die. Most suicidal people do not want death; they want the pain to stop. The impulse to end it all, however overpowering, does not last forever.

- **"People who commit suicide are people who were unwilling to seek help."**

Studies of suicide victims have shown that more than half had sought medical help within six months before their deaths.

- **"Talking about suicide may give someone the idea."**

You don't give a suicidal person morbid ideas by talking about suicide. The opposite is true-bringing up the subject of suicide and discussing it openly is one of the most helpful things you can do.

Persons who may be at high risk for suicide:

- Persons who are severely depressed and feel hopeless
- Persons who have a past history of suicide attempts
- Persons who have made concrete plans or preparations for suicide

How to find out if someone is suicidal:

Ask these questions-in the same order-to find out if the person is seriously considering suicide:

1. **"Have you been feeling sad or unhappy?"**

A "yes" response will confirm that the person has been feeling some depression.

2. **"Do you ever feel hopeless? Does it seem as if things can never get better?"**

Feelings of hopelessness are often associated with suicidal thoughts.

3. **"Do you have thoughts of death? Does it seem as if things can never get better?"**

A "yes" response indicates suicidal wishes but not necessarily suicidal plans. Many depressed people say they think they'd be better off dead and wish they'd die in their sleep or get killed in an accident. However, most of them say they have no intention of actually killing themselves.

4. **"Do you ever have any actual suicidal impulses? Do you have any urge to kill yourself?"**

A "yes" indicates an active desire to die. This is a more serious situation.

5. **"Do you have any actual plans to kill yourself?"**

If the answer is "yes," ask about their specific plans. What method have they chosen? Hanging? Jumping? Pills? A gun? Have they actually obtained the rope? What building do they plan to jump from? Although these questions may sound grotesque, they may save a life. The danger is greatest when the plans are clear and specific, when they have made actual preparations, and when the method they have chosen is clearly lethal.

6. **"When do you plan to kill yourself?"**

If the suicide attempt is a long way off (say, in five years) danger is clearly not imminent. If they plan to kill themselves soon, the danger is grave.

7. "Is there anything that would hold you back, such as your family or your religious convictions?"

If the person says that people would be better off without them, and if they have no deterrents, suicide is much more likely.

8. "Have you ever made a suicide attempt in the past?"

Previous suicide attempts indicate that future attempts are more likely. Even if a previous attempt did not seem serious, the next attempt may be fatal. All suicide attempts should be taken seriously. However, suicidal "gestures" can be more dangerous than they seem, since many people do kill themselves.

9. "Would you be willing to talk to someone or seek help if you felt desperate? Whom would you talk to?"

If the person who feels suicidal is cooperative and has a clear plan to reach out for help, the danger is less than if they are stubborn, secretive, hostile, and unwilling to ask for help.

Suicide

Facts at a Glance

2012

Suicide

- Suicide was the tenth leading cause of death for all ages in 2010.¹
- There were 38,364 suicides in 2010 in the United States—an average of 105 each day.¹
- Based on data about suicides in 16 National Violent Death Reporting System states in 2009, 33.3% of suicide decedents tested positive for alcohol, 23% for antidepressants, and 20.8% for opiates, including heroin and prescription pain killers.²
- Suicide results in an estimated \$34.6 billion in combined medical and work loss costs.¹

Nonfatal Suicidal Thoughts and Behavior

- Among adults aged ≥18 years in the United States during 2008-2009:³
 - An estimated 8.3 million adults (3.7% of the adult U.S. population) reported having suicidal thoughts in the past year.
 - An estimated 2.2 million adults (1.0% of the adult U.S. population) reported having made suicide plans in the past year.
 - An estimated 1 million adults (0.5% of the U.S. adult population) reported making a suicide attempt in the past year.
- There is one suicide for every 25 attempted suicides.³
- Among young adults ages 15 to 24 years old, there are approximately 100-200 attempts for every completed suicide.⁴
- In a 2011 nationally-representative sample of youth in grades 9-12:⁵
 - 15.8% of students reported that they had seriously considered attempting suicide during the 12 months preceding the survey;

- 12.8% of students reported that they made a plan about how they would attempt suicide during the 12 months preceding the survey;
- 7.8% of students reported that they had attempted suicide one or more times during the 12 months preceding the survey; and
- 2.4% of students reported that they had made a suicide attempt that resulted in an injury, poisoning, or an overdose that required medical attention.

Gender Disparities

- Suicide among males is four times higher than among females and represents 79% of all U.S. suicides.¹
- Females are more likely than males to have had suicidal thoughts.³
- Firearms are the most commonly used method of suicide among males (56%).¹
- Poisoning is the most common method of suicide for females (37.4%).¹

Racial and Ethnic Disparities

- Among American Indians/Alaska Natives aged 15- to 34-years, suicide is the second leading cause of death.¹
- The suicide rate among American Indian/Alaska Native adolescents and young adults ages 15 to 34 (31 per 100,000) is 2.5 times higher than the national average for that age group (12.2 per 100,000).¹
- Of students in grades 9-12, significantly more Hispanic female students (13.5%) reported attempting suicide in the last year than Black, non-Hispanic female students (8.8%) and White, non-Hispanic female students (7.9%).⁵

Suicide Facts at a Glance

Age Group Differences

- Suicide is the third leading cause of death among persons aged 15-24 years, the second among persons aged 25-34 years, the fourth among person aged 35-54 years, and the eighth among person 55-64 years.¹
- Among 15- to 24-year olds, suicide accounts for 20% of all deaths annually.¹
- Suicide rates for females are highest among those aged 45-54 (rate 9 per 100,000 population).¹
- Suicide rates for males are highest among those aged 75 and older (rate 36 per 100,000).¹
- The rate of suicide for adults aged 75 years and older was 16.3 per 100,000.¹
- The prevalence of suicidal thoughts, suicide planning, and suicide attempts is significantly higher among young adults aged 18-29 years than among adults aged ≥30 years.³

Nonfatal, Self-Inflicted Injuries*

- In 2011, 487,700 people were treated in emergency departments for self-inflicted injuries.¹
- Nonfatal, self-inflicted injuries result in an estimated \$6.5 billion in combined medical and work loss costs.¹

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**The term "self-inflicted injuries" refers to suicidal and non-suicidal behaviors such as self-mutilation.*

Mental Health Services, Providers, and Resources

Major Mental Health Services

24-hour emergency service: available at hospitals or mental health clinics

Outpatient care: regular appointments for treatment at a clinic or private practice

Inpatient service: care is provided in a hospital or institutional setting

Partial hospitalization: care provided on occasional days, nights, or weekends, at a hospital, with person living at home and going to work as much as possible

Psychological Assessment: Therapeutic assessments help the person being assessed. Problems are identified and recommendations are made. Forensic assessments help establish the facts for use in court. At the request of an attorney or court order, determinations are commonly made insanity, competence, or risk/danger.

Consultation, education, and prevention: assist community in dealing with persons with mental illnesses and in developing programs that help in the prevention of emotional or thought disorders

Key Mental Health Service Providers

Psychiatrists: Medical doctor who specializes in mental disorders and can evaluate & diagnose all types of mental disorders, carry out biomedical treatments, prescribe medication & psychotherapy.

Psychologists: Licensed professional with doctoral degree who provides assessment & psychotherapy with individuals, groups, or families. Some are licensed to prescribe medications.

Psychiatric Nurses: Registered professional nurses who have advanced academic degrees at the Master's degree level or above and are concerned with prevention, treatment, and rehabilitation of mental health-related problems. They conduct individual, family, and group therapy and also work in mental health consultation, education, and administration.

Social Workers: Licensed or certified professionals who have advanced degrees in social work. They provide individual, family, and group therapy, and client advocacy with governmental and civic agencies, and expansion of community resources.

Mental Health Counselors: Have earned at least a Master's degree and are certified by the National Board for Certified Counselors. They provide counseling services to help individuals, couples, and families. They focus on promotion and enhancement of healthy lifestyles.

Case Managers/Outreach Workers: Assist persons with serious mental illness to obtain the services they need to live in the community. They monitor a person's needs to assure that appropriate agencies are involved. In many instances they also act as advocates for the client.

Key Mental Health Resources

- Mental health centers
- Outpatient clinics
- Private/group practice
- General hospitals
- Psychiatric hospitals
- Nursing homes
- Jails and prisons
- Residential treatment centers
- Partial care organizations
- Family/social service agencies
- University counseling or medical centers
- Transitional facilities
- Substance abuse treatment facilities
- Community services case management
- Advocacy groups (i.e. Alliance for the Mentally III)

**Adapted with permission of Gene Deisinger, Ph.D.*