



SMART
Recovery

Life beyond addiction

Facilitator Best Practices for Addressing
Mental Health Disorders and Suicide
in SMART Recovery® Meetings

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Introduction

The objective of this guide is to provide facilitators with best practices to use when participants bring up the topics of mental health disorders and suicide in SMART Recovery meetings.

This guide also provides information and definitions applicable to the intersection of addiction, mental health disorders, and suicide. While facilitators will rarely use much medical terminology, meeting participants may occasionally. Thus, it is beneficial for facilitators to be familiar with such terms to avoid being surprised by, or uncomfortable, with them.

Much of the information in this guide is from the websites of the Mayo Clinic, the National Alliance on Mental Health (NAMI), the National Institute of Mental Health (NIMH), the QPR Institute (Question, Persuade, Refer), and the Substance Abuse and Mental Health Services Administration (SAMHSA). Source links have been provided throughout and a complete list is found at the end of this document.

Facilitators can learn more by taking a course from Mental Health First Aid and/or the QPR Institute.

<https://www.mentalhealthfirstaid.org/>

<https://qprinstitute.com/>

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Overview of the Intersection of Addiction and Mental Health Disorders

Mental health disorders are far more common than most people realize. The lack of awareness is the result of an education gap around mental health disorders and the fear/stigma of discussing them. Education and conversation are critical because

- 1 in 5 U.S. adults experience mental health disorders each year.
- 1 in 25 U.S. adults experience serious mental health disorders each year.

<https://nami.org/Learn-More/Mental-Health-Conditions>

Moreover, according to the National Survey on Drug Use and Health, 9.2 million individuals who have Alcohol Use Disorder (AUD) and Substance Use Disorder (SUD) experienced mental health disorders *and* a substance use disorder in 2018.

<https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf>

Behavioral disorders such as gambling, eating, internet, and other non-substance use disorders also occur with mental health disorders, AUD and SUD.

<https://www.drugabuse.gov/publications/research-reports/common-comorbidities-substance-use-disorders/what-are-treatments-comorbid-substance-use-disorder-mental-health-conditions>

Medical professionals increasingly recommend Integrated Treatment Plans tailored for the complex needs of individuals with addiction and mental health disorders. Cognitive Behavior Therapy (CBT) is almost always mentioned in these plans.

<https://www.drugabuse.gov/publications/research-reports/common-comorbidities-substance-use-disorders/what-are-treatments-comorbid-substance-use-disorder-mental-health-conditions>

Because SMART Recovery's approach is based on Rational Emotive Behavior Therapy (REBT) and CBT, which are effective in treating mental health disorders, SMART Recovery can fit well with an individual's integrated treatment plan. Mental health and medical professionals often recommend SMART Recovery for their clients.

<https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-the-evidence-10242019.pdf>

Definitions

Anxiety Disorder

Anxiety disorders are the most common mental health concern in the United States. Over 40 million adults in the U.S. (19.1%) have an anxiety disorder. There are many types of anxiety disorders, including generalized anxiety, panic, and phobias, as well as specific anxiety disorders such as fear of flying, social anxiety, agoraphobia, and separation anxiety.

<https://www.nimh.nih.gov/index.shtml>

Bipolar Disorder

Formerly called manic-depressive illness or manic depression, bipolar disorders cause unusual, sometimes dramatic, shifts in mood, energy, activity levels, concentration, and the ability to carry out routine tasks. Bipolar disorder affects men and women equally.

People with bipolar disorder can also experience anxiety, attention-deficit hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD), and substance use disorders.

<https://nami.org/About-Mental-Illness/Mental-Health-Conditions/Bipolar-Disorder>

Borderline Personality Disorder

Borderline personality disorder (BPD) is marked by an ongoing pattern of varying moods, self-image, and behavior. People with borderline personality disorder may experience intense episodes of anger, depression, and anxiety that can last from a few hours to several days.

It is common for people with BPD to experience suicidal ideation and engage in self-harming behavior such as cutting.

People with BPD can also experience anxiety, ADHD, PTSD, and substance use disorders.

<https://nami.org/About-Mental-Illness/Mental-Health-Conditions/Borderline-Personality-Disorder>

Co-Occurring Disorder, Dual Diagnosis and Comorbidity

These terms are used when a person has two or more disorders.

<https://www.nimh.nih.gov/index.shtml>

<https://www.nami.org/About-Mental-Illness/Common-with-Mental-Illness/Substance-Use-Disorders>

Depression

Mild depression is common, but major depressive disorder or clinical depression is a serious mood disorder. Severe symptoms affect how people feel, think, and handle daily activities such as sleeping, eating, or working. Clinical depression is a common precursor to or consequence of AUD and SUD. Suicidal thoughts often accompany severe depression.

<https://www.nimh.nih.gov/index.shtml>

Post-Traumatic Stress Disorder

Post-Traumatic Stress Disorder (PTSD) may develop in people who have experienced shocking, frightening, or dangerous events such as military combat, physical violence, accidents, unexpected death of a loved one, childhood abuse, and domestic violence. While most traumatized people experience short term symptoms, the majority of them do not develop ongoing (chronic) PTSD.

Symptoms usually begin within three months of the traumatic incident, but sometimes not until years afterward.

<https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml>

https://www.nimh.nih.gov/health/publications/post-traumatic-stress-disorder-ptsd/20-mh-8124-ptsd_38054.pdf

https://www.ptsd.va.gov/understand/what/ptsd_basics.asp

What Facilitators Need to Know

- Facilitator resources include peer support, regional coordinators, SMART Meeting Management Meetings, the Facilitators Manual, the facilitator threads found on SMARTRecovery.org and SMARTcal and SMARTrec
- There are appropriate, helpful responses and techniques to use in meetings when mental health disorders and/or suicide are brought up.
- Facilitators and meeting helpers benefit by having basic knowledge of mental health disorders.
- SMART has a prepared response for addressing the topic of mental health disorders. (see Best Practices)
- SMART supports the use of prescribed medications.
- Some participants say their treatment provider recommended they try SMART Recovery.

Best Practices

The SMART Recovery Facilitators Manual 2nd Edition, 2015, Chapter 8, Questions Facilitators Are Asked, Page 100, states:

Many people with substance and behavior addiction suffer from other emotional or psychiatric issues. SMART can't solve every problem, so we encourage these participants to seek professional treatment and guidance of a psychiatrist, psychologist, or other mental health professional to help them with their mental health issues.

- Always remember SMART volunteers are not substitutes for mental health care providers.
- Keep your local suicide prevention information in your phone or with you.
- Use the term *mental health disorder* instead of *mental illness*.
- Use the terms *co-occurring* or *dual diagnosis* rather than *co-morbidity*.
- Strive for a welcoming atmosphere in meetings for those who bring up mental health disorders, as we do with everyone else.
- Avoid using technical medical terminology in meetings as much as possible.
- Do not let the mention of mental health disorders distract from the SMART approach of addiction recovery.

- Make sure your and the group’s responses about mental health disorders are not dismissive.
- Do not get into, or allow the group to get into, a discussion about mental health disorders causing a person to engage in addictive behavior. Instead:
 - *“We are glad you are here with us. We are here to work on changing our addictive behavior and that is proven to be helpful with mental health disorders.”*
 - OR
 - *“In SMART, participants benefit most by taking primary responsibility for their own recovery. Would anyone in the group like to share their experience of how addiction recovery helped with their mental health disorders?”*
- Participants might mention using medications with mental health disorders. SMART supports the proper use of medications. Reinforcement of this may be helpful, but **SMART meetings are always to be kept about self-help addiction recovery**, not a discussion on medications used in treating mental health disorders.
- The official position of SMART on use of medications is:

Use of Medications to Treat Addictions and Mental Health

SMART Recovery supports the scientifically informed use of psychological treatment and legally prescribed psychiatric and addiction medication.

<https://www.smartrecovery.org/about-us/>

Suicide Discussions in Meetings

When a participant brings up suicide or appears suicidal in a SMART meeting, it is an intense emotional experience for all present. This section will teach you

- How to respond to immediate crisis situations,
- Several important warning sign questions to ask,
- Myths and facts about suicide.

This section also provides contact information for national suicide prevention and crisis organizations and a sample of a county website for suicide prevention and crisis assistance.

Most of the text in this section has been copied from the Mayo Clinic website and the QPR Institute. Facilitators can learn more by taking a course from the QPR Institute.

<https://www.mayoclinic.org/diseases-conditions/suicide/in-depth/suicide/art-20044707>
<https://qprinstitute.com/>

What to do in an Immediate Crisis Situation

- Take any threat or talk of suicide seriously.
- Don't leave the person alone if possible.
- Ask the person if they have a plan to commit suicide.
- Call 911 or try to persuade the participant to call a local suicide prevention crisis prevention number right away.
- Try to find out if the person is under the influence of alcohol or drugs or may have taken an overdose.
- In SROL meetings try to get the participant to give you (or your meeting helper) their contact information privately. Try to persuade the participant to call 911 or their local/national suicide prevention/crisis prevention number right away.
- If a participant provides details about how they plan to end their life and doesn't have a plan to stay safe, it is recommended you contact the local rescue authorities and provide all information you have including the participant's name, if known. Under these circumstances the rules of confidentiality do not apply.

Best Practices When Suicide Comes Up

- In addition to what's listed here, the Facilitator Manual 2nd Edition, pages 61 through 64, contains information and best practices for dealing with suicide in meetings.
- When someone says they are thinking about suicide, taking action is always the best choice. Here's what to do:
 - Acknowledge the participant's courage in talking about their feelings.
 - Always take any threat or talk of suicide seriously.
 - Be sensitive, but ask direct questions, such as:
 - Are you thinking about suicide?
 - Do you have a plan?
 - If the answer to either or both of these questions is yes, the next three best practices are crucial in possibly saving a life.
 - A suicidal or severely depressed person may not have the energy or motivation to find help. Encourage and help the person seek treatment.
 - If the person doesn't want to consult a doctor or mental health care provider, suggest they find help from a support group, crisis center, faith community, teacher, or other trusted person. You can offer support and advice – *but remember that you are not a substitute for a mental health care provider.*
 - Always keep your local Suicide Prevention contact information with you. Here's an example of a county resource: <https://www.countyofsb.org/behavioral-wellness/suicide-prevention.sbc>

Common Myths and Facts About Suicide

Myth: No one can stop a suicide

Fact: If people in crisis get the help they need, they will probably never be suicidal again.

Myth: Confronting a person about suicide will only make them angry and increase the risk of suicide.

Fact: Asking someone directly about suicidal intent lowers anxiety, opens communication, and lowers the risk of an impulsive act.

Myth: Only experts can prevent suicide.

Fact: Suicide prevention is everybody's business, and anyone can help prevent the tragedy of a suicide.

Myth: Suicidal people keep their plans to themselves.

Fact: Most suicidal people communicate their intent during the week preceding their attempt.

Myth: People who talk about suicide don't go through with it.

Fact: People who talk about suicide may try, or even complete, an act of self-destruction.

Myth: Once a person decides to commit suicide, there is nothing anyone can do to stop them.

Fact: Suicide is the most preventable kind of death, and almost any positive action may save a life.

Suicide Prevention Resources in the U.S.

National Suicide Prevention Lifeline

1-800-273-8255 or

text the Crisis Text Line (text HELLO to 741741)

TTY The deaf and hard of hearing: 1-800-799-4889

24 hours access and available in English and Spanish. All calls are confidential.

Veterans Crisis Line

1-800-273-8255

<http://www.suicidepreventionlifeline.org/>

<http://www.befrienders.org>

<https://www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml>

Online Resources Cited

1. <https://www.nimh.nih.gov/index.shtml>
2. <https://www.nami.org/About-Mental-Illness/Common-with-Mental-Illness/Substance-Use-Disorders>
3. <https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml>
4. https://www.ptsd.va.gov/understand/what/ptsd_basics.asp
5. https://www.nimh.nih.gov/health/publications/post-traumatic-stress-disorder-ptsd/20-mh-8124-ptsd_38054.pdf
6. <https://nami.org/About-Mental-Illness/Mental-Health-Conditions/Bipolar-Disorder>
7. <https://nami.org/About-Mental-Illness/Mental-Health-Conditions/Borderline-Personality-Disorder>
8. <https://www.smartrecovery.org/about-us/>
9. <https://www.mayoclinic.org/diseases-conditions/suicide/in-depth/suicide/art-20044707>
10. <https://www.countyofsb.org/behavioral-wellness/suicide-prevention.sbc>
11. <https://qprinstitute.com/>
12. <http://www.suicidepreventionlifeline.org/>
13. <http://www.befrienders.org>
14. <https://www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml>