ACUTE CARE/EMERGENCY DEPARTMENT

PEER SUPPORT TRAINING

ACUTE CARE (PSYCHIATRIC INPATIENT UNIT)

EMERGENCY DEPARTMENTS

PEER SUPPORT WORKER'S ROLE

POLICIES AND PROCEDURES

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MENTAL HEALTH CONDITIONS

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BC MENTAL HEALTH ACT

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RESTRAINT

SECLUSION

RISK AND SAFETY

BURNOUT

ACUTE CARE (PSYCHIATRIC INPATIENT UNIT)

The inpatient psychiatric unit is a unique environment. You may be working with a peer several times over several days, or you may speak to them one time and one time only. As such, working in acute care environments requires peer support workers to be flexible and adaptive in how they support the peers that they work with. This training will begin to equip you with the tools and techniques needed to be at your best in such complex environments, while acknowledging that the learning you will do once you are on the job in your new position will be absolutely invaluable.

What does acute care mean? Psychiatric inpatient units are places for people in mental health crisis who may need safety monitoring and assessment as well as therapy and medication management.

Discussion: What do you think the inpatient psychiatric unit is like?

What A Psychiatric Ward Is Really Like Behind Closed Doors

A young woman with bipolar disorder shares what she learned after being admitted first as a teen and later as an adult.

Article by: Katie Dale

You know the feeling when you walk through a doorway and you've forgotten why you're there? That's how it felt to walk through the hospital door and enter the psychiatric ward for the first time. A little bit surreal.

The first time I entered those doors was 14 years ago—I was just 16 and hiding under a very thin white blanket while seated in a wheelchair. My parents escorted through the doors. Now, you may be wondering why I was under a blanket. In the frame of mind I was in, it was hard to tell, but I've since learned that I was exhibiting the symptom of paranoia that many people with bipolar disorder experience. I was frightened out of my mind, and rightfully so. Only a few nights earlier I had heard demons chanting the name of my savior in my head: "*Jesus Christ! Jesus Christ!*"

On the day I was admitted, I remember waiting in the ER for what seemed like hours, beforehand. When I arrived, there was a whole new team of medical personnel wanting to see who was underneath the blanket. After hearing my Mom prompt me, I braved the new place and shyly stood up on my feet. A friendly aide greeted me.

“Hi – I’m Kim. You must be Katie.” She was the first face of hope I met there. After taking me to the nurse’s office to get my vitals, I met Holly, another aide, with a sparkling personality that also helped put me at ease for the remainder of my three weeks there.

It wasn’t until my Mom and Dad left, though, that the experience of the psych ward began to envelop all my senses. Here are a few things to expect in the psych ward, based on my experience at 16 and again at 24, that I would have appreciated knowing in advance.

How is the day structured there?
There is a schedule that isn’t necessarily the same every day. But you can be sure the staff will keep you on schedule. You are expected to go to bed at a reasonable hour, and sleep for at least 8 hours. There is order to the day. Mine often looked like this: time to prepare for the day (I got an hour in the morning), breakfast, quiet time, recess/physical activity, TV time, study time (for school-aged patients), recreation time and group therapy. After lunch, more of the same activities follow until a break for dinner which is often followed by visitor hours, movie time and lights out. The activities don’t necessarily occur in that order but the schedule is typically posted in a visible place.

When can I see my doctor?
At least once a week I would see the doctor. Maybe not as often as I wanted, but at least as often as he could see me. I recommend being as honest and transparent as possible with the doctor. They want to know how you’re doing, so tell them if you’re having a cruddy day, or if your symptoms are bothering you. They are there to help you.

Are patients violent?
I can’t say there weren’t times when patients got out of control and the staff had to intervene but if you follow the rules and avoid confrontation with others, you should have no problem. Try to keep your distance physically and emotionally from people who you think may have the potential to be violent. Also, remember that many people in the psych ward may just like you and you may even find a friend or two during your time there. I created a lifelong friendship at the psychiatric ward.

What kind of testing is performed?
They draw your blood upon admission. They also take your vitals regularly, usually morning and evening, but at least once a day.

What does the facility look like?
The three psych wards I've been in were pretty plain on the inside. Unfortunately, they don't seem to make interior design a priority. The first one had no pictures on the walls, and the second had about three abstract paintings, and 2 illustrations that reminded me of the *Silence Of The Lambs* movie poster (eerie, I know). Another adult ward I stayed in had vaulted ceilings with large photos of beautiful locations around the world. There are usually minimal decorations and "homey" items. It's easy to understand that it would be a risk to keep any home-like furnishings in the rooms, so it was pretty bare, needless to say.

Are the beds comfortable?
Honestly, all of the beds I had slept on were pretty stiff. They had plywood frames and no headboards, with a couple inches of mattress padding. But the sheets and linens were cleaned regularly, thankfully.

How long is the typical stay?
I do know that some people were out the next day. And some people stay longer. I was there for 3 weeks. Some people stay a few months. Doctors and staff regularly review the patients' behaviors. Their input in part dictates the length of treatment at the facility. The staff wants to ensure you're safe and not a harm to yourself or others before you are discharged.

What do you wear?
When I was in the juvenile ward, we wore scrubs. In the adult ward, we wore casual, comfortable everyday clothing. They confiscate any belts, hoodie strings, shoestrings, and the like so as to take away anything that may pose a safety risk.

What kind of physical activity goes on?
This may vary from place to place, but there was always a recreation time to either interact with others in a gym or outside in the enclosed courtyard. Take advantage of the physical activities, your brain needs it as much as your body. And you may end up passing on it during times you want to be alone to think or relax.

How can I avoid sensory overload?

It may be best that once in a while, during times that the patients congregate in a group, you may want to go to your room to rest, away from the noise and commotion. There were days it was hard for me to handle the day-to-day activities in my mental illness, and an even greater a struggle to deal with a blaring movie on TV or a crowd of people talking loudly waiting for their meds in the dayroom. Permit yourself to take breaks from the anxiety-inducing activities, know and identify your triggers, and learn coping skills.

A final note: be sure to **make the most of it**. Your time in the psych ward may be the darkest night of the soul, or a welcome reprieve from the lifestyle you lead that could help you get your bearings while you're away. In either case, know there is a light at the end of the tunnel. It may seem like the moments are going on forever, but just remember, "T*his too shall pass*." So, while you're waiting for discharge, cooperate, and work on you.

Being isolated within a hospital psychiatric unit may seem contrary to what you need when you're not in a stable frame of mind. You're not surrounded by friends or family inside those walls, though they should be more than welcome to come visit you. I would encourage you to seek professional help when deciphering whether or not you should be admitted to a psychiatric unit. I know I received the help I could not have gotten elsewhere had I not been committed. In the end, my mental health benefitted greatly from it.

Discussion: How can you work at your best in a psychiatric unit?

Here is some information to working and being at your best:

Diversity of Workload: The biggest constant in each day is change. Change from one activity to the next, from one peer to the next, from one meeting to the next, with little warning. Being able to shift gears quickly is critical, as is tolerance for interruptions and frequent changes in plans.

Diversity of Peers: It's hard to estimate how many of the peers are dealing with which diagnoses. There is always a range in mental status and other characteristics. Since mental illness and hardship know no divisions, peers are of all backgrounds and communities. Some have had dozens of hospitalizations and have difficulty living independently. For some, their inpatient status is the mark of a dramatic life change that has sobered, scared, or frustrated them, and just accepting this change is much of the work of their stay.

Groupwork: These peers have been brought together by various missing pieces: the puzzles of their lives have broken down, and much does not fit as it did before. Perhaps pieces have been missing or misplaced for some time. In a mix of being between homes and privileged, sober and struggling with substance use issues, depressed and struggling with psychosis, crisis is the great equalizer. As much as peers might bond over the restrictive rules that are innate in hospital or institutional settings, they build strong relationships based on the broken structure of their lives before their stay, and they together face the fears of returning. Watching the most diverse patients form the strongest of bonds, especially as groups unfold, is an ever-inspiring joy.

One-on-One Time: There is little time for daily, extended conversations. Peers have gone through other interviews already, and they are still trying to integrate this new experience into their views of themselves and the world. They often bloom with a few words of reassurance, the chance to tell their story, and the opportunity to hear more about resources available to them. Some peers may be completely unable to connect initially but be very available a few days later. Either way, you've made a connection at a time when many people feel at their most disconnected. Being available to peers throughout their stay, in whatever limited ways possible, lends continuity to their experience, satisfaction for the peer support worker, and a valuable aspect to the recovery process.

Collaboration: Doctors, nurses, mental health workers, occupational therapists, psychologists, students, social workers, and peer support workers sit side by side in a rich discussion. However, this could also be the place where your voice is lost. If autonomy is highly important to you, this may be a struggle, as psychiatrists are the primary providers in this environment. The key is to plan ahead and have questions or concerns written down.

Linking to Resources: Peers may come to the unit isolated, underprivileged, and confused. They may feel they have no options, but together, you will work to discover them. Every interaction with a peer is an opportunity to provide outlets, supports, and information.

Quick Rewards: Although the rapid pace of a unit can leave one gasping for air, it can also involve fast progress. In a contained environment, changes in medications, psychotherapy, and other approaches can happen quickly, and the structure itself can be stabilizing. In the space of (for instance) a week's time, a person can begin to carry on an appropriate conversation again, want to live again, or lose fears of persecution. Away from outside stressors, peers can practice new skills, gather support, and utilize numerous treatments, intensively and powerfully. Many face great difficulties at discharge. Some may return. But the moments of connection and insight that you can facilitate are carried with them. We are in the business of hope and new chances.

Challenging Realities: There are difficulties to which peers must return. The wish is for safe housing, rehab beds, comprehensive outpatient services, and solid support

networks. Many of these dreams are elusive. Peers may have to be discharged sooner than is optimal. However, peers are discharged with the skills and resources you have taught and empowered them with. Many peers do build new lives out of this momentary nesting ground.

Unfinished Stories: In a hospital, a great portion remains untold. For example, one can sometimes wonder how outpatient treatment is proceeding. In general, no news is good news.

Safety Issues: While it would be foolish to pretend risk is limited to certain environments, this setting may involve sporadic violence, both emotional and physical. As a peer support worker, as much as you may want to help, you do not intervene if someone behaves aggressively. The staff is well-trained. But you do need to understand how acute illnesses can affect a peer's self-control. You will need to be prepared for anything, especially to de-escalate a situation quickly. While people with mental illnesses are more likely to be victims of violence than perpetrators, emotional and behavioral dysregulation are common symptoms. Fortunately, there are terrific resources, especially the staff, and the contained environment.

Shared Space: Don't expect a lot of privacy on an inpatient unit. Desks are often situated together and the pressure to meet deadlines and work within the treatment plan is significant. Much of your unit experiences, whether in groups with peers or in teams with staff, is about building new truths, and new treatments, together. Magic happens every day, and it is shared, discussed, and sometimes debated. If this is a new role, it may take time to be integrated as part of the team. Be confident in your role as your value will shine through.

Discussion: What do you think of the ideas we just shared?

Sources:

https://www.socialworker.com/feature-articles/practice/Is_a_Psychiatric_Unit_the_Right_Setting_for_You%3F/

https://www.psycom.net/what-a-psychiatric-ward-is-really-like

PSYCHIATRIC UNIT HANDOUT

Working and Being at Your Best

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EMERGENCY DEPARTMENTS

Emergency departments are unique healthcare environments. As a peer support worker working in an emergency department, you are most likely to be the first point of contact for a peer seeking support during a crisis. As such, being able to provide compassionate, empathetic and appropriate care in a potentially high stress environment is critical to work in the Emergency Department.

Discussion: What do you think the emergency department is like?

The main event of your emergency department visit will likely be a psychiatric evaluation. The team of mental health professionals will determine a working diagnosis and plan of action for treatment.

My Experience Going to the Emergency Room

By Alyse Ruriani

When someone is actively suicidal, we often tell them to call the National Suicide Prevention Lifeline, call 911, or go to the local Emergency Room. These are all correct responses, but they are also scary, big steps for someone in a mental health crisis to take. I am going to try to demystify what happens at the emergency room when you go there for suicidal thoughts and planning by sharing my own experiences.

After telling the emergency room staff the reason why I was there, I was evaluated.

Whenever you go into the emergency room, for whatever reason, you tell the staff why you are there. You can word this however you want: I am feeling suicidal, I have a suicide plan, I'm having suicidal thoughts, I'm feeling really depressed, etc. I went with my parents, so they talked to the staff for me because I was unable to. (If you feel as though you need support, it's a good idea to go with your parents or guardians or someone you trust.)

In my visits to the emergency room, they have had a mental health crisis professional come to evaluate me. The evaluation is assessing your suicide risk to determine what level of care you need. This means that you should be extremely honest with the person- they are just trying to get you the help that you need and that fits your situation. I was asked if I have a plan, if I've had previous attempts/thoughts/hospitalizations, what medications I am on (if any), any issues going on in my life, and other questions to determine my mental state.

My level of care needed was determined and they found me a place in that level of care.

In mental health treatment, there are different levels of care, meaning how much supervision and treatment you need.

- Inpatient hospitalization (IP) is 24/7, acute care and support. You spend both days and nights there. Depending on your area, it may be a floor of a regular hospital or a freestanding psychiatric hospital. This treatment is also at hospitals or clinics. Inpatient hospitalization is used when the person is at risk for harming themselves or someone else. The average length of stay is 5-7 days, but varies greatly. This is usually the outcome for an actively suicidal person.
- Partial hospitalization program (PHP) is an outpatient day treatment where you are there for 6+ hours either everyday or every week day. Outpatient means you sleep at home. This can be at the hospital, at a clinic, or at a mental health care center. Partial hospitalization treatment usually consists of 1:1 therapy, psychiatry, group therapy, psycho-educational groups, and recreational/expression therapy.
- Intensive Outpatient Program (IOP) is about 3-4 hours, usually at night or in the afternoon, and is 3-4 times a week, Like partial treatment, you sleep at home. This option is used a lot in situations where the person is safe enough to be unsupervised but is struggling enough to need more intensive care than weekly therapy. This can also be done fairly easily in conjunction with school and/or work.
- Outpatient Treatment is your typical weekly therapy/psychiatry/group meetings. Sometimes if a person is safe but is experiencing suicidal thoughts and they don't do Intensive Outpatient, they will do regular outpatient 2 or 3 times a week with their therapist or do weekly sessions with their therapist and supplement with a weekly group therapy session.

Discussion: How can you work at your best in an emergency department?

In the emergency department setting, staff are focused on achieving a high level of productivity within especially tight time constraints. Staff may face an unpredictable work environment, with long shifts, challenging patient loads and "frequent exposure to potentially traumatic events" (Schneider & Weigl, 2018). Staff workloads and emotional drain are frequently pointed as key stressors (Johnston et al., 2016) and physicians and nurses experience a moderate to high level of burnout (Bragard, Dupuis, & Fleet, 2015; Hunsaker, Chen, Maughan, & Heaston, 2015). Peer support workers working in this environment are exposed to the same challenges. Given this context, peer support workers working within emergency departments need to be especially flexible, responsive, agreeable, extroverted, and comfortable working with multi-disciplinary teams. In addition, peer support workers must be especially skilled at remaining calm amidst chaos.

Remember, you will be working with an individual who has just been through a very traumatic event. They may also be angry, shocked, or confused as to why and how they ended up in the emergency department. They may also be feeling acute withdrawal

symptoms. Such as, you might also be the last person that they want to talk to, and they may not be ready to talk about recovery or treatment options at all. Your most important role will be to just be there with the individual. Listen, empathize and validate their feelings. You may feel like you are not doing enough, but you are! Your presence may just be the glimpse of hope that person needs. As you then follow-up with the individual and slowly start to build trust, they may then be ready to engage in recovery support services.

While important for all peer support workers, because of the nature of the work environment, those working within an emergency department setting must have superior coping skills and a high level of self-management, which involves taking an active role in one's recovery and wellness.

Source:

https://eipd.dcs.wisc.edu/non-credit/WI_Voices/Peer-Support-ED-Setting/Transcript/RecoveryU%20Module%201_%20Peer%20Support%20in%20the%20ED%20Setting.pdf

EMERGENCY DEPARTMENT HANDOUT

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PEER SUPPORT WORKER'S ROLE: THE DO'S AND DON'T'S

Group Activity

We'll now divide into two groups. One group will cover the do's of the peer support worker's role in acute care and emergency department settings and the second group will cover the don't's. Choose someone to report back to the large group.

Having role clarity is an important way that the peer support worker can integrate successfully into the hospital or emergency department setting. Knowing what you are and what you are not helps you stay on the right path of providing appropriate, evidence-based, and effective peer support.

A peer support worker is a person with lived experience. You are a role model for positive recovery behaviors and lifestyle. You see the person in the context of their role, family, and community and motivates through hope and inspiration. A peer support worker supports many pathways to recovery. You can function as an advocate. A peer support worker may work with a person on how to accomplish tasks and acquire needed resources. You use language based on common experience. You help the person find professional help if needed. A peer support worker shares knowledge of local resources. You encourage, support, and praise. A peer support worker helps to set personal goals.

Remember, the most important role of the peer support worker is to let individuals know they are not alone, to share our own lived experience and to listen. Sometimes, the best way that you can support another person is to just be there, and by just being there, you show someone who is struggling that there is hope.

As a peer support worker, you will have the opportunity to share resources with an individual who may be ready to seek help and when that window of opportunity arrives, it is very important that you're ready to share a list of resources available to that person.

You do not give professional advice. A peer support worker is not an authority figure. You do not see the person as a case or diagnosis. You do not motivate with fear or consequences. You do not do tasks for the person. You do not use clinical language or provide basic necessities like housing. You do not provide case management services. Peer support workers do not diagnose, assess, or treat. You do not mandate behaviors. Peer support workers do not tell a person how to live their recovery.

Navigating the traditional treatment system can be challenging. Remember, you are **not** a case manager or counselor, but you can act as a bridge for the individual to learn about the different options they have for help. You can connect them with services that will be able to guide them through the process of getting professional help or other

types of recovery support services. Some examples of traditional treatment options include: inpatient or residential treatment, intensive outpatient treatment, outpatient treatment, substance use disorder, or co-occurring disorders counseling.

Building trust is one of the most important parts of the peer support worker role. You will not only need to build trust with the individual you are supporting, but in the environment where the peer support is taking place. In the hospital or emergency department setting, you will need to ensure that you are also working to build the trust of the staff. Remember, they may have never worked with an individual in recovery or someone who is vocal about recovery. They may have preconceived notions about mental illness, addiction and recovery. For the individual you are working with, they may have just experienced a very scary event. They may also be suffering from a host of experiences, attitudes, stigma and beliefs that can act as barriers to building a trusting relationship from the start. Having patience with both the individuals you are working with and staff will be very important. In order to build trust, you will also need to work to eliminate barriers like stigma. The best way to do this? Be yourself. Through your actions, show individuals how a person in recovery from a mental health condition and/or substance use disorder acts.

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POLICIES AND PROCEDURES

In order to be an effective peer support worker in the hospital or emergency department setting, we will need to have done an orientation with other staff on policies and procedures specific to the location or health system where we will be working. Depending on the hospital or emergency department, these policies and procedures may be different. It is important to consult with the supervisor to ensure that we have had the appropriate orientation to these policies and procedures. Don't be afraid to ask for clarification.

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https://eipd.dcs.wisc.edu/non-credit/WI_Voices/Peer-Support-ED-Setting/Transcript/RecoveryU%20Module%201_%20Peer%20Support%20in%20the%20ED%20Setting.pdf

COMMUNICATION SKILLS

Communication means more than just the words we use; it's our tone, cadence, our body language. The non-verbal cues we use may help or cause harm in our interactions with the peers we serve. Nowhere is this more evident than in acute care/emergency department settings. In some cases, we may be the first person who identifies themselves as a peer that a person has ever spoken to. Maybe we are supporting them as they seek help for the first time. Maybe you have met them before when they have sought help previously. In these and any number of other circumstances, having a good understanding of our body language and how it may affect the peers we are supporting is paramount.

BODY LANGUAGE

Discussion: How do people communicate other than with words? *Eye contact, posture, personal space, facial expression, tone of voice*

Be aware of your body language in order to communicate assertively. A mismatch between your verbal and non-verbal messages reduces the effectiveness of what you are trying to say. Are you sitting at eye level with them or standing over them? Are you slouched in your chair or sitting up attentively? Is your cell phone ringer off?

OARS

We will use the acronym OARS for some effective communication skills. *Write OARS downward on flipchart and see if students can guess what they stand for.*

Open Ended Questions

Affirmative Responses

Reflective Responses

Summarizing

OPEN ENDED VS CLOSED ENDED QUESTIONS

How do open-ended questions usually begin? (what and how) Open-ended questions provide an opportunity for the speaker to explore and expand. How do closed questions usually begin? Closed-ended questions direct the speaker to give a specific short response, such as 'yes' or 'no'.

A reporter asks both closed and open-ended questions: Who? What? When? Where? How? – we avoid using Why?

Discussion: What do you think is the reason is that we avoid using a question starting with Why?

Discussion: What are some examples of open-ended questions?

"Tell me more about_____?"
"What do you think you will do?"
"When you responded the way you did, how did you feel about your reaction?"

Partner Activity

With a partner, share something you think might be of interest, anything. The other person will listen, use appropriate body language and ask open-ended questions to gather more information about what is being shared. You'll have 3 minutes each.

Discussion: How did it go? Did you have any trouble avoiding using yes/no closed-ended questions?

AFFIRMATIVE RESPONSES

Positive affirmations are statements and gestures that recognize client strengths and acknowledge behaviors that lead in the direction of positive change, no matter how big or small. Affirmations build confidence in one's ability to change. To be effective, affirmations must be genuine and meaningful.

You are clearly a resourceful person *That's a good suggestion*

You did excellent in that situation

If we`re not sincere in what we are saying, our peers will see right through us. The more transparent we are, the more real what we say will be.

A statement that conveys and brings focus/attention to something positive, acknowledges a person's strengths and efforts, and validates them and their feelings and behaviours.

"You have been working really hard, that's amazing!"
"You are really good at _____!"

Partner Activity

We`ll now give this a try. With the person sitting beside you, one person will say something they`re proud of like accomplishing a goal and the other person will give an affirmative response. Then switch turns. You`ll have a few minutes to do this.

Discussion: What was it like providing affirmations?

REFLECTIVE RESPONSES

In using reflective responses we're focusing on what the other person is feeling and thinking. Most times we think people are looking for advise, when all they really want is a sounding board. This skill involves paraphrasing or repeating back to them what someone tells you in your own words. It puts you in the other person's shoes and it helps you to understand what the person is saying.

A statement or paraphrase that involves listening carefully, then making a reasonable guess about what the other person is saying (mirrors their words or interpreting the underlying sentiment).

"That sounds really hard for you?"
"It sounds like ____" or "I get the sense that ____"
"So, on the one hand it ____ And, yet on the other hand ___" Is that right?

Partner Activity

With a partner one person will be the talker and share something they're currently working on in your life like a hobby or a new year's resolution. The other person will only respond with reflective responses and use effective body language. Nothing else. No questions. No problem solving, just reflective responses. You'll have three minutes and then you can switch turns.

Discussion: How was that for you?

SUMMARIZING

Summarizing is pulling everything together to help ensure that you have heard correctly what has been said. Regardless of what they say, remain calm and non-judgmental.

Let me see if I understand so far…

Here's what I heard, tell me if I missed anything

Here's an example of summarizing. "Over the past few months you have been experiencing more anxiety and it's starting to affect your ability to have fun. You are frustrated and want to do something about it but don't know what to do. Does that sound right?" This provides them the opportunity to provide more meaning or correct your understanding. Remember, be genuine – don't say you understand if you don't.

Partner Activity

We`ll now give this a try. With the person sitting beside you, one person will share about an adventure they've experienced and then the other person will summarize. Then switch turns. You`ll have three minutes and then you can switch turns.

Discussion: How was that for you?

ROLE PLAY

We'll use the SKILLS HANDOUT for the next role play activity.

Let's get into groups of 3. *(WAIT UNTIL GROUP ASSEMBLES THEMSELVES)*

We will have 3 roles: one person will be the talker, one person will be the responder and one person will be the observer. So, first, decide within your group who is going to play which role. Everyone will get a chance to play each role during each role play. *(WAIT FOR THE GROUP TO DECIDE)*

This is how the role plays will take place: the talker and responder will have 5 minutes and during that time the talker is going to be **sharing something they're currently working on in their life (like a hobby, skill or goal)** Don't pick something too intense as we don't have counselors available at the end of this class.

The observer will be taking notes of what is happening with respect to the skills that we will be practicing (OARS, empathy …..).

I will tell you when 5 minutes is up and then you'll have a few minutes to debrief. The observer will share with the group their observations (what went well, what didn't go so well and what could be improved upon) and the talker and responder will share their observations. Then you will switch roles. Then you will switch roles again until each person has played each role.

The responder is going to demonstrate effective body language, listening, asking open-ended questions to gather more information if needed, respond with reflective responses. *(5 minutes)*

Switch roles. *(5 minutes)*

Switch roles. *(5 minutes)*

DISCUSSION:

What was it like to be aware of practicing these skills?

What were the easiest parts?

What were the most difficult parts?

COMMUNICATION SKILLS HANDOUTS

SUMMARY OF COMMUNICATION SKILLS (OARS)

O: OPEN-ENDED QUESTIONS

Use —Where, when, what? or —How? in your questions to get the information you need. Avoid closed ended questions.

What have you tried before? How would you like things to be different?

A: AFFIRMATIVE RESPONSES

Affirmations are statements and gestures that draw attention to a persons strengths and acknowledge behaviors that reinforce positive actions they're taking towards their goals, no matter how big or small. Affirmations must be authentic, should be provided in the moment and be meaningful to the person.

You are clearly a resourceful person *That's a good suggestion*

You did excellent in that situation

R: REFLECTIVE RESPONSES

This skill requires that you listen very carefully, paying attention to your client's body language and behavior and reflect using your own words and perceptions.

You're feeling _____ because _____ *It sounds like…*

I noticed you just… *So you feel…*

S: SUMMARIZING

Summarizing is pulling everything together to help ensure that you have heard correctly what has been said. Make sure that you are both on the same page and don't shy away from asking for more clarity.

Let me see if I understand you so far…

Here's what I heard, tell me if I missed anything

Open-ended Questions: provide an opportunity for the speaker to explore and expand.	**OBSERVATIONS**
Affirmative Responses: involves statements or gestures that acknowledge that the other person has been heard and encourage them to continue talking.	
Reflective Responses: involves translating what someone tells you in your own words.	
Summarizing: pulling everything together to help ensure that you have heard correctly what has been said	

STAGES OF CHANGE

One of the best-known approaches to change (like trying to get rid of a bad habit or behaviour and / or trying to develop a new one) is the Stages of Change or Transtheoretical Model, introduced in the late 1970s by researchers James Prochaska and Carlo DiClemente who were studying ways to help people quit smoking. The Stages of Change model has been found to be an effective aid in understanding how to recognize how ready someone is to go through a change in behavior. This is important to know when setting realistic goals.

In this model, change occurs gradually and relapses (returning to a previous stage of change or behaviour) are an inevitable part of the process. People are often unwilling or resistant to change during the early stages, but they eventually develop a proactive and committed approach to changing a behavior. This model demonstrates that change is rarely easy (as anyone who has tried to keep a New Year's resolution can attest to). It often requires time, education and a gradual progression of small steps toward a goal.

1. **PRECONTEMPLATION** "I won't": You can't see any problem, have no intention of changing your behaviour, you deny having a problem, and you don't want to change yourself, only the people around you.

If your peer is in this stage, begin by asking them some questions. Have you ever tried to change this behavior in the past? How do you recognize that you have a problem? What would have to happen for you to consider your behaviour a problem?

2. **CONTEMPLATION** "I might": You have a desire to stop feeling so stuck. You acknowledge that there is a problem, struggle to understand it, and begin to think seriously about changing it. You can visualize the destination and even how to get there, but you're not ready to go yet and are still far from taking action.

If your peer is contemplating a behaviour change, there are some important questions to ask: Why do you want to change? Is there anything preventing you from changing? What are some things that could help you make this change?

3. **PREPARATION** "I will": You plan to take action and are making the final adjustments before beginning to change your behaviors-cutting short the preparation stage, i.e., quitting cold turkey, lowers your chance of success.

If they are in the preparation stage, there are some steps you can take to improve their chances of successfully making a lasting life change. With them, gather as much information as you can about ways to change their behavior. Prepare a list of motivating statements (what are the benefits and consequences of making the change AND what are the benefits and consequences of NOT making the change). Write down your goals. Find resources such as support groups, counselors, or friends who can offer advice and encouragement. Plan for lapse or relapse; what should they do if they're thinking about relapsing, strategies to avoid triggers, and plans to get back on track.

4. **ACTION** “I am”: You modify your behaviour and your environment. This is the busiest period and requires the greatest commitment of time and energy.

If your peer is currently taking action towards achieving a goal, congratulate and reward them for any positive steps they take. Reinforcement and support are extremely important in helping maintain positive steps toward change.

5. **MAINTENANCE** “I have”: You work to consolidate the gains you’ve attained and struggle to prevent relapses. Maintenance is a tremendous challenge that requires a strong, long-term commitment.

If they are trying to maintain a new behavior, look for ways to avoid temptation. Try replacing old habits with more positive actions. Encourage them to reward themselves when are able to successfully avoid a relapse. If they do falter, don’t be too hard on them or give up and tell them the same. Instead, remind them that it was just a minor setback. As you will learn in the next stage, relapses are common and are a part of the process of making a lifelong change.

6. **RELAPSE**: You go back to where you were.

The key to success is to not let these setbacks undermine their self-confidence. If they lapse back to an old behavior, take a hard look at why it happened. What triggered the relapse? What can they do to avoid these triggers in the future?

Sources:

http://hardlynormal.com/blog/2008/01/18/the-six-stages-of-change/

https://www.verywellmind.com/the-stages-of-change-2794868

STAGES OF CHANGE HANDOUT

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MOTIVATIONAL INTERVIEWING

Individuals with substance abuse disorders are usually aware of the dangers of their substance-using behaviour but continue to use substances anyway. They may want to stop using substances, but at the same time they do not want to. They enter treatment programs but claim their problems are not all that serious. These disparate feelings can be characterized as ambivalence, and they are natural, regardless of the client's state of readiness. It is important to understand and accept the client's ambivalence because ambivalence is often the central problem--and lack of motivation can be a manifestation of this ambivalence (Miller and Rollnick, 1991).

Motivational Interviewing is often recommended as an evidence-based approach to behavior change. "Motivational Interviewing is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion." *(Miller & Rollnick, 2013, p. 29)*

Principles of Motivational Interviewing

1. Express empathy through reflective listening: We cannot change other people, but we can create an empathic environment in which people are more likely to move toward positive change.
2. Develop discrepancy between clients' goals or values and their current behavior. People are more likely to choose to change when they recognize that their behavior is in direct conflict with their own personal values and goals. (i.e. they don't want to take their medication but when they don't take their medication, they're behaviour becomes erratic and they've lost their job before because of it and are currently on probation. They're goal is to keep their job.)
3. Adjust to client resistance rather than opposing it directly. The concept of resistance in Motivational Interviewing is understood to be relational. (i.e. "I understand you really don't like this medication because of some of the side effects. Let's talk to your doctor about potential changes." Vs "But you have to take your medications."
4. Support self-efficacy and optimism. Self-efficacy is a person's belief that they are capable of the change they want to make, that they'll be successful in a situation. A primary goal of Motivational Interviewing is to provide hope and enhance confidence that change is possible.

Core Elements

Motivational Interviewing is practiced with an underlying **spirit** or way of being with people:

- **Partnership**. Motivational Interviewing is a collaborative process. The Motivational Interviewing practitioner is an expert in helping people change; people are the experts of their own lives.
- **Evocation**. People have within themselves resources and skills needed for change. Motivational Interviewing draws out the person's priorities, values, and wisdom to explore reasons for change and support success.
- **Acceptance**. The Motivational Interviewing practitioner takes a nonjudgmental stance, seeks to understand the person's perspectives and experiences, expresses empathy, highlights strengths, and respects a person's right to make informed choices (they are fully aware of any risks and consequences) about changing or not changing.

Core Skills

Motivational Interviewing uses the core skills of OARS, attending to the language of change and the artful exchange of information:

Open-ended questions draw out and explore the person's experiences, perspectives, and ideas. Evocative questions guide the client to reflect on how change may be meaningful or possible.

Affirmation of strengths, efforts, and past successes help to build the person's hope and confidence in their ability to change.

Reflections are based on careful listening and trying to understand what the person is saying, by repeating, rephrasing or offering a deeper guess about what the person is trying to communicate.

Summarizing ensures shared understanding and reinforces key points made by the client.

Attending to the language of change identifies what is being said against change (sustain talk) and in favor of change (change talk) and, where appropriate, encouraging a movement away from sustain talk toward change talk.

Exchange of information respects that both the clinician and client have expertise. Sharing information is considered a two way street and needs to be responsive to what the client is saying.

Partner Activity

With a partner, talk about a time it's been hard to change, what were the difficulties, and what would have made it successful if it wasn't?

Discussion: How was that?

Fundamental Processes

These processes describe the “flow” of the Motivational Interviewing conversation although we may move back and forth among processes as needed:

Engaging: This is the foundation of Motivational Interviewing. The goal is to establish a productive working relationship through careful listening to understand and accurately reflect the person’s experience and perspective while affirming strengths and supporting autonomy.

Focusing: In this process an agenda is negotiated that draws on both the client and practitioner expertise to agree on a shared purpose, which gives the clinician permission to move into a directional conversation about change.

Evoking: In this process the clinician gently explores and helps the person to build their own “why” of change through eliciting the client’s ideas and motivations. Ambivalence is normalized, explored without judgement and, as a result, may be resolved. (discrepancies: i.e. when you meet to work on their budgeting goal of being able to pay for their rent, you notice that they always get an expensive latte before meeting with you and they have talked about the gifts they have been giving to friends and acquaintances.) This process requires skillful attention to the person’s talk about change.

Planning: Planning explores the “how” of change where the practitioner supports the individual to consolidate commitment to change and develop a plan based on the person’s own insights and expertise. This process is optional and may not be required, but if it is the timing and readiness of the client for planning is important.

Partner Activity

With a partner, use the fundamental processes with engaging (setting the stage of comfort and safety), focusing (identify what the peer wants to change), evoking (explore why the peer wants to change), and planning (explore how the peer can make a change). You’ll have 5 minutes each.

Change Talk

Change talk and sustain talk reflect two sides of a person's ambivalence about changing. The skillful individual understands that difference and guides the client away from sustain talk and toward change talk, listening especially for statements that show commitment.

Change talk in general refers to clients' statements about their desire, ability, reasons and need for change. Sustain talk is the opposite of change talk. Clients may use

sustain talk to indicate: their desire to stay as they are, their worries about being able to change, reasons not to change; need to stay as they are.

To successfully navigate the hurdles of Motivational Interviewing, you need to recognize change talk when it occurs. In the world of Motivational Interviewing, the acronym DARN CAT summarizes different kinds of change talk and commitment language.

Desire (I want to change) "I really want to lose weight."

Ability (I can change) "I can walk twice a week."

Reasons (It's important to change) "I know I'll feel better if I lose 50 pounds."

Needs (I should change) "I have to lose weight if I'm going to be able to walk upstairs."

Commitment language (I will make a change)

Action (current movement) (I am prepared and willing to change)

Taking steps toward change (I am taking specific actions to change)

The two parts of the acronym separate at a natural place. DARN represents "preparatory" change talk and CAT represents "mobilizing" change talk.

Activity

Using DARN, identify a change you'd like to make. Then using CAT, identify where you are at with regards to the change you identified.

Discussion: Would anyone like to share their DARN CAT?

Change Talk Strategies

- **Asking evocative questions**: "What worries you about your current situation?"
- **Using the importance ruler** (also use this regarding a client's confidence to change): "How important would you say it is for you to ____? On a scale of zero to ten, where zero is not at all important and ten is extremely important, where would you say you are?"

0	1	2	3	4	5	6	7	8	9	10
Not at all important										**Extremely important**

- **Exploring the decisional balance**: "What do you like about your present pattern?" "What concerns you about it?"
- **Elaborating**: "What else?"
- **Querying extremes**: "What concerns you most about ___? "What are the best results you could imagine if you made a change?"

- **Looking back**: “What were things like before you ___? What has changed?”
- **Looking forward**: “How would you like things to be different a year from now?”
- **Exploring goals and values**: “What things are most important to you?”

Role Play

Using OARS and the Change Talk Strategies, with your partner work through the change process. You’ll have 5 minutes and then you can switch partners.

Discussion: How was that?

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Core Skills

Motivational Interviewing uses the core skills of OARS, attending to the language of change and the artful exchange of information:

- **Open ended questions** draw out and explore the person's experiences, perspectives, and ideas. Evocative questions guide the client to reflect on how change may be meaningful or possible. Information is often offered within a structure of open questions (Elicit-Provide-Elicit) that first explores what the person already knows, then seeks permission to offer what the practitioner knows and then explores the person's response.
- **Affirmation** of strengths, efforts, and past successes help to build the person's hope and confidence in their ability to change.

- **Reflections** are based on careful listening and trying to understand what the person is saying, by repeating, rephrasing or offering a deeper guess about what the person is trying to communicate. This is a foundational skill of MI and how we express empathy.
- **Summarizing** ensures shared understanding and reinforces key points made by the client.
- **Attending to the language** of change identifies what is being said against change (**sustain talk**) and in favor of change (**change talk**) and, where appropriate, encouraging a movement away from sustain talk toward change talk.
- **Exchange of information** respects that both the clinician and client have expertise. Sharing information is considered a two way street and needs to be responsive to what the client is saying.

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Focusing: In this process an agenda is negotiated that draws on both the client and practitioner expertise to agree on a shared purpose, which gives the clinician permission to move into a directional conversation about change.

Evoking: In this process the clinician gently explores and helps the person to build their own “why” of change through eliciting the client’s ideas and motivations. Ambivalence is normalized, explored without judgement and, as a result, may be resolved. This process requires skillful attention to the person’s talk about change.

Planning: Planning explores the “how” of change where the person supports the individual to consolidate commitment to change and develop a plan based on the person’s own insights and expertise. This process is optional and may not be required, but if it is the timing and readiness of the client for planning is important..

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0 1 2 3 4 5 6 7 8 9 10
Not at all important — Extremely important

- Exploring the decisional balance: "What do you like about your present pattern?" "What concerns you about it?"
- Elaborating: "What else?"
- Querying extremes: "What concerns you most about ___? "What are the best results you could imagine if you made a change?"
- Looking back: "What were things like before you ___? What has changed?"

- Looking forward: “How would you like things to be different a year from now?”
- Exploring goals and values: “What things are most important to you?”

COMPASSIONATE COMMUNICATION

THE 4 STEPS OF COMPASSIONATE COMMUNICATION

These are steps that can be both helpful in your own lives and are skills you can teach your peer to use to improve their relationships and problem solving skills at home, with friends or in the workplace. Using compassionate communication reduces the potential for a power struggle and can prevent a conversation from escalating. Don't forget about the tone, body language and context (if the conversation is already heated then it may be best to take a break and come back when everyone is calm).

Step 1 - To say what was observed happening (in a conflict it is usually what happened that upset us or the other.)

These should be purely factual observations, with no component of judgment or evaluation. For example, "It's 2:00 a.m. and I hear your stereo playing" states an observed fact, while "It's way too late to be making such an awful racket" makes an evaluation. People often disagree about evaluations because they value things differently, but directly observable facts provide a common ground for communication.

Activity: Write down three observations about yourself. Then write down three evaluations about yourself.

Step 2 - To say what the feelings are.

Perform this step with the aim of accurately identifying the feeling that you or the other person are experiencing in that moment, not with the aim of shaming them for their feeling or otherwise trying to prevent them from feeling as they do. For example, "There's half an hour to go before the show starts, and I see that you're pacing *(observation).* Are you nervous?" Or, "I see your dog running around without a leash and barking *(observation).* "I'm scared." Feelings are sometimes hard to put into words.

Activity: Take a moment to notice what you're feeling right now. Close your eyes if you're comfortable doing that. Go inside and find your feeling. What do you feel right now? *(Pause)* And now? *(Pause)* And now? *(Pause)* Did you notice how many times your feelings changed from moment to moment?

Step 3 - To say what the underlying wants, needs, values or levels of importances are. (usually what you wanted to happen or were afraid it wouldn't happen)

When our needs are met, we have happy, pleasant feelings; when they are not met, we have unpleasant feelings. By tuning into the feeling, you can often find the underlying

need. Stating the need, without morally judging it, gives you both clarity about what is alive in you or the other person in that moment. For example, "I see you looking away while I'm talking, and you've been speaking so quietly, I can't hear you *(observation).* I'm feeling uncomfortable *(feeling)* because I'm needing connection right now."

What might be my need if I had the following thoughts:

“That’s totally irresponsible, what he just said.” *Answer:* Needs: *Understanding, empathy, honesty*

“Everyone else here knows more about peer support than I do.” *Answer:* Needs: *Competence, acceptance, respect*

“She always takes more time than anyone else.” *Answer:* Needs: *Mutuality, consideration, efficiency*

“This is boring.” *Answer:* Needs: *Stimulation, purpose, challenge*

“I hope my voice doesn’t start shaking.” *Answer:* Needs: *Acceptance, competence, effectiveness*

Step 4 - (Optional) To make a request of the other.

Ask clearly and specifically for what you want right now, rather than hinting or stating only what you don't want. For example, "I notice that you haven't spoken in the last ten minutes *(observation).* Are you feeling bored? *(feeling)*" If the answer is yes, you might bring up your own feeling and propose an action: "Well, I'm bored, too. Hey, how would you like to go to Science World?" or perhaps, "I'm finding these people really interesting to talk with. How about we meet up in an hour when I'm done here?" For the request to really be a request—and not a demand—allow the other person to say no or propose an alternative. You take responsibility for getting your own needs met, and you let them take responsibility for theirs.

Activity

Which of the following would be examples and why?:

Observation: “I notice that you’ve been leaving your dinner dishes in the sink after you finish eating” OR “I notice you expect me to clean up after you ever night”

Feeling: “I feel like you don’t care about me” OR “I feel angry when I find your dishes in the sink”

Need: “I need you to start doing your dishes” OR “I need to have orderly surroundings to help me relax”

Request: “I would like you to take care of your own dishes at least within a half hour of eating” OR “You have to stop being such a pig”

So, listen to the difference when we put it all together:

“I notice you expect me to clean up after you every night. I feel like you don’t care about me. I need you to start doing your own dishes. You have to stop being such a pig.”

OR

“I notice that you’ve been leaving your dinner dishes in the sink after you finish eating. I feel angry when I see your dishes in the sink. I need to have orderly surroundings to help me relax. I would like you to take care of your own dishes at least within a half hour of eating.”

This way of communicating will open the doors to further communication and could result in getting one’s needs met. Let’s look to the handout which shows us how to respond with Compassionate Communication.

We’ll now do an observation, feeling, need and request. What would that look like for the following statements:

“Your dog just made a mess on my lawn.” *Answer: When I see your dog leaving turds on my lawn, I feel upset. We have kids who play here and I want the yard to be a safe, clean space for them. Would you be willing to use this plastic bag to remove the turds?”*

“Hey kids, flashlights aren’t toys. Don’t waste batteries. They cost money.” *Answer: When I see you kids playing with the flashlights under the blanket, I feel uneasy. I want these flashlights to last so they’ll be available if we have an emergency. Would you be willing to put them away?*

PARTNER ACTIVITY

With your partner, come up with a scenario you’d like to try Compassionate Communication. Share your scenario with your partner. Then, come up with a response of expressing yourself honestly. Based on what you said, your partner will then hear you with empathy. When finished, switch partners roles? We’ll share a few of these so, do write down your responses.

Who would like to share their scenario?

Is there any feedback from the group about this?

Source:

http://www.wikihow.com/Practice-Nonviolent-Communication

COMPASSIONATE COMMUNICATION HANDOUT

Expressing yourself with honesty:

When I _____

I felt _____

Because I was wanting _____

And I would now like _____

Hearing another with empathy:

When you _____

Did you feel _____

Because you were wanting _____

And would you now like _____

CULTURAL SAFETY

“No culture can live if it attempts to be exclusive.” ~Mahatma Ghandi

In acute care/emergency department environments, you will be working with peers that bring with them their own unique and diverse backgrounds and world views. In acknowledging those differences and having an understanding of the importance of providing culturally safe support, we can ensure that we provide peers with appropriate and equitable care.

What is culture? Culture is what informs our way of being—it’s what shapes our beliefs and values and influences our behaviors. For example, chugging a cup of coffee and a bagel on-the-go is unique to New York culture, while other countries and cultures—like in France and Japan—might strictly treat eating and walking as two separate activities.

What is cultural awareness? Cultural awareness is one’s understanding of the differences between themselves and people from other countries or other backgrounds, especially differences in attitudes and values.

What is cultural sensitivity? Cultural sensitivity is being aware that cultural differences and similarities exist, while not judging people based on that. A non-judgemental mindset lets you observe cultural differences without labelling them as ‘good’ or ‘bad’, or ‘right or wrong’. This doesn’t mean that you have to be an expert in other cultures. It just means being willing to be open-minded and to ask questions to get more information, rather than having a knee-jerk reaction to anything you don’t agree with.

What is cultural competence? Cultural competence is the ability of a person to effectively interact, work, and develop meaningful relationships with people of various cultural backgrounds.

What is cultural safety? Cultural safety is an environment that is safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning, living and working together with dignity and truly listening”

An important principle of cultural safety is that it doesn’t ask people to focus on the cultural dimensions of any culture other than their own. Instead, cultural safety is primarily about examining our own cultural identities and attitudes, and being open-minded and flexible in our attitudes towards people from cultures other than our own. Identifying what makes someone else different is simple - their English isn’t very good or they don’t do things in the same way as others (Morris 2010). Understanding our own culture, and its influence on how we think, feel and behave is much harder. However, in the increasingly multicultural environments in which we all live and work, the importance of being culturally safe in what we do cannot be underestimated.

Identifying Your Culture

Let's now look at the cultures we belong to. **So, what cultures do you belong to?**

Partner Activity

What is often neglected is the equal importance of knowing one's own culture, values, and beliefs in order to relate more effectively across cultural lines. Awareness of our own culture is important, because it can keep us from projecting our values onto others.

With a partner answer the questions from your handout under Who Are You? and the Perception questions. You'll have 15 minutes.

Myths in Intercultural Communication

1. Myth: We're Really All the Same: Although we share a common human nature and need for survival, due to culture individuals have fundamentally different ways of perceiving themselves, the world and their actions within it.
2. Myth: I Just Need to Be Myself in Order to Really Connect: Although having good intentions can assist, simply retaining your own sense of identity does not guarantee success in intercultural understanding or communications.
3. Myth: I have to adopt the Practices of the Other Culture in Order to Succeed: Individuals will need to adapt to other culture's practices rather than necessarily adopt them and change your own fundamental perspective.
4. Myth: It's really all about Personality: Aspects of an individual's personality, such as whether or not an individual is an introvert or extrovert can be attributed different meanings in different cultures. Therefore, personality alone does not guarantee success in intercultural interactions, (Walker, 2003, p. 203).

An additional incorrect belief is that it is sufficient to simply learn about the etiquette and business cultural practices of a specific country. While this is valuable information, without any context for understanding, one is left to memorize protocols, which are difficult to understand without context, or retain. An additional incorrect belief is that simply learning the language of another country will lead to cross-cultural understanding. Again, while language skills are valuable, without a cultural framework for understanding, an individual could still not be effective communicating.

Principles for Cultural Safety

- **Protocols** – respect for cultural forms of engagement.
- **Personal knowledge** – understanding one's own cultural identity and sharing information about oneself to create a sense of equity and trust.
- **Process** – engaging in mutual learning, checking on cultural safety of the service recipient.
- **Positive purpose** – ensuring the process yields the right outcome for the service recipient according to that recipient's values, preferences and lifestyle.
- **Partnerships** – promoting collaborative practice. (Adapted from Ball, 2007b, p.1)

Understanding Other Cultures

Developing cultural competence is a process rather than an end point. There are three ways to understand other cultures:

1) **Cultural knowledge**

Learning more about other cultures and being aware of current events is often key in learning about various cultural groups' points of view. When working with people from different cultural backgrounds, it can be useful to learn about their culture's practices, values, and beliefs. For example, learning about the languages spoken in their communities, child-rearing practices, or religious traditions can help us understand and interact with individuals and groups of various backgrounds.

2) **Self-assessment**

Reflecting critically on our own biases and prejudices helps to develop the skills necessary to effectively interact and engage with individuals whose cultural background is different than our own. Realizing that everyone has biases is an important step for building cultural competence. The problem is when we deny or fail to acknowledge our biases. Our interactions and perceptions of others may be influenced by our biases. These biases may cause us to inadvertently act in ways that are discriminatory towards others. However, if we are aware of our biases, we can work to diminish our own prejudices and the implications they may have in our interactions with others.

3) **Beyond tolerance**

Tolerating different cultural backgrounds is a step in the right direction. However, tolerance is not always optimal. In fact, tolerance usually means that you are simply putting up with something that is undesirable. Cultural competence goes beyond

“putting up with” differences and instead involves being appreciative, affirming, and inclusive of all cultural backgrounds.

Discussion

What lens are you looking at others through and what context (i.e. their culture, socioeconomic status, education)?

Communication

Overall, cultural competence has three important components: active listening, demonstrating empathy, and effective engagement.

1) **Active Listening**

When was the last time you engaged in an active listening conversation with someone who has vastly different experiences and beliefs than you? Actively listening to an individual allows you to learn about that person’s culture and experiences. There are three components to active listening:

1) Listen for total meaning by focusing on the content that is being given and concentrating on what is being said. Active listening entails thinking about the feeling behind the content or the emotion involved.
2) Avoid mental distractions through active listening. This means listening with focus and not becoming involved in mental chitchat about how you are going to respond to a person or question.
3) Ask more questions of the other person than offer solutions. Do not jump directly to giving people advice or offering solutions about what you perceive to be the problem or their problem.

2) **Empathy**

Demonstrating empathy is the art of seeing and feeling the situation of another, walking in another person’s shoes, or seeing the world as that person sees it. Empathy involves understanding that person’s perceptions and the conclusions that person draws about his or her life experiences. It does not mean you have to agree with that person’s perceptions and conclusions, but at the very least, you are able to see the other person’s position.

3) **Engagement**

Effective engagement needs to be mutually beneficial and a reciprocal learning experience in which you learn from one another. Focus on the behaviors and the situation, not the person. If the focus of the conversation or interaction is about a tradition or belief, keep the feedback within the context of that tradition or belief. Do not say, *You are being silly because you believe that Muslims should be able to step out of*

class to pray six times a day. Focus on understanding the tradition or practice. Approach the topic by saying: *I understand this is part of your religion, but I do not understand how it effects your belief in God and why you are required to pray six times a day*. This opens up dialog in which the person can explain to you the tenants of that culture and the requirement of prayers.

Role Play

We'll now do a role play with a partner. One person will share their personal holiday traditions, and the other will communicate using the three skills of active listening, demonstrating empathy and engagement. Remember, be open-minded and curious.

Building Cultural Understanding and Awareness

It can be very easy to stick with what you know, rather than try to meet people who are different from you. However, actively trying to understand and embrace cultural differences can open you up to a whole world of experiences. Here are six things you can do:

1) **Become Self-Aware**

Work out your own beliefs, values and personal biases. This includes biases about your own cultural background.

Discussion: How can you become more self-aware?

You could think about what assumptions you make about your friends, peers, people you work with and strangers you see walking down the street. What assumptions do you make about people from the same background as you?

2) **Do your Research**

Learning about different cultures can be a great way to develop an understanding of cultural diversity.

3) **Talk to Someone from a Different Cultural Background**

Try and get to know someone from a different cultural background better. You don't necessarily have to ask them directly about their culture, but by getting to know them as a friend or peer, you'll automatically find out more about their life and experiences. Just being curious and open-minded can be helpful.

Discussion: How could you find someone from a different cultural background?

You could have a chat or catch-up with an acquaintance, friend or co-worker that you've wanted to get to know better. Remember to treat them just like you would anyone else, and don't think of them only as a way to get to know about other cultural backgrounds.

4) **Travel!**

One of the best ways to experience and understand other cultures is to actually live among them. It might take a while to save for, but planning a trip overseas to a country you're interested in can be the best way of opening yourself up to new cultures. Or you could check out some virtual travel and history experiences from the comfort of your own home.

5) **Be more Accepting**

Sometimes, for one reason or another, it's not all that easy to understand some cultural differences. In these situations, the best approach is just to acknowledge that some people are different and to accept that that's okay. You don't have to understand, or even agree with, someone in order to accept them.

Discussion: How can you be more accepting of others?

You could practise being empathetic towards the people around you and be mindful of your thoughts about others. Try not to compare or judge. Learn more about how you can become more accepting.

SOURCES

http://www.intstudentsup.org/diversity/cultural_safety/

https://www.pmi.org/learning/library/analyze-understand-culture-intercultural-communication-6864

https://extensionpublications.unl.edu/assets/html/g1375/build/g1375.htm

https://au.reachout.com/articles/understanding-a-different-culture

CULTURAL SAFETY HANDOUT

Who Are You?

Where do you come from?
What do you value in others?
Who are your friends?
What do you value in yourself?
What are your core beliefs?
What do you do?
What kind of music do you like?
What's your family like?

Perception

What are some of the things that have influenced you or helped to shape your perception of cultures and how you interact with various cultures?

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Building Cultural Understanding and Awareness

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2) Do your Research
3) Talk to Someone from a Different Cultural Background
4) Travel
5) Be more Accepting

TRAUMA-INFORMED PRACTICE

Trauma-Informed Practice is a strengths-based framework grounded in an understanding of and responsiveness to the impact of **trauma**, that emphasises physical, psychological, and emotional safety for everyone, and that creates opportunities for survivors to rebuild a sense of control and empowerment (Hopper et al., 2010)

TYPES OF TRAUMA

Acute trauma: This results from a single stressful or dangerous event.

Chronic trauma: This results from repeated and prolonged exposure to highly stressful events. Examples include cases of child abuse, bullying, or domestic violence

Complex trauma: This results from exposure to multiple traumatic events.

Trauma is not defined by the event; it's determined by the response to it

GUIDING PRINCIPLES

- **Safety** – Strive to create environments where people feel physically and emotionally safe.
- **Choice** – Maintaining appropriate boundaries and making tasks clear
- **Collaboration** – Striving for dignity and equality in our relationships by sharing power and decision-making so that everyone has a role to play.
- **Trustworthiness** – Striving to build and maintain trust by being transparent in our actions and choices.
- **Empowerment** – Striving to recognize, validate, and build on the strengths that people have to offer, and work to facilitate recovery rather than control it.

Utilizing a trauma-informed approach does not necessarily require disclosure of trauma. Rather, services are provided in ways that recognize the need for physical and emotional safety, as well as choice and control in decisions affecting one's treatment. A key aspect of trauma-informed services is to create an environment where service users do not experience further traumatization or re-traumatization (events that reflect earlier experiences of powerlessness and loss of control) and where they can make decisions about their treatment needs at a pace that feels safe to them.

CONCEPTS OF TRAUMA

The three E's of Trauma: Events, Experiences and Effects:

1. **Event** and circumstances may include the actual or extreme threat of physical or psychological harm (i.e., natural disasters, violence, etc.) or severe, life-

threatening neglect for a child that imperils healthy development. These events and circumstances may occur as a single occurrence or repeatedly over time.

2. **Experiences** of these events or circumstances helps to determine whether it is a traumatic event. A particular event may be experienced as traumatic for one individual and not for another. How the individual labels, assigns meaning to, and is disrupted physically and psychologically by an event will contribute to whether or not it is experienced as traumatic. How the event is experienced may be linked to a range of factors including the individual's cultural beliefs, availability of social supports, or to the developmental stage of the individual, or fifty.

3. **Effects** may occur immediately or may have a delayed onset. The duration of the effects can be short to long term. In some situations, the individual may not recognize the connection between the traumatic events and the effects. Examples of adverse effects include an individual's inability to cope with the normal stresses and strains of daily living; to trust and benefit from relationships; to manage cognitive processes, such as memory, attention, thinking; to regulate behavior; or to control the expression of emotions.

The four R's: Realization or understanding of how trauma affects people, Recognize the signs of trauma, Respond to trauma, Resist Re-traumatization:

1. **Realizing** the widespread impact of trauma and understands potential paths for recovery

2. **Recognizing** the signs of trauma

3. **Responding** by putting this knowledge into practice

4. **Resisting** re-traumatization

PARTNER ACTIVITY

With a partner, go through the handout under Trauma Self-Awareness asking each other the questions. You'll have 15 minutes.

Discussion: How was that?

THE PEER SUPPORT WORKER'S ROLE IN TRAUMA

Trauma Awareness—A trauma-informed approach begins with building of the commonness of trauma experiences; how the impact of trauma can be central to one's development; the wide range of adaptations people make to cope and survive after trauma; and the relationship of trauma with substance use, physical health, and mental health concerns.

Discussion: What are some signs of a trauma response? *Sweating, change in breathing (breathing quickly or holding breath), muscle stiffness, difficulty relaxing, flood of strong emotions (e.g., anger, sadness, etc.), rapid heart rate, startle response, flinching, shaking, staring into the distance, becoming disconnected from present conversation, losing focus, inability to concentrate or respond to instructions, inability to speak*

Emphasis on Safety and Trustworthiness— Depending on the type of trauma experienced, individuals may feel unsafe in new environments and have difficulty trusting others and their intentions. Physical, emotional, and cultural safety for clients is key to trauma-informed practice because trauma survivors often feel unsafe, are likely to have experienced abuse of power in important relationships and may currently be in unsafe relationships or living situations.

Discussion: How can we provide a safe and trustworthy environment?

- Consider all barriers (using a social determinants of health lens),
- attend to immediate needs (food, clothing, intoxication, acute mental health state),
- be as transparent, consistent and predictable as possible (explain why before doing something),
- respect healthy boundaries and expectations by clarifying role (what can and cannot be done),
- clearly outline program/treatment expectations (patient rights),
- explain how information will be shared and the limits to confidentiality,
- collaboratively develop some grounding strategies (ask what physical and emotional safety means to the individual,
- use open questions to develop a plan together. 'What have you found helpful to calm down and get focused when you're feeling anxious? What makes it worse? What is helpful from my side to offer you the best support when you are upset?')

The safety and needs of practitioners must also be considered within a trauma-informed service approach.

Discussion: What is vicarious trauma?

Vicarious trauma occurs by being exposed to client's traumatic experiences. It is not the result of being exposed to a single story but rather the cumulative effect of exposure to traumatic material. We feel affected by the sorrows and suffering of the people we support but hold these feelings secret, as we may think this is a sign of weakness and we should be strong. As a consequence of being exposed to stories of trauma, we begin to view and experience people, the world, and ourselves differently.

To address vicarious trauma, it is suggested to pay attention to three key areas, known as the ABC's:

Awareness of our needs, emotions, and limits

Balance between our work, leisure time, and rest

Connection to ourselves, to others, and to something greater (e.g., spirituality)

Opportunity for Choice, Collaboration, and Connection—Trauma-informed services create safe environments that foster a sense of efficacy, self-determination, dignity, and personal control for those receiving care. Experiences of trauma often leave individuals feeling powerless, with little choice or control over what has happened to them (interpersonal violence, natural disaster, etc.), and possibly, what they have done (war, political violence, motor vehicle accident, etc.). Collaboration involves sharing expertise and power. Offering choice, whenever possible, gives control and responsibility back to individuals.

Discussion: How can we provide an environment of choice, collaboration and connection?

- Working through the details together (when meeting etc.),
- exploring and problem solving barriers to participation and attendance (child care, transportation, non-support at home, language),
- eliciting the individual's priorities and hopes for treatment (hopes, expectations, concerns),
- inquiring about others who may be helpful to include in some aspect of their care (a support person, another professional, etc.),
- using statements that make collaboration and choice explicit ('I'd like to understand your perspective.' 'Let's look at this together.' 'Let's figure out the plan that will work best for you.' 'What is most important for you that we should start with?' 'It is important to have your feedback every step of the way.' • 'This may or may not work for you. You know yourself best.' 'Please let me know at any time if you would like a break or if something feels uncomfortable for you.'),
- working in a feedback-informed way (check-ins, "How was it for you to talk about this?")

Strengths Based and Skill Building—Clients in trauma-informed services are assisted to identify their strengths and to (further) develop resiliency and coping skills.

The strengths-based perspective focuses on strengths instead of weaknesses and is a basic tenant of working with everyone, but especially with people who have experienced trauma and who may see themselves as inherently weak due to their experiences. Your

ability to assist and support a client who has experienced trauma through active, attentive and compassionate listening can lead to the client making meaning of the experience, which can foster posttraumatic growth. It is about maintaining a sense of hope that not only can a person who has experienced trauma survive, but they can also experience positive life changes as a result.

Discussion: How can we provide a strength-based and skill building environment*?* *Emphasize teaching and modeling skills for recognizing triggers, calming, centering, and staying present.*

The Power of Language

Working in a trauma-informed way requires a shift in thinking and language. Unfortunately, the behaviours and responses of those with trauma experiences are often misunderstood and labelled in stigmatizing and deficit-based ways (e.g., something is missing or wrong with the individual). Practitioners make the shift in their practice from “what is wrong with this person?” to “what has happened to this person?”. This can be particularly helpful when the practitioner feels stuck and struggles to understand. The practitioner may not know the whole story; however, working in this way helps you uncover many layers and complexities and may require adaptation of the approach accordingly.

ROLE PLAY

With a partner, one partner will share a trauma from the scenarios, and the other will respond using the skills we’ve learned to date. Please remember that as peer support workers, we may be carrying our own trauma and experiences. If these conversations are triggering please do not hesitate to ask for a different scenario.

Discussion: How was that?

SOURCES

https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf

http://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care/what-is-trauma-informed-care.html

https://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

https://www.compalliance.com/the-3-es-4-rs-and-6-principles-of-trauma-informed-care-part-2-in-a-series/

SCENARIOS

An individual is describing traumatic experiences at the hands of their mother during their childhood. They are very emotional.

A woman is describing a painful traumatic experience involving witnessing killings in her village in her home country.

A young woman discloses that she was sexually assaulted a few months ago. She goes on at length about the situation, asks for your advice, and says that she feels she needs to work on the impacts she is only now acknowledging. She says she feels comfortable talking with you.

You are speaking with a man in his mid-40s who says his childhood was really hard, and that he lived in fear of his father for most of it. You ask him if his father abused him, and his reply is, “Yeah, he was really mean and he’d let you know with his fists when he was angry. He also knew how to take it to the next level of humiliation in my room at night.” You feel he is referring to sexual abuse.

You are speaking with a woman whose emotions of panic, anxiety and hopelessness are very strong. She seems overwhelmed, distracted, and in need of immediate help. She states that she’s been bombarded with memories and flashbacks recently, has missed work, is crying a lot, and isn’t really feeling she’s in reality. She needs help now.

You are speaking with a veteran who states that the war is still with him in his mind. He feels like he just left Afghanistan yesterday. He wonders if the pain will ever go away.

TRAUMA-INFORMED PRACTICE HANDOUT

TRAUMA SELF-AWARENESS

1. What are your underlying assumptions about the experience of those with trauma and how people recover? How might this belief influence your work with others?
2. What particular responses or behaviours of those you are assisting might trigger you? How do you know when this is happening? How will you respond?
3. How do your cultural background and personal experiences of diversity influence your interactions with others? What are you bringing to the relationship?
4. There may be some experiences in your life that could influence your ability to provide trauma-informed care. How are you managing? What are you noticing in your body? Are there areas in your life that you need to pay more attention to? Who can you turn to for support?

The three E's of Trauma:

1. Event
2. Experiences
3. Effects

The four R's:

1. **Realizing** the widespread impact of trauma and understands potential paths for recovery
2. **Recognizing** the signs of trauma
3. **Responding** by putting this knowledge into practice
4. **Resisting** re-traumatization

GUIDING PRINCIPLES

1. Safety
    - Ensuring physical and emotional safety
    - Meeting people where they are
    - The person’s culture is respected and incorporated into all stages of intervention
    - Identification and on-going assessment of triggers and plans to address these
    - Establish and maintain predictable routines to increase the sense of safety
    - Maintain a calm environment to decrease hyperarousal
    - Support and promote positive and stable relationships in the person’s life
    - Ensure opportunities for success
2. Trustworthiness
    - Maximizing trust through transparency, task clarity, consistency, and interpersonal boundaries

- Provide clear information about when, where, and by whom services will be provided
- Be on time
- Do what you say you will do, and if you can't do it, take responsibility
- Talk about the good, the bad, and the ugly
- Avoid "tricking" or "catching" people

3. Choice
    - Maximizing client experiences of choice and control
    - When and where will you meet?
    - How does the person prefer to communicate?
    - How does the person prefer to be addressed?
    - Who will be on the team?
    - What services does the person want?
    - Person decides which goals to work on first
    - When does the person want to terminate services?
4. Collaboration
    - Sharing of power
    - Ask about a client's goals or priorities
    - Service plans should be developed by the client, with the support of the case manager
    - Ongoing assessment of which services have been effective
    - Do goals and service plans need to be adjusted?
    - Shared expectations for the helping relationship
    - During emotional times ask, "How can I support you right now?"
5. Empowerment
    - Prioritizing empowerment and skill-building
    - Focus on empowerment instead of management and control
    - Build upon strengths and promote resilience

THE PEER SUPPORT WORKER'S ROLE IN TRAUMA – SUMMARY

TRAUMA AWARENESS—A trauma-informed approach begins with building of the commonness of trauma experiences; how the impact of trauma can be central to one's development; the wide range of adaptations people make to cope and survive after trauma; and the relationship of trauma with substance use, physical health, and mental health concerns.

EMPHASIS ON SAFETY AND TRUSTWORTHINESS— Depending on the type of trauma experienced, individuals may feel unsafe in new environments and have difficulty trusting others and their intentions. Physical, emotional, and cultural safety for clients is key to trauma-informed practice because trauma survivors often feel unsafe, are likely to have experienced abuse of power in important relationships and may currently be in unsafe relationships or living situations.

OPPORTUNITY FOR CHOICE, COLLABORATION, AND CONNECTION—Trauma-informed services create safe environments that foster a sense of efficacy, self-determination, dignity, and personal control for those receiving care. Experiences of trauma often leave individuals feeling powerless, with little choice or control over what has happened to them (interpersonal violence, natural disaster, etc.), and possibly, what they have done (war, political violence, motor vehicle accident, etc.). . Collaboration involves sharing expertise and power. Offering choice, whenever possible, gives control and responsibility back to individuals.

STRENGTHS BASED AND SKILL BUILDING—Clients in trauma-informed services are assisted to identify their strengths and to (further) develop resiliency and coping skills.

The strengths-based perspective focuses on strengths instead of weaknesses and is a basic tenant of working with everyone, but especially with people who have experienced trauma and who may see themselves as inherently weak due to their experiences. The ability of the service provider to assist and support a client who has experienced trauma through active, attentive and compassionate listening can lead to the client making meaning of the experience, which can foster posttraumatic growth. It is about maintaining a sense of hope that not only can a person who has experienced trauma survive, but they can also experience positive life changes as a result.

VICARIOUS TRAUMA

Vicarious trauma occurs by being exposed to client's traumatic experiences. It is not the result of being exposed to a single story but rather the cumulative effect of exposure to traumatic material.

To address **vicarious trauma**, it is suggested to pay attention to three key areas, known as the ABC's:

• **A**wareness of our needs, emotions, and limits

• **B**alance between our work, leisure time, and rest

• **C**onnection to ourselves, to others, and to something greater (e.g., spirituality)

RECOVERY- ORIENTED PRACTICE

Recovery-oriented practice is based on dignity and respect for the individual, recognizes the possibility of recovery and wellness, maximizes self-determination and self-management of mental health, and helps families understand and support their loved ones. The approach acknowledges that individuals' expectations about themselves have a strong influence on behaviour and outcomes, and that clinicians often err on the side of caution and underestimate a patient's potential, which can lead to self-defeat.

The principles of a recovery-oriented approach include understanding that each person is different and should be supported to make their own choices, listened to and treated with dignity and respect. Each person is the expert of their own life and support should assist them to achieve their hopes, goals and aspirations. Recovery will mean different things to different people.

A recovery approach should drive everything you do as a peer support worker and be reflected in your attitude, words and actions. This means being respectful and non-judgemental, and using words that are easily understood (no jargon).

In a recovery oriented approach it is important that you:

- support each person to have control over their life regardless of their emotional experiences
- see each person as an individual and not just focus on their mental health condition
- acknowledge individual differences, such as age, gender, culture, beliefs and support networks
- try to understand each individual's situation and experience, as each person is different
- understand that mental health conditions vary significantly from person to person, including how often someone has a period of unwellness and for how long
- remember that each person's journey is unlikely to be a straight path but more likely to be a mix of achievements and setbacks
- be optimistic and support the person to have a meaningful life, based on their choices, goals, strengths and abilities
- help build independence.

PARTNER ACTIVITY

With a partner, ask each other the questions under Exploring Recovery from the handout. You'll have 10 minutes.

Discussion: How was that?

THE PEER SUPPORT WORKER'S ROLE IN RECOVERY

- Understanding recovery is personal and unique to each individual.
- Understanding each individual has a right to their own path and journey towards wellness.

- Honouring diversity.
- Being culturally responsive and safe.
- Facilitating interconnections between community and health-related resources for their care.
- Fostering and building positive environments that address clients' true needs and fostering a culture and language of hope (Cirpili & Shoemaker, 2014 & Mental Health Commission of Canada, 2015).

SOURCES

https://www.mentalhealthcommission.ca/sites/default/files/2016-07/MHCC_Recovery_Guidelines_2016_ENG.PDF

https://mharesource.rnao.ca/section-five/recovery-oriented-approach-teaching-activities-and-resources

RECOVERY-ORIENTED PRACTICE HANDOUT

EXPLORING RECOVERY

- Who defines recovery?
- Does recovery mean that you no longer have an illness?
- What is the difference between traditional medical care versus recovery care?
- What is positive risk taking?
- How would you promote informed choice and options to peers in relation to care planning?
- How would you engage in a conversation about what brings meaning to someone's life?
- What is relapse prevention?

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STORY OF RECOVERY

WHAT IS A RECOVERY STORY?

Sharing your story is an important recovery experience and there are many incentives for doing so. The key is to ensure that what you share empowers you in your efforts in your personal journey of recovery and offers hope and information to those who may be struggling. A recovery story is a personal accounting of your experiences and the journey to wellness.

A recovery story, though it includes details of your life, often focuses on insight and hope gained in the recovery. A recovery story describes your attitudes, feelings, goals, values and/or skills, as well as the resources that were important to overcoming challenges.

WHY YOU SHOULD TELL YOUR RECOVERY STORY

As peer support workers, you're in recovery and have the unique position to speak to others traveling down the same road you've been down. You have a story to tell — and it has the potential to provide great hope to those who hear it. It's both an individual story of your personal journey from addiction to recovery and a communal story that relates to the greater whole of humanity.

Discussion: What are some reasons to share your recovery story?

According to RtoR.org, there are several reasons to share your recovery story:

- Sharing your story with another person makes your recovery more real. It's not a recovery story until you tell someone about it.
- In writing or telling about a difficult time, you can organize past events into a structured story that makes sense to others and ultimately helps you better make sense of the experience as well.
- Studies show that sharing difficult experiences with others can improve health and well-being by establishing supportive bonds and reaffirming positive values and lessons learned from life experience.
- Your story will help other people who feel hopeless and alone in their struggles. It could be the catalyst another person needs to finally get help.
- Storytelling is one of the great foundations of civilization – it's how we build community and create connections.

- Your emotional resilience and coping capacity is strengthened by the realization that you have something to give others that can help them.

HOW AND WHEN YOU SHOULD TELL YOUR RECOVERY STORY

Your recovery story, like your recovery, is yours and yours alone. Before telling your story, there are some things to consider in order to ensure that it benefits you and peers.

Sharing your story will likely bring up strong emotions and can leave you feeling exposed and vulnerable, so it's important to be in the right state of mind. As always, your recovery and health come first.

Once you decide the time is right, here are some tips on what to include in your recovery story, according to the New England MIRECC Peer Education Center:

- Early indications you were beginning to have a problem
- Descriptions of yourself and your situation at your lowest point
- What helped you get from there to where you are
- How you accomplished this and who helped
- What you've overcome to get to where you are today
- Strengths and supports you've developed and used
- Things you do to maintain your wellness and recovery

Remember this is a story of recovery, not of illness. Instead of focusing on the impacts of the illness and reliving details, focus on your wins and how you've overcome challenges and maintained wellness.

And while sharing your story will benefit you, it should also benefit those who hear it. Focus on the positive, transformative experiences you've had in your journey to recovery, and provide hope for peers.

SOURCES

https://blackbearrehab.com/blog/recovery-story-share/

https://www.mainemphp.org/uploads/2/7/3/9/27399337/telling_your_recovery_story.pdf

STORY OF RECOVERY HANDOUT

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Your Recovery Story Worksheet

What were some of the early indications you were having difficulties?

How would you describe yourself and your situation when you were at your worst?

What couldn't you do?

What helped you move from where you were to where you are now?

What did you do?

What did others do?

What have you overcome to get where you are today?

What have you learned about yourself, now that you are in recovery?

What strengths and skills have you developed?

What are some of the things that you do to keep you on the right path?

How has your recovery changed your plans and hopes for the future?

MENTAL HEALTH CONDITIONS

The DSM (Diagnostic Statistical Manual) is a tool used to identify a particular set of behaviours that are consistent with one of the labels in the DSM. It is important to know some of the diagnostic labels you might hear in your work, however, labels do not define the human being that is behind the label.

We will go over the various diagnostic labels so that you are familiar with them and can understand the people you are working with when they use them. However, it is vital that you remember as a peer support worker, you know your peers as people, not their labels.

It is of utmost importance that we, as peer support workers, provide the same support to each peer we work with regardless of their diagnosis. With that said, having a general understanding of what some of the more common challenges our peers may be experiencing and how these challenges are then factored into a diagnosis, can be helpful in the work that we do.

It is important to remember that we are unique individuals, and no two peers will ever experience mental illness in exactly the same way, even though we may share the same diagnosis. Receiving a particular diagnosis does not define you as a person, only as a way forward for your care providers to get an idea of what forms of support and therapies may be best to start off with when treating you.

Along the recovery journey, many of us may start off with one diagnosis, and find that that initial diagnosis may stay the same or change as we gain better insight into our own individual challenges as well as our strengths.

28 MENTAL HEALTH CONDITIONS

Mood Disorders

Mood disorders are “a psychiatric condition in which the principal feature is a prolonged, pervasive emotional disturbance.” Mental disorders included in this mental health category affect not only your emotions but also your thoughts and your physical functioning.

1. **Major Depression**

Major depression is one of the mental disorders that is characterized by persistent sadness and other symptoms. However, you won’t have manic or hypomanic symptoms if you have this mental health condition.

Emotions – sad, hopeless, guilty, irritability, anxiety, emptiness, loss of interest in things once enjoyed

Thoughts – trouble concentrating and making decisions, suicidal thoughts

Physical – appetite and weight changes, unexplained aches and pains, insomnia or sleeping too much, fatigue

2. **Persistent Depressive Disorder**

Persistent depressive disorder is a mental health issue in which you experience symptoms of depression most days for at least two years.

3. **Bipolar Disorder**

Several mental disorders come under the umbrella of bipolar disorder. If you have one of these mental health conditions, you will have depressive episodes with any of the depression signs. You will also have manic or hypomanic symptoms. Manic symptoms include:

Emotions – upbeat, wired, expansive, euphoric

Thoughts – grandiose or racing thoughts, distractibility, excessive self-confidence, lack of judgment, extreme risk-taking

Physical – increased energy or agitation, needing less sleep or food

4. **Postpartum Depression**

You might have this mental disorder anytime from pregnancy to a year after your baby's birth. In addition to other depression symptoms, you might experience excessive crying, withdrawing from family, difficulty bonding with the new baby, and feelings that you're a bad mother. If the mental health condition is severe, you might even have trouble caring for your baby.

5. **Premenstrual Dysphoric Disorder**

More severe than PMS, symptoms of this mental health condition include mood swings, irritability, and other signs of depression, along with cramps, bloating, pain, and headaches. The symptoms start about a week to ten days before your period and go away after your period begins.

Anxiety Disorders

These mental disorders come with excessive worry, fear, and nervousness. Yet each mental health condition is unique, and often relatively easy to recognize once you know the symptoms.

6. **Generalized Anxiety Disorder**

GAD is one of the mental disorders marked by worry and tension. Its symptoms are often unrelated to what's happening and seem to come out of nowhere to affect your mental health.

Feelings – restlessness, being on edge, irritability

Thoughts – excessive worry, unrealistic views, trouble concentrating

Physical – muscle tension, headaches, sweating, nausea, needing to go to the bathroom often, tiredness, sleep problems, trembling, startling easily

7. **Obsessive-Compulsive Disorder**

Obsessive-compulsive disorder includes several mental disorders. Each of these mental health problems includes both obsessive and compulsive symptoms.

Obsessive – fear of dirt or contamination, doubting, uncertainty, needing things to be symmetrical, thoughts of losing control or harming yourself, unwanted aggressive, sexual, or religious thoughts

Compulsive – excessive washing and cleaning, checking, counting, strict adherence to a routine, needing constant reassurance

8. **Panic Disorder**

Panic attacks are the main feature of this mental health condition. Many of the symptoms seem physical, yet the state isn't physically dangerous.

Thoughts and Feelings – sense of impending doom, fear of death, feeling of unreality.

Physical – nausea, chest pain, headache, light-headedness, numbness or tingling, shortness of breath, rapid heart rate, trembling, chills, sweating, abdominal cramping

9. **Phobias**

Phobias are mental disorders in which you feel extreme fear when something triggers the phobia. The trigger could be heights, snakes, closed-in spaces, or a range of other possibilities. Symptoms include:

Feelings – fear of dying, losing control, or fainting, sense of being detached from your body

Physical – unsteadiness, light-headedness, dizziness, choking sensation, pounding heart or fast heartbeat, chest pain or tightness, sweating, hot or cold flushes, shortness of breath, nausea, tingling, trembling

10. **Agoraphobia**

Agoraphobia is a mental health challenge in which you have such intense anxiety symptoms that you avoid going to or even thinking about places and situations that bring up feelings like helplessness, embarrassment, or a sense of being threatened.

11. **Social Anxiety**

Social anxiety is a frustrating mental health problem for anyone who would like to or needs to interact with people socially. Symptoms include:

Fears – of being judged, embarrassed, or humiliated, of strangers, that others will notice you look anxious, of physical symptoms others might notice

Behaviors – avoiding speaking to others or being the center of attention, analyzing your social performance after the fact

Physical – blushing, trembling, sweating, fast heartbeat, nausea, breathlessness, dizziness, blank mind, muscle tension

Eating Disorders

Eating disorders are mental disorders that affect both your physical and psychological health. They all include intense feelings and behaviors related to eating.

12. **Anorexia Nervosa**

Anorexia nervosa is one of these mental disorders. It is a mental health problem in which you eat very little and typically lose weight at a rate that is alarming to your friends and family. You can find a full list of symptoms at the National Eating Disorder Association. Here are a few of the most common.

Feelings and Behaviors – preoccupied with food, dieting, and weight; talking about being fat and needing to diet, saying you're not hungry, having food rituals, unrealistic body image, wearing multi-layered baggy clothes

Physical Signs – dramatic weight loss, stomach cramps, menstrual irregularities, sleep problems, feeling cold constantly, dry skin and nails, cavities, thinning hair, muscle weakness, and poor wound healing and immune response

13. **Bulimia**

Another of these mental disorders is bulimia, in which you eat and sometimes binge on food but then purge in an attempt to get rid of the calories you consumed. If you have this mental health problem, you might have an intense fear of gaining weight, be worried about your body shape and size, eat large amounts of food at one time, force yourself to vomit and fast between binges.

14. **Binge Eating**

Another mental health issue people sometimes have is binge eating. In this disorder, you eat large amounts of food in a short time, but there are other signs as well.

Feelings – that you're out of control, depressed, disgusted with yourself, ashamed, or upset

Behaviors – eating when you're full, eating fast while binging, eating alone or secretly, dieting without weight loss

Trauma-Related Disorders

When something extremely distressing happens to you, you might have mental health problems in this category. Trauma-related mental disorders are reactions to terrifying, disturbing, or life-threatening events.

15. **Post-Traumatic Stress Disorder**

Stressful events, like being in combat or being assaulted, can trigger PTSD. This mental health condition can last for months or years if left untreated. Symptoms include intrusive memories, nightmares, avoiding anything that reminds you of the event, negative thoughts and feelings, being easily startled, trouble sleeping, irritability, anger, aggression, and feeling emotionally disconnected or numb.

16. **Acute Stress Disorder**

Acute stress disorder is one of the mental health conditions in which you feel symptoms of anxiety. Signs usually come up after a traumatic event and last for up to a month. In addition to anxiety symptoms, you might also feel numb or a sense of unreality, or have vivid flashbacks or difficulty remembering the event.

Impulse Control Disorders

If you have these mental disorders, your behavior is so out of control that you can cause harm to yourself and others. These behaviors go against laws, societal norms, and best practices, yet you engage in them without thinking.

17. **Kleptomania**

Kleptomania is a mental health problem in which you steal things you don't need. You might have increasing tension just before you take something and feel a sense of relief afterward.

18. **Pyromania**

If you have pyromania, you're fascinated with fire and may set things on fire, often harming others or destroying property in the process.

19. **Intermittent Explosive Disorder**

Mental disorders like intermittent explosive disorder can cause harm to others as well as impact your mental health. Brief flashes of anger and violence characterize this mental health issue. Additionally, these outbursts are all out of proportion to the events that trigger them. An everyday annoyance can set off a fit of rage.

Psychotic Disorders

Mental health conditions in the psychotic category are mental disorders in which you have a break with reality. Some of these mental health problems are chronic, while others are short-lived.

20. **Schizophrenia**

Schizophrenia is one of the severe chronic psychiatric disorders. Symptoms usually start between the ages of 16 and 30. They include positive signs (things that happen) and negative symptoms (things that are absent or decreased).

Positive Symptoms – hallucinations, delusions, dysfunctional ways of thinking, movement disorders

Negative Symptoms – reduced facial expressions, decreased feelings of pleasure in the everyday, trouble starting or continuing with activities, speaking very little

21. **Schizoaffective Disorder**

This mental health condition is a mix of schizophrenic disorder and mood disorder. The two types of schizoaffective disorder are manic type and depressive type. In addition to manic or depressed, and schizophrenic symptoms, someone with this mental health issue might have incoherent speech, bizarre behavior, trouble functioning at work, school, or in social situations, and problems with grooming.

22. **Brief Psychotic Disorder**

If you're under extreme stress, you might develop brief psychotic disorder very rapidly. This temporary mental health problem can have intense symptoms, including hallucinations and delusions. Although you return to your normal functioning shortly afterward, the time when you're having psychotic symptoms can be dangerous to you and others around you.

Personality Disorders

Personality disorders are mental health problems that last for many years or even for your entire life. When you have one of these mental health disorders, your thoughts, emotions, and actions are dysfunctional and may bring harm to your relationship and other aspects of your life. Here are some of those mental health disorders.

23. **Narcissistic**

Those with narcissistic personality disorder have little empathy for others. They're self-centered and have an excessively elevated self-image. You might think you have extraordinary powers, talents, and beauty. You might expect others to praise you continually if you have this mental health issue.

24. **Borderline**

People with borderline personality disorder tend to be impulsive, have unstable self-image and intense relationships, have mood swings and suicidal behavior, fear to be alone, and may have transitory paranoia. This mental health problem can make your life feel like a whirlwind of emotion.

25. **Avoidant**

People with this mental health condition are extremely sensitive to rejection and criticism. They avoid interpersonal contact and new activities. They may be very shy and feel inferior to others. Their mental health suffers, partly because they become so isolated from others.

26. **Paranoid**

If you have a paranoid personality disorder, you distrust and are suspicious of others. You erroneously think that others are trying to hurt you or that they're untrustworthy. You hear innocent remarks and view them as personal attacks. You hold grudges and may become hostile when you believe others have insulted you. When others suggest you might need mental health treatment, you might be suspicious of their motives.

27. **Dependent**

When you have a dependent personality disorder, you might feel excessively dependent on others. You might be clingy or submissive. You might fear to be on your own, having

to take care of yourself, disagreeing with others, or disapproval. You might have low self-confidence and difficulty doing activities on your own. Even if your relationship partner abuses you, you might put up with it rather than going out on your own. And if the relationship ends despite this, you might feel the need to jump into another relationship immediately.

Addiction and Substance Abuse Disorders

Substance abuse disorders can be very distressing and can impact your life in profound ways. These conditions aren't merely due to a lack of willpower or not trying. They are significant mental health diseases.

28. **Alcohol, Illegal or Prescription Drugs**

Sometimes it's hard to tell if you have a mental health problem when you use alcohol or other addictive substances. After all, many people drink socially and harmlessly. However, there are several signs that you might need help with substance abuse disorder.

You might feel you need to use the substance many times every day. You need more overtime to achieve the same effects. You might steal to get the substance and always be concerned about keeping a supply of it on hand. You try to quit using it, but you are unsuccessful. And, anytime you do stop using it, you have withdrawal symptoms.

SOURCE:

https://www.betterhelp.com/advice/psychiatry/do-i-have-a-mental-illness-28-mental-disorders-and-their-symptoms/?utm_source=AdWords&utm_medium=Search_PPC_c&utm_term=_b&utm_content=107920133490&network=g&placement=&target=&matchtype=b&utm_campaign=11558188695&ad_type=text&adposition=&gclid=CjwKCAiAl4WABhAJEiwATUnEF_G5psHuVeYoRgkmVcTMg1Im5myJsDvX8AJ_k4JpUqrwiBUrioGy2hoC_uoQAvD_BwE

COMMON MEDICATIONS

Side effects are common when taking medications. It is important to be aware of the side effects because people may mention them while meeting with you. **Never give advice on medications to take or not to take.** This is not part of your work. You may discuss your experiences and especially what you found helpful, but not in a way that gives advice or tells the person that they should do the same. Some medications, when first started, can have more side effects, but over time pass as the body adjusts to the new medication. You can support the person to continue through this uncomfortable and difficult time.

Remember, medication is one of many tools that can control symptoms of a mental health condition. As a peer support worker, you are a role model of hope of someone who manages their symptoms to the fullest extent possible.

Many of you may find medication or medications to be a particularly useful tool in helping you manage your mental health challenges. Educating yourselves around the medication you are prescribed ultimately helps you have a better understanding of your own treatment plan and can help you better articulate what it is about a medication that you feel is or isn't working for you.

You must always remember though that you as peer support workers are not qualified to give medical advice, nor is it appropriate to tell your peers your general opinions on certain medications. Each person on your peer's care team has a particular role, and yours (though equally important) is based on your own lived experience, not years of medical training. If someone asks you which medication they should take, encourage them to talk about this with their doctor or pharmacist; you want to help them but it would be best for them to consult the professionals.

What are antidepressants?

The doctor, or psychiatrist, may offer antidepressants if one has very low mood or symptoms of depression. They can also help if one has other mental health problems, including anxiety.

Scientists aren't sure how antidepressants work. But they think that they may work by increasing levels of certain chemicals in the brain that help improve mood and emotions.

Antidepressants should start to work within 2-3 weeks. There is no set time for how long one should take antidepressants. The doctor may ask one to take antidepressants for 6 months after the symptoms are gone. This can help stop the symptoms coming back. The doctor will work out how much one should take, and for how long.

Are there different types of antidepressant?

All antidepressants work in different ways. One type of antidepressant may suit someone more than another. Here, we give an overview of the different types.

Selective serotonin re-uptake inhibitors (SSRIs)

The National Institute for Health and Clinical Excellence (NICE) suggests that SSRIs have fewer side effects than the other types of antidepressants. All the following medications treat low mood and depression. Some may also treat other conditions, including anxiety, bulimia, panic disorder, and obsessive-compulsive disorder.

Examples: Cipramil, Cipralex, Prozac, Faverin, Seroxat, Lustral

Serotonin-noradrenaline reuptake inhibitors (SNRIs)

SNRIs are similar to SSRIs. They are also used to treat depression.

Examples: Cymbalta, Effexor, Edronax

Tricyclic antidepressants (TCAs)

TCA's can treat depression, obsessive compulsive disorder and bipolar disorder. TCA's can take 2 to 4 weeks to work. These are older medicines, and generally have more side effects than other antidepressants.

Examples: Amitriptyline, Clomipramine, Dosulepin or Dothiepin, Doxepine, Imipramine, Lofepramine, Nortriptyline, Mianserin, Trimipramine.

Mono-amine oxidase inhibitors (MAOIs)

MAOIs are an older antidepressant. These are not prescribed as much. The doctor should monitor one if they take these. One cannot eat certain foods if they take these. The doctor should give more information if they prescribe these.

Examples: Socarboxazid, Phenelzine. This is also branded as Nardil, Tranylcypromine, Moclobemide. This is also branded as Manerix.

Other medication

Below is a list of other medication which can treat depression.

- Mirtazapine. This is also branded as Zispin.
- Trazodone. This is also branded as Molipaxin.

Are there any side effects?

Different antidepressants will have different side effects. The newer antidepressants should have fewer side effects than the older ones. People can have different reactions to medication.

Typically, a patient information leaflet comes with the medication. This leaflet includes the possible side effects they might get. Below tells about the common side effects.

SSRIs

Common: Dizziness, feeling irritable, problems sleeping, vivid dreams, flu-like symptoms (for example nausea, headaches, chills), feeling tearful, 'shock-like' feelings

Occasional: Memory and concentration problems, movement disorders

SNRIs

Common: Tiredness, dizziness, light-headedness, headache, sleeplessness, nightmares, nausea, diarrhoea, ringing in the ears, tingling, 'shock-like' feelings

Occasional: Memory and concentration problems, movement disorders

Tricyclics

Common: Problems sleeping, dreaming a lot, flu-like symptoms (for example nausea, muscle pain, headaches, excessive sweating, chills)

Occasional: Movement problems, mania, unusual heart ~~pace~~ rate

MAOIs

Common: Feeling irritable, anxiety, problems sleeping, vivid dreams, slowed speech and a lack of muscle co-ordination

Occasional: Hallucinations, delusions

What are antipsychotics?

Psychosis is a medical term. If one has psychosis, they might see or hear things (hallucinations) that are not there or they might have ideas or beliefs that do not match reality (delusions). Some people describe it as a break from reality. Doctors may call these ‘psychotic symptoms’, a ‘psychotic episode’ or a ‘psychotic experience’.

Psychotic symptoms can be part of conditions such as schizophrenia, schizoaffective disorder, personality disorder and bipolar disorder. But some people can have psychotic symptoms without having any of these conditions.

If one has psychosis, the doctor may offer antipsychotic medication to help with symptoms. Antipsychotics can help to control symptoms of psychosis. This can help to feel more in control of life, particularly if one is finding the psychotic symptoms distressing.

According to the Royal College of Psychiatrists, 4 out of 5 people who take antipsychotics find they are successful in treating their symptoms. It is not possible to predict which one will work best, so one may have to try a few before finding the right one.

Some antipsychotics are used to treat mania (which is a symptom of bipolar disorder) and psychotic symptoms of depression.

How do antipsychotics work?

The brain contains chemicals which help to carry messages from one part of the brain to another. One of these chemicals is called dopamine. It is thought that high levels of dopamine may cause the brain to function differently and may cause the symptoms of psychosis. Antipsychotic medications reduce the amount of dopamine in the brain or restore the balance of dopamine with other chemicals in the brain.

Are there different types of antipsychotics?

Some people talk about two types of antipsychotic medication. The doctor might call them the following.

- Typical or ‘first generation’. These medications have been used since the 1950s.
- Atypical or ‘second generation’. These medications have been used since the 1990s.

The main difference between these types is in their side effects. First generation antipsychotics may have more of an effect on one’s movement than newer ones. Although this does not mean newer generation antipsychotics don’t have any side effects on one’s movement.

This distinction can make it easier to talk about the different medications. But one should think about each antipsychotic individually. This is because everyone reacts differently to medication. One can never be certain how they will be affected by side effects or whether the medication will work for them. This can mean that the first medication they try may not be the right one for them.

If one has been on an antipsychotic for a few weeks and the side effects are too difficult to cope with, encourage them to ask their doctor about trying a different one.

Antipsychotic medication can come as tablets, a syrup or as an injection. The injections are called a depot. A depot can be useful if one struggles to remember to take medication, or might take too much. The doctor should take one's views into account when prescribing medication.

First generation antipsychotics (Typical)

The first generation of antipsychotics have been prescribed since the 1950s. The following medications are typical antipsychotics. They have been listed by their generic name with the brand name in brackets.

- Benperidol (Anquil)
- Chlorpromazine (Largactil)
- Flupentixol (Depixol)
- Fluphenazine (Modecate)
- Haloperidol (Haldol)
- Levomepromazine (Nozinan)
- Pericyazine
- Perphenazine (Fentazin)
- Pimozide (Orap)
- Promazine
- Sulpiride (Dolmatil, Sulpor)
- Trifluoperazine (Stelazine)
- Zuclopenthixol (Clopixol)

Second generation antipsychotics (Atypical)

The second generation of antipsychotics have been used more since the 1990s. Although some of them were developed before then. They have been listed by their generic name with the brand name in brackets.

- Amisulpride (Solian)
- Aripiprazole (Abilify, Abilify Maintena)
- Clozapine (Clozaril, Denzapine, Zaponex)
- Risperidone (Risperdal & Risperdal Consta)
- Olanzapine (Zyprexa)
- Quetiapine (Seroquel)
- Paliperidone (Invega, Xeplion)

Clozapine

Clozapine works slightly differently to others. It is sometimes given to people who are treatment resistant. This means other medication hasn't helped their symptoms. The

National Institute for Health and Care Excellence (NICE) says that people with schizophrenia should only be offered clozapine after having tried 2 other drugs.

Clozapine can cause one's white blood cell numbers to drop, but this is rare. This could mean that one gets infections more easily. If an individual takes clozapine, they will need regular blood tests to make sure their white blood cell count is healthy.

If the white blood cell numbers start dropping, one will be asked to stop taking the medication. They will have another blood test after they have stopped clozapine to make sure they are back to normal. The doctor might decide to change the dose of clozapine or offer another type of medication.

What are the side effects?

The medication should come with a leaflet called a 'patient information leaflet'. This leaflet will tell what the side effects are and explain what to do if one is experiencing any side effects.

Side effects of antipsychotics can include the following:

- Stiffness and shakiness →This can often be reduced by lowering the dose. But, if a high dose is necessary, the shakiness can be treated with anticholinergic drugs. This is the same kind of medication that is used for Parkinson's disease.
- Uncomfortable restlessness (akathisia)
- Movements of the jaw, lips and tongue (tardive dyskinesia)
- Sexual problems due to hormonal changes
- Sleepiness and slowness
- Weight gain
- A higher risk of getting diabetes
- Constipation
- Dry mouth
- Blurred vision

Not all antipsychotics will have these side effects. Second generation or atypical antipsychotics are less likely to cause movement side effects, but one might still experience them. If one does then the doctor might change the medication.

What are benzodiazepines?

Benzodiazepines are a type of sedative. They are usually a short-term treatment given for 2-4 weeks. They are sometimes known as 'benzos.'

Benzodiazepines will usually be taken through your mouth by tablet or solution. In rare situations they can be injected to help control panic attacks.

What are benzodiazepines used for?

Severe anxiety

One may be given benzodiazepines for the short-term relief of severe anxiety. One should not be given them for long term relief.

Panic disorders

One may be given benzodiazepines:

- When one first start taking antidepressants
- If doesn't respond to antidepressants

Sleeping

Benzodiazepines can be used to treat insomnia. Insomnia means that one finds it difficult to fall asleep or stay asleep.

One should only be offered benzodiazepines to treat insomnia if it is severe, disabling or is causing a lot of distress.

They should only be offered for short term use.

Acute alcohol withdrawal

Long acting benzodiazepines are used to help with the effects of acute alcohol withdrawal.

One should stay in hospital during withdrawal if they have severe alcohol dependence. Withdrawal without medical support can cause dangerous side effects such as seizures.

Are there different types of benzodiazepines?

There are 2 different types of benzodiazepines. These are hypnotics and anxiolytics.

Hypnotics are shorter acting. They are mostly used for treating sleep problems such as insomnia.

Anxiolytics are longer lasting. They are mostly used for treating anxiety.

Examples of Hypnotics: Flurazepam, Loprazolam, Lometazepam, Nitrazepam, Temazapam

Examples of Anxiolytics: Alprazolam, Chlordiazepoxide Hydrochloride, Diazepam, Lorazepam, Oxazepam, Clobazam

Are there any side effects?

Not everyone who takes benzodiazepines will get side effects. Talk to the doctor if you are worried about side effects.

Addiction

One should only be prescribed benzodiazepines for the shortest amount of time possible. Taking benzodiazepines regularly for a few weeks or more can lead to addiction. Doctors recommend that one only takes them for 2-4 weeks.

Intermittent use may help to avoid addiction. Intermittent means that one doesn't take it regularly. For example, one doesn't take it every day.

The risk of addiction is higher if one has a history of drug or alcohol abuse. Or if one has a personality disorder.

Common side effects

Common side effects include:

- drowsiness or sleepiness
- dizziness
- headache
- confusion
- numbed emotions
- reduced awareness
- muscle weakness
- tremor
- Ataxia. Such as:
    - balance and walking
    - speaking
    - swallowing
    - your motor skills, such as writing and eating
    - vision

One has an increased risk of falls and associated fractures if they are elderly and use benzodiazepines.

Less common and rare side effects

Less common and rare side effects include:

- stomach upset and diarrhoea
- nausea,
- vomiting
- constipation
- depression
- insomnia
- dry mouth
- increased appetite
- memory loss
- delusions
- aggression

What are mood stabilisers?

Mood stabilisers are a type of medication that can help if one has unhelpful moods swings such as mania, hypomania and depression They help to control and ‘even out’ these mood swings.

One’s mood may change quickly between mania and depression.

The doctor may prescribe mood stabilisers if one has an episode of mania, hypomania or depression that changes or gets worse suddenly. This is called an acute episode. Some people need to take mood stabilisers as a long-term treatment to stop this from happening. One may experience mania or depression if they have a condition such as bipolar disorder, schizoaffective disorder, depression or personality disorder.

Are there different types of mood stabilisers?

There are different types of medication that can help stabilise one’s mood. The National Institute of Health and Care Excellence (NICE) produce guidelines for the assessment and treatment of mental illnesses, such as bipolar disorder and schizoaffective disorder. The doctor should use these guidelines to decide which medication to offer.

The most common mood stabilisers are listed below.

Lithium

Lithium is used for the long-term treatment of mania. It can reduce how often one gets an episode and how severe they are. It has been found to reduce the risk of suicide.

NICE guidance for bipolar disorder recommends lithium as a first choice to treat episodes of mania and also for long-term treatment.

To make sure that the lithium is working properly and is not at a dangerous level, one should have tests to check the lithium levels in their blood every 3 to 6 months. The doctor may give a booklet to keep a record of one’s lithium levels.

Lithium comes in 2 forms. A tablet and a liquid.

The tablets are made from lithium carbonate. There are different brand names for the tablets. Some of these are:

- Camcolit
- Priadel
- Liskonum

The liquid is made from lithium citrate. The main brand names for the liquid are:

- Priadel liquid
- Li-liquid

Valproate

NICE guidance for bipolar disorder recommends valproate to treat episodes of mania and also for long-term treatment. Especially if lithium has not worked or is unsuitable.

Valproate is a medication used to treat epilepsy. But it is also used to treat mania. There are different forms of valproate. Valproic acid comes in the form of tablets and capsules. The main brand names for valproic acid are:

- Belvo
- Depakote
- Convulex

Sodium valproate can be given by injection, tablets and granules. The main brand names for sodium valproate are:

- Episenta
- Epilim

Lamotrigine

This is sometimes called Lamictal. It is a medication used to treat epilepsy. It can come in the form of a tablet or a dispersible tablet. Which means that one dissolves it in water before taking it.

It can treat bipolar disorder when depression is the main problem. NICE guidance does not recommend it to treat episodes of mania, or as a first option for long-term treatment of bipolar disorder.

Antipsychotics

Antipsychotic medication can help to stabilise mood. This type of medication is normally used to treat symptoms of psychosis. Symptoms of psychosis include delusions, hallucinations and paranoia. Some of the newer antipsychotics can be used to treat bipolar disorder. NICE guidelines recommend the following antipsychotics if you have bipolar disorder.

- Olanzapine
- Haloperidol
- Quetiapine
- Respiridone

Are there any side effects?

If one takes mood stabilisers they may find that they get side effects. Some side effects may only last for a short time or become easier to cope with. If one is worried about the side effects of medication, speak to the doctor. Sometimes a lower dose or changing the medication will reduce side effects.

Side effects of lithium

Most side effects are directly related to how much lithium is in the blood stream. These are some side effects of lithium:

- stomach pain
- feeling sick
- shaking
- a metallic taste in your mouth
- feeling thirstier and needing to pass urine more frequently
- weight gain

One should get regular blood tests to make sure they have a safe level of lithium in their blood.

Taking lithium can change the amount of sodium in one's body. This can lead to higher levels of lithium which can cause poisoning. This can be made worse by diarrhoea or vomiting, not drinking enough water or other medications. If one would like more advice about this, speak to the doctor.

Side effects of valproate

Valproate can cause:

- stomach upset and feeling sick
- hair loss

- memory loss
- problems concentrating
- headaches
- dizziness
- confusion
- deafness
- feeling sleepy
- hallucinations
- tremors

In women, valproate can cause increased testosterone levels. This can lead to periods stopping and abnormal hair growth.

Valproate may be linked to a condition called polycystic ovaries in women. This can affect how the ovaries work, which can cause symptoms including excessive body hair, irregular periods, problems getting pregnant or acne.

If one is pregnant, valproate can cause problems with the unborn baby. If one is able to have children, the doctor must not prescribe valproate unless one is on the pregnancy prevention programme.

Valproate can affect how one's liver works, so one will need regular tests. NICE guidance says to test the liver at the start of treatment and every 6 months after that.

Side effects of lamotrigine

Common side effects include:

- aggression
- joint pain
- becoming agitated
- vomiting and diarrhoea
- drowsiness
- dizziness
- dry mouth
- tiredness
- irritability
- headaches
- tremors
- sleep problems

Side effects of antipsychotics

The side effects of antipsychotics can be different depending on which type of antipsychotic one takes.

SOURCE

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SUBSTANCE USE

The term “substance use” refers to the use of drugs or alcohol, and includes substances such as cigarettes, illegal drugs, prescription drugs, inhalants and solvents. A substance use problem occurs when using alcohol or other drugs causes harm to you or to others. Substance use problems can lead to addiction.

Anyone, at any age or any stage of their life can develop a substance use problem. It is important to know that no matter how you are feeling, you are not alone. There is help out there.

What are the types of substances?

The substances involved tend to be members of the 10 classes of drug that typically cause substance-related disorders:

- Alcohol
- Antianxiety and sedative drugs
- Caffeine
- Cannabis (including marijuana and synthetic cannabinoids)
- Hallucinogens (including LSD, phencyclidine, and psilocybin)
- Inhalants (such as paint thinner and certain glues)
- Opioids (including fentanyl, morphine, and oxycodone)
- Stimulants (including amphetamines and cocaine)
- Tobacco
- Other (including anabolic steroids and other commonly abused substances)

These substances all directly activate the brain's reward system and produce feelings of pleasure. The activation may be so strong that people intensely crave the substance. They may neglect normal activities to obtain and use the drug.

Substance use disorders can develop whether or not a drug is legal or has an accepted medical use (with or without a prescription).

The terms "addiction," "abuse," and "dependence" have traditionally been used in regard to people with substance use disorders. However, those terms are all too loosely and variably defined to be very useful and also are often used judgmentally. Thus, doctors now prefer to use the more comprehensive and less negative term "substance use disorder”. Instead of saying, “My name is ___ and I’m an addict”, we’re using ‘person-first language’ and saying, “My name is ___ and I am a person living with a substance use issue” Though some language is changing, some is not. We need to see people as individuals not labels.

What is substance use and addiction?

Many people use substances such as drugs or alcohol to relax, have fun, experiment, or cope with stressors, however, for some people the use of substances or engaging in certain behaviours can become problematic and may lead to dependence.

Addiction is a complex process where problematic patterns of substance use or behaviours can interfere with a person's life. Addiction can be broadly defined as a condition that leads to a compulsive engagement with a stimulus, despite negative consequences. This can lead to physical and/or psychological dependence. Addictions can be either substance related (such as the problematic use of alcohol or cocaine) or process-related, also known as behavioural addictions (such as gambling or internet addiction). Both can disrupt an individual's ability to maintain a healthy life, but there are numerous support and treatment options available.

A simple way of understanding and describing addiction is to use the **4C's** approach:

- **C**raving
- Loss of **C**ontrol of amount or frequency of use
- **C**ompulsion to use
- Continued substance use despite **C**onsequences

How common is substance use and addiction?

Substance use is quite common on an international scale and statistics vary depending on the substance being consumed. It is estimated that nearly 5% of the world's population have used an illicit substance, 240 million people around the world use alcohol problematically, and approximately 15 million people use injection drugs.

In Canada, it is estimated that approximately 21% of the population (about 6 million people) will meet the criteria for addiction in their lifetime. Alcohol was the most common substance for which people met the criteria for addiction at 18%. Cannabis, also known as Marijuana, has one of the highest rates of cannabis use in the world, with more than 40 per cent of Canadians having used cannabis in their lifetime and about 10 per cent having used it in the past year.

What is an overdose?

An overdose (OD) is when the body is overwhelmed by exposure to a toxic amount of a substance or combination of substances. The body becomes unable to maintain or monitor functions necessary for life, like breathing, heart rate, and body temperature regulation. Not everyone who overdoses will die; however, there can be long-term medical impacts from overdose, such as brain damage from lack of oxygen.

What are the signs of an overdose?

- breathing is slow or not breathing at all
- nails and/or lips are blue
- choking or throwing up
- making gurgling sounds
- skin is cold and clammy
- can’t wake them up

Sources

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HARM REDUCTION

What is harm reduction?

Harm Reduction is an evidence-based, client-centred approach that seeks to reduce the health and social harms associated with addiction and substance use, without necessarily requiring people who use substances from abstaining or stopping. Essential to a harm reduction approach is that it provides people who use substances a choice of how they will minimize harms through non-judgemental and non-coercive strategies in order to enhance skills and knowledge to live safer and healthier lives.

Harm reduction acknowledges that many individuals coping with addiction and problematic substance use may not be in a position to remain abstinent from substances. The harm reduction approach provides an option for users to engage with peers, medical and social services in a non-judgemental way that will 'meet them where they are'.

What are the principles of harm reduction?

1. PRAGMATISM

Harm reduction accepts that the non-medical use of psychoactive or mood-altering substances is a near-universal human cultural phenomenon. It acknowledges that, while carrying risks, drug use also provides the user and society with benefits that must be taken into account. Harm reduction recognizes that drug use is a complex and multifaceted phenomenon that encompasses a continuum of behaviours from abstinence to chronic dependence, and produces varying degrees of personal and social harm.

2. HUMAN RIGHTS

Harm reduction respects the basic human dignity and rights of people who use drugs. It accepts the person's decision to use drugs as fact and no judgment is made either to condemn or support the use of drugs. Harm reduction acknowledges the individual person's right to self-determination and supports informed decision making in the context of active drug use. Emphasis is placed on personal choice, responsibility and self-management.

3. FOCUS ON HARMS

The fact or extent of an individual's drug use is secondary to the harms from drug use. The priority is to decrease the negative consequences of drug use to the user and others, rather than decrease drug use itself. While harm reduction emphasizes a change to safer practices and patterns of drug use, it does not rule out the longer-term

goal of abstinence. In this way, harm reduction is complementary to the abstinence model of addiction treatment.

4. MAXIMIZE INTERVENTION OPTIONS

Harm reduction recognizes that people with substance use issues benefit from a variety of different approaches. There is no one prevention or treatment approach that works reliably for everyone. It is choice and prompt access to a broad range of interventions that helps keep people alive and safe. Individuals and communities affected by drug use need to be involved in the co-creation of effective harm reduction strategies.

5. PRIORITY OF IMMEDIATE GOALS

Harm reduction establishes a hierarchy of achievable steps that taken one at a time can lead to a fuller, healthier life for people using substances and a safer, healthier community. It starts with “where the person is” in their drug use, with the immediate focus on the most pressing needs. Harm reduction is based on the importance of incremental gains that can be built on over time.

6. PEOPLE USING SUBSTANCES INVOLVEMENT

The active participation of people using substances is at the heart of harm reduction. People using substances are seen as the best source of information about their own substance use, and are empowered to join with service providers to determine the best interventions to reduce harm from drug use. Harm reduction recognizes the competency of people using substances to make choices and change their lives.

What are the benefits of harm reduction related to substance use?

Harm reduction has many benefits for people who use substances. It also helps their families, friends and communities. Research shows harm reduction activities can:

- Increase referrals to support programs and health and social services
- Reduce stigma and increase access to health services
- Reduce sharing of substance use equipment
- Reduce hepatitis and HIV
- Reduce overdose deaths and other early deaths among people who use substances, including alcohol
- Increase knowledge around safer substance use
- Increase knowledge around safer sex and sexual health and increase condom use

What are some examples of harm reduction?

Some practices that take a harm reduction approach include: using a nicotine patch instead of smoking, consuming water while drinking alcohol, using substances in a safe environment with someone they trust, and needle exchange programs for people who inject drugs. Harm reduction doesn't just apply to the use of substances. We engage in harm reduction in our everyday lives to minimize a risk, such as wearing a helmet when riding a bike or enforcing seatbelts when driving in a car.

Overdose Prevention Sites (which are also referred to as supervised injection services or safe consumption sites) are facilities that fall under the umbrella of harm reduction. These facilities are health services that provide a hygienic environment for people to consume substances under the supervision of medical professionals. In addition to supervised injection, individuals are provided with sterile supplies, education on safer consumption, overdose prevention and intervention, medical and counselling services, and referrals to drug treatment, housing, income support and other services. Most sites are 80% run by people with the lived or living experience of substance use. Overdose prevention sites have been known to reduce costs for the health care system, prevent blood borne illnesses such as HIV or Hepatitis C, helps individuals access support services and prevent overdose deaths. In addition, research shows that the existence of an overdose prevention site in a community does not lead to increased crime, and works to decrease public substance consumption. These facilities are helpful in reducing the harms related to substances, particularly opioids. Overdose prevention sites are an evidence-based component to a comprehensive treatment response.

What are some other examples of harm reduction programs?

1. Impaired driving prevention programs. The programs increase awareness of the risks of driving under the influence of substances
2. Outreach and support programs
3. Information and resources on safer ways to use substances. It covers opioid use, stimulants and other substances
4. Supply distribution and needle recovery programs
5. Options for opioid substitution (agonist) therapies such as methadone or suboxone
6. Take home naloxone kits. The kits include medication to reverse an opioid overdose. This helps prevent brain injury and death
7. Supervised consumption/injection services and overdose prevention services. These services help prevent overdose deaths. They can reduce other harms by providing a safer, supervised environment for people using substance
8. Mental wellness and healing support programs and centres
9. Peer support programs run and attended by people with experience using substances. The programs must receive enough funding for consistent service

What are the goals of harm reduction?

The overarching goal of the harm reduction approach is to prevent the negative consequences of substance use and to improve health. Harm reduction approaches and programming are supported internationally by global institutions such as UNAIDS, United Nations office on Drugs and Crime, and the World Health Organization, and it is seen as a best practice for engaging with individuals with addiction and substance use issues.

A frequent misconception of harm reduction is that it supports, or encourages, illicit substance use and does not consider the role of abstinence in addiction treatment. However, harm reduction approaches do not presume a specific outcome, which means that abstinence based interventions can also fall within the spectrum of harm reduction goals. Essentially, harm reduction supports the idea that those with addiction or substance use issues should be treated with dignity and respect and have a wide selection of treatment options in order to make an informed decision about their individual needs and what would be the most effective for them, while also reducing the harms.

Sources:

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BC MENTAL HEALTH ACT

The Mental Health Act is the law that describes what should happen when someone who is living with a mental illness needs treatment and protection for themselves/others.

In Canada, every province has a mental health law that is used to serve the people living in that province. People living in B.C. are governed by the B.C. Mental Health Act.

How can a person with mental illness receive treatment?

A person experiencing a mental illness can receive treatment and support through a voluntary or involuntary process.

1. **Voluntary treatment** under the B.C. Mental Health Act means that the person is able and willing to seek treatment and support for their mental illness when they need it. In this case the person may seek treatment voluntarily, or by choice, at a hospital setting, from a family doctor, a psychiatrist (mental health doctor) or at a community mental health and substance use centre.
2. **Involuntary treatment** means that the person is not willing or able to seek help or treatment when they are experiencing severe mental illness that affects their ability to manage their lives safely, and they cannot be treated safely as a voluntary patient in the community. When this happens, the person may be brought to a hospital by police or through an order by a Judge or Justice of the Peace. This is to ensure the person is protected from harming themselves/others and prevent their mental illness from getting worse.

The B.C. Mental Health Act lists four criteria, or rules, that must be followed before a doctor can decide that the person experiencing a mental illness can be certified under the Act.

1. Is suffering from a disorder of the mind that seriously impairs the person's ability to react appropriately to their environment or to associate with others (as per the definition from Part 1 of the Act).
2. Requires psychiatric treatment in or through a designated facility.
3. Requires care, supervision and control in or through a designated facility to prevent the person's substantial mental or physical deterioration or for the person's own protection or the protection of others.
4. Is unsuitable to be a voluntary patient.

What is extended leave?

Extended leave means that the person continues to be certified under the Mental Health Act after discharge from a designated facility, such as a hospital or other mental health care location.

Some reasons for extended leave may include:

- The person needs further treatment but they lack the insight into their need for continued treatment and are unwilling to continue treatment in the community.
- The person's mental and physical health may deteriorate (get worse) without certification, but they don't have to be in a designated facility.

In the case of an extended leave, the person is supported by a community mental health team that monitors his/her mental health and well-being and provides treatment and support as necessary. If the person is not able to follow the care or treatment plan in place, the mental health team has the ability to admit the person back to hospital.

What will happen to a person once they have been certified?

Certification under the Mental Health Act is temporary, which means the doctor has to regularly monitor and review the person's mental health and the need for involuntary treatment to determine whether or not the person still meets the criteria for continued certification.

The person can only be treated in hospital as an involuntary patient for 48 hours after the first doctor examines him/her. During that time, a second doctor must examine the person and decide if the person still needs involuntary treatment and then sign a second certificate that will be valid for one month.

How long can a person be certified?

After the first one month, if the person still needs to be treated involuntarily, the doctor can renew the certification for another one month and following this, it can be extended to three months. From then onwards, the certificate can be renewed every six months until the person no longer needs involuntary treatment.

Who can cancel a certification under the Mental Health Act?

A Mental Health Act certificate can be cancelled in two ways:

1. **By a doctor who is usually a psychiatrist.** Once the doctor examines a person and they find that the person no longer meets the requirement for certification under the Mental Health Act, the doctor must decertify (cancel) the person.
2. **By a review panel:** If the review panel finds that the person no longer meets the requirement for certification, the panel must decertify the person immediately. The person then has the choice of voluntarily treatment in or out of hospital.

What rights does a person have if certified? (Form 13)

- the right to know the name and location of the facility.

- the right to know the reason why they are there. The doctor must write the reasons for the hospitalization on the medical certificate (Form 4) or, if the certification has been renewed, on the renewal certificate (Form 6). One has the right to know what is on the certificate.
- the right to contact a lawyer. A lawyer can help the person challenge their certification by asking a judge to review their case. They may have to pay the lawyer's fee and court costs. A lawyer can also give legal advice about one's rights as a certified patient. If one can't afford a lawyer, Access Pro Bono offers 30 minutes of free legal advice over the phone. Call to make an appointment: 604-482-3195 ext. 1500 in the Lower Mainland 1-877-762-6664 ext. 1500 elsewhere in BC 10 am–4 pm, Monday to Friday.
- The right to be examined regularly by a medical doctor to see if one still needs to be an involuntary patient.
- the right to apply to the review panel to decide if one should be discharged. If one doesn't agree with the doctor's decision, one can challenge the hospitalization. There is no cost for a review panel hearing. A review panel is independent of the hospital and includes: 1) a lawyer, 2) a doctor who is not on the person's treatment team, and 3) a member of the community. They will hear the case and decide if the person meets the criteria for hospitalization. If they decide that they don't, they'll be decertified. If they decide that they do, they'll have to stay in the hospital. To apply for a review panel hearing, ask a nurse to help fill out Form 7. If one is in a 1-month certification period, the hearing will be scheduled within 14 days from when one applies. The person has the right to have an advocate or lawyer represent them and help prepare and present the case to the review panel. A person can call witnesses to testify on their behalf. They can ask the review panel if they can bring someone to support them, but it's up to the chair of the panel to decide if this will be allowed. Once a hearing is scheduled, if the person needs help finding an advocate or lawyer to represent them, call the Mental Health Law Program: 604-685-3425 in the Lower Mainland 1-888-685-6222 elsewhere in BC 10 am–noon & 1:30 pm–4:30 pm, Monday to Friday.
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- the right to speak with a lawyer

What if a person is unhappy about their care?

If the person has complaints about the way they've been treated, they can contact the Office of the Ombudsperson: 1-800-567-3247 PO Box 9039 STN PROV GOVT Victoria, BC V8W 9A5 bcombudsperson.ca The Office of the Ombudsperson is an independent body that investigates public institutions, like the hospital.

SOURCES

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https://www.bcmentalhealthrights.ca/wp-content/uploads/2018/05/MHARA-pamphlet-2018.pdf

BC MENTAL HEALTH ACT HANDOUT

The Mental Health Act is the law that describes what should happen when someone who is living with a mental illness needs treatment and protection for themselves/others.

In Canada, every province has a mental health law that is used to serve the people living in that province. People living in B.C. are governed by the B.C. Mental Health Act.

How can a person with mental illness receive treatment?

A person experiencing a mental illness can receive treatment and support through a voluntary or involuntary process.

1. **Voluntary treatment** under the B.C. Mental Health Act means that the person is able and willing to seek treatment and support for their mental illness when they need it. In this case the person may seek treatment voluntarily, or by choice, at a hospital setting, from a family doctor, a psychiatrist (mental health doctor) or at a community mental health and substance use centre.
2. **Involuntary treatment** means that the person is not willing or able to seek help or treatment when they are experiencing severe mental illness that affects their ability to manage their lives safely, and they cannot be treated safely as a voluntary patient in the community. When this happens, the person may be brought to a hospital by police or through an order by a Judge or Justice of the Peace. This is to ensure the person is protected from harming themselves/others and prevent their mental illness from getting worse.

The B.C. Mental Health Act lists four criteria, or rules, that must be followed before a doctor can decide that the person experiencing a mental illness can be certified under the Act.

1. Is suffering from a disorder of the mind that seriously impairs the person's ability to react appropriately to their environment or to associate with others (as per the definition from Part 1 of the Act).
2. Requires psychiatric treatment in or through a designated facility.
3. Requires care, supervision and control in or through a designated facility to prevent the person's substantial mental or physical deterioration or for the person's own protection or the protection of others.
4. Is unsuitable to be a voluntary patient.

What is extended leave?

Extended leave means that the person continues to be certified under the Mental Health Act after discharge from a designated facility, such as a hospital or other mental health care location.

Some reasons for extended leave may include:

- The person needs further treatment but they lack the insight into their need for continued treatment and are unwilling to continue treatment in the community.
- The person's mental and physical health may deteriorate (get worse) without certification but they don't have to be in a designated facility.

In the case of an extended leave, the person is supported by a community mental health team that monitors his/her mental health and well-being and provides treatment and support as necessary. If the person is not able to follow the care or treatment plan in place, the mental health team has the ability to admit the person back to hospital.

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ELECTROCONVULSIVE THERAPY (ECT)

While working in acute care environments, you may find yourself working with and supporting peers who are receiving Electroconvulsive therapy (ECT) as part of their treatment plan. ECT is one of the most stigmatized forms of therapy but educating ourselves on why it is used and what it entails can be helpful for both ourselves and the peers whom we are supporting.

What is Electroconvulsive therapy (ECT)?

Electroconvulsive therapy (ECT) is one of the most controversial and misunderstood treatments for mental illness. In fact, it is safe and effective for treating severe depression when patients have symptoms that haven't responded to medication, counselling or other psychosocial treatments. It is also used to treat conditions such as mania and schizophrenia. ECT can be used to treat people with an acute illness and to maintain their improvement.

How does Electroconvulsive therapy (ECT) work?

As with many medical treatments, the actual way that ECT relieves symptoms of illness is unknown. It is now believed that ECT affects some of the chemicals that transfer impulses or messages between nerve cells in the brain, so it may correct some of the biochemical changes that accompany some mental disorders.

Research has shown that 60 to 80 per cent of people with depression achieve remission with a course of ECT. This treatment often helps people who do not feel better after trying other treatments, such as medications.

A course of ECT consists of individual treatments that are most often given three times per week. The total number of treatments and their frequency are determined by your doctor. The total number of treatments varies—usually between eight and 19—but it could be more or fewer.

Each treatment is given while one is asleep under general anesthesia. The anesthetic (the drug that puts one to sleep) is injected by an anesthesiologist (a doctor who specializes in giving the medicine) through a needle inserted in a vein. One will be given oxygen through a face mask. One’s heart rate, blood pressure and oxygen level are monitored during the treatment. One will be asleep for about five to 10 minutes.

Each treatment procedure involves passing a small, controlled electric current between two metal discs (electrodes) that are applied on the surface of the scalp and/or temple. The current passes between the electrodes and through part of the brain in order to stimulate the brain. It causes a controlled therapeutic seizure that usually lasts 20 to 90 seconds.

One can talk to their psychiatrist and members of the health care team about how to stay healthy.

One may need to have ongoing maintenance ECT, take medication, join a therapy group or have one-to-one talk therapy. Together with the psychiatrist and the support people, one will make a treatment and follow-up care plan.

Who can Electroconvulsive therapy (ECT) benefit?

ECT is an effective treatment for severe depression. It is usually recommended when people have symptoms that have not responded to medications or psychosocial treatments.

Risk of Side Effects

Headache: One may get a headache. This may be caused by anesthetic, the ECT treatment or not having anything to eat or drink for a long time.

Muscle stiffness: One may get some muscle stiffness from the medication given during the treatment to relax your muscles.

Nausea: One may get nausea from the anesthetic or from not eating and drinking for a long time.

Confusion: One may feel confused after an anesthetic and ECT treatment. It is best to rest for the next 24 hours and have someone with them during this time. Confusion caused by anesthetic and ECT does not last long.

Memory loss: One may have some problems with loss of memory. This can last between a few weeks and several months. Avoid making major decisions while one is having ECT treatments.

Improved ECT techniques and clear guidelines for the use of ECT have reduced the risk and severity of memory side-effects.

ECT Myths

1. ECT is like *One Flew Over a Cuckoo's Next*

   ECT today is a sophisticated procedure – nothing like how it's portrayed in that old movie. Today, ECT is performed under general anesthesia. Patients are monitored continuously to reduce the risk of complications. Patients are asleep and unaware of the stimulation.

2. ECT is a miracle cure

   ECT is an incredible therapy, but it is not a miracle cure. Depression is a chronic condition, and relapses can occur after ECT. If relapse occurs, maintenance treatments to patients who have previously completed ECT therapy can be given to regain control of depression symptoms.

3. I'll get insured during the seizure.

Patients lie down while the medically-controlled seizure is induced. People who experience spontaneous seizures often fall down and risk head injury. This won't happen during at ECT treatment. In fact, most patients don't move or jerk their limbs at all, those who do move only minimally.

There is a risk of shoulder dislocation or biting the tongue during the procedure, similar to during a non-medical seizure. However, because this procedure is medically-controlled, precautions are taken to reduce the risk such as giving patients medication to relax the muscles and placing the bite blocks in their mouths during the procedure.

4. I'll have permanent brain damage.

For many patients, this is the most worrisome ECT myth. However, there is no evidence of structural brain damage in patients who have ECT. Some patients have slight memory loss of recent events, and in most patients, this resolves within a few months after treatment ends.

SOURCES

https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/electroconvulsive-therapy

https://utswmed.org/medblog/electroconvulsive-therapy-depression/

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RESTRAINTS

Unfortunately, while you are working in acute care/emergency department environments, there may be times when the peers you are supporting are placed in restraints. While this may be traumatic, it is best to try to remember that restraints are not meant to be a punitive action, but rather an intervention to prevent harm to your peer or others. Here we will discuss in more detail what you as peer support workers need to know about the use of restraints.

What is a restraint?

- Under the *Mental Health Act* "restrain" means to "place under control when necessary to prevent serious bodily harm to the patient or to another person by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the physical and mental condition of the patient". This type of restraint is not a treatment.
- The doctor and members of the clinical team must take into consideration one's mental and physical condition in order to determine the minimal restraint necessary to prevent harm to oneself or others. Restraint can be by force (for example, being held down by staff), or mechanical (for example, being tied to a chair; being strapped to the bed), or environmental (for example, being locked in a seclusion room). Restraint can also be chemical when medication is given to either by mouth or by injection/needle.

When can restraints be used?

- In situations where one's behaviour poses an immediate serious threat to their own safety or serious threat to the safety of others, one may be restrained to bring the behavior under control.

Can a person be restrained if they are a voluntary or informal patient?

- If one is a voluntary or informal patient, the *Mental Health Act* does not authorize a psychiatric facility to detain or restrain them.
- However, hospital staff; have a duty under the common law to restrain one if they feel that such immediate action is necessary to prevent serious bodily harm to them or others. Following the use of a restraint, a doctor must immediately assess the person to see if the criteria for being made an involuntary patient applies. If not, the restraints should be immediately discontinued.

What protections are available to when staff put a person in restraints?

- Restraints may only be used where there is concern that one would seriously harm themselves or others.
- In every instance, staff is required to use minimum restraint that is necessary and discontinue the use of restraint as soon as the behavior is under control.

- Staff must assess one's mental and physical condition to determine the minimum restraint that is necessary to use.
- Staff must never use restraints as a punishment or as a response to difficult behavior.

What should staff do to support a person while they are being restrained?

- While one is being restrained one should be observed by staff to ensure that the restraints do not cause physical pain or harm.
- One has the right to speak to the doctor and any staff about their experience in restraints. Staff should assess one's condition regularly so that the restraints may be discontinued at the earliest possible time.
- Staff should provide counselling to the person throughout the period when restraints are being used, including telling them what behavior resulted in placing them in restraints and assuring them that as soon as they have regained control of their behavior, the use of restraints will be discontinued.
- Staff should also tell one what sort of behavior they are looking for to indicate that they have regained control and are no longer at risk of harming themselves or others.
- The *Mental Health Act* requires that staff document in the person's record of personal health information:
  - a statement that they were restrained,
  - a description of the type of restraint used,
  - a description of the behavior, which caused the person to be restrained, and
  - if using a chemical restraint - the type of chemical used, dosage, and method (i.e., injection or by mouth)
- Staff should respond to one's personal care needs while they are in restraints. These include giving fluids, meals, access to hygiene, activities, exercise, fresh air, limb massage, appropriate clothing and rotation of restraints.

May a person express a preference about the type of restraint that is given to them?

- Yes. If one has a strong preference for one form of restraint over another, one may ask that staff respect one's choice.

How will a person know if they are being given a chemical restraint or treatment?

- Staff should inform the person at all times whether the medications are being administered as treatment or restraint. One has the right to ask that the purpose of the medication be explained.

What options does a person have if they think there were problems about the use of restraints in their situation?

- If one feels that the restraints used were excessive, used longer than necessary or not justified, one can:
  - if one is a patient in a psychiatric facility with a Patient Advocate, request that staff call the Patient Advocate.
  - if one is a patient in any other psychiatric facility (for example, a psychiatric unit in a general hospital), request that staff call the patient representative or patient relations officer who can help the person contact a lawyer.
  - express concerns to staff.

SOURCE:
https://www.sse.gov.on.ca/mohltc/ppao/en/Pages/InfoGuides/2016_Restraints.aspx?openMenu=smenu_InfoGuides

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SECLUSION

Seclusion is a method of restraint during which a person is contained in a room that is either locked or "from which free exit is denied" (Mayers et al., 2010, p. 61). A person who has been contained and prevented from leaving a space in the course of a psychiatric intervention is considered to be experiencing seclusion, whether or not the intervention is carried out in a formal secure room, or other alternatively-labelled environment, including a person's hospital bedroom. People who are secluded must be certifiable under the Mental Health Act of British Columbia, or present an immediate safety risk to themselves or others (BC MoH, Oct 2013).

It is critical that the use of seclusion be prevented. Most people who have experienced seclusion report it as coercive, shameful, humiliating, punitive, confusing, and/or alienating; no matter how carefully it is delivered (MoH, 2013). To date, there is no evidence that seclusion contributes to healing or recovery, and there is strong support for the claim that it can be harmful to the person being secluded, as well as to those who witness or deliver the intervention (MoH, 2013).

"When seclusion must take place, it is a short term, emergency intervention designed to protect and enhance the safety of the individual person and others on the unit. Seclusion should take place only in a room designed specifically for that purpose, conform to protocols that are part of a facility's standard operating procedure, and not be delivered on an ad hoc basis (Pereira et al. 2007)." (PQHSSG for secure rooms in designated Mental Health Facilities under the BC Mental Health Act, 2013 pg. 17)

Other interventions must be used prior to initiating seclusion. These can include:

- Meaningful daily activities that prevent aggression by promoting engagement
- A non-coercive, collaborative, consistent approach to care
- Private spaces to lower stress and encourage relaxation
- Efforts to identify a person's individual triggers and coping strategies
- Sensory interventions to promote self-management
- Assessment of nicotine/substance withdrawal issues
- Increased levels of observation

A person demonstrating behaviours that poses immediate and imminent risk to hurting self and/or to others may be placed in secure room as an emergency measure.

- Seclusion shall never be used as a disciplinary or punitive measure
- Seclusion shall not be used solely to prevent damage to property
- Seclusion shall not be used solely to prevent absconding

Source: VCH/PH Secure Room Policy (Final Draft Dec 2014)

RISK AND SAFETY

Often patients are under a great deal of stress. This can in turn lead to intense feelings, some of which may result in anger and aggressive behaviors. While our patients' safety is always one our highest priorities, it is also equally important that our staff feel supported and safe at all times as well. There are proactive approaches that staff can implement so as to avoid circumstances than may result in their safety being compromised, however it is inevitable that there will also be events where this cannot be avoided. All staff should be familiar with the following protocol which offers techniques for preventative safety measures and the plan of action to follow if a crisis occurs.

Preventive Measures

- Be aware of your attire: Be certain that you are wearing clothing that is easy to move in and shoes that are conducive to moving quickly/running. Do not wear jewelry that hangs (i.e., long earrings, lanyards that do not quickly release, necklaces, etc.) or hair styles that can be easily grabbed (ponytails).
- Keep your seating area situated nearest to the exit: Provide yourself with the advantage of being closest to the door. Do not inadvertently trap yourself in a room by allowing a patient to sit closest to the door. Be cognizant of the room set up and the placement of your desk.
- Keep the room free of objects that can be used as weapons: Be aware of items such as lamps, paperweights, or anything else that is within the patient's reach to utilize as a weapon.
- Always use the "buddy system": Never be alone in the office and always inform your colleagues of any concerns you may have about a particular patient ahead of time so that they may be vigilant. Do not leave the building with an agitated patient.
- Be aware of your environment and those around you at all times: Please know when to cancel a session, end a session, and/or call for help. Always take a moment to scan your surroundings, be mindful of what is happening around you, and refrain from being on your cell phone when walking alone.
- Always know your exact location/address: This is for the benefit of quickly expediting emergency personnel, if needed

Recognizing Patient Behavior and Knowing How to Respond

Recognizing Intoxication: Patients who appear to be under the influence of alcohol and/or drugs should be assessed for safety. When you notice signs of intoxication you should alert staff member. Recognize also that agitation may be the result of withdrawal rather than intoxication. If the patient is acting in a manner that is unsafe, agitated, or

threatening, security should be called (see additional information about responding to agitated patients).

Recognizing Anxious Behavior: Patients who may exhibit any of the following behaviors may be starting to escalate or become agitated. Do not hesitate to remove yourself from the situation and alert a staff member if you notice these behaviors. Simply letting the patient know you will 'be back in a couple of minutes can suffice.

> **Behaviors may include:** Head dropped down, face flushed, eye brow twitching, excessive swallowing, bulging veins in neck or forehead, nervous laughing, restlessness, sweaty palms/brow , minimal eye contact, excessive or minimal talking, confused, rubbing or pulling at ear lobes, repetitive movements, rubbing hands together, tapping, bouncing knee, sigh or stutter, shaking.

De-escalation Techniques:

- Provide personal space - greater than 4 feet
- Supportive eye contact: maintain direct eye contact 90% of the time, looking away 10% of the time
- Supportive gestures: palms up at waist level, leaning body and head slightly forward
- Supportive stance: Stand at a 45 degree angle
- Supportive facial expressions
- Empathic listening: "You must feel…"
- Supportive verbal communication: Speech: Volume, tone, rate Avoid saying: "Calm down", "Be reasonable", "You're wrong", "These are the rules" Try saying: "I seem to be upsetting you, would you like to talk to someone else?"

Recognizing Conflict: Unmet expectations (related to past experiences), frustration, anger, disappointment. Triggers for patients can be if they feel threatened, feeling that they are treated unjustly or provoked.

> Conflict resolution techniques:
> - Allow patient to vent
> - Use silence as a verbal strategy
> - Supportive Stance If patient continues to be angry/agitated:
> - Assume assertive stance
> - Hands palm down and waist level
> - Direct eye communication
> - Speak with a calm, confidence voice- use their name
> - Set verbal limits which must be reasonable and that can be enforced "John please control your behavior by lowering voice or we will have to call the

police" "It's your choice, you have 2 minutes" If patient continues to be angry/agitated: • Raise hands, palm out

- Yell "stop" or distracting statement, push panic button (if available)
- Divert: Throw or drop an object
- Escape *In the event that the following should occur, the aggression protocol should be implemented.

Recognizing Threatening Behavior: Face gets red, lips pushed rolled forward, direct prolonged eye contact, head and shoulders back, standing tall, hands pumping, finger pointing, yelling, cursing pounding fists, spitting (If a patient has reached this phase, it is best to end any interaction/visit/session and to safely exit the area. In addition, it's important to remove any other persons (staff, patients) from the vicinity as well.)

Recognizing Threat for Violence: Face becomes white, eye brows drop, lips tighten, head down and forward, rapid breathing, mouth breathing, may go from yelling to silent, repeating statements, voice strained, speaking quickly, changes stance to angular posture, shoulders shift, bobbing on toes, stopping movement. Target glance: will look at the area to attack. Settling: lowers body in order to push off rear foot. When body dips, move to a position of advantage behind chair or desk. (If a patient has reached this phase, it is best to end any interaction/visit/session and to safely exit the area. In addition, it's important to remove any other persons (staff, patients) from the vicinity as well. Please refer to the latter half of this protocol for further instruction.)

Invoking the Aggression Protocol: Protect yourself! Remove yourself from the room if you can safely do so. Leave the room if possible and press your panic button. If you are alone and cannot leave the room for assistance, press your panic button. This will alert neighboring staff to call security. If you hear the panic button go off in a colleague's office, call security. Consider the safety of the other patients in the office/building. If possible, ask them to leave the area until the situation is contained. If located within the Hospital or on the premises call security.

Debriefing: Be prepared to have a staff debriefing with your team within 24 hours of the incident. Plan to process the circumstances which occurred and perhaps consider what, if anything could have been done differently. An incident reporting form will also be required.

SOURCE

https://www.mass.gov/doc/patient-and-staff-safety-protocol-bidh-plymouth/download

RISK AND SAFETY HANDOUT

Preventive Measures

- Be aware of your attire: Be certain that you are wearing clothing that is easy to move in and shoes that are conducive to moving quickly/running. Do not wear jewelry that hangs (i.e., long earrings, lanyards that do not quickly release, necklaces, etc.) or hair styles that can be easily grabbed (ponytails).
- Keep your seating area situated nearest to the exit: Provide yourself with the advantage of being closest to the door. Do not inadvertently trap yourself in a room by allowing a patient to sit closest to the door. Be cognizant of the room set up and the placement of your desk.
- Keep the room free of objects that can be used as weapons: Be aware of items such as lamps, paperweights, or anything else that is within the patient's reach to utilize as a weapon.
- Always use the "buddy system": Never be alone in the office and always inform your colleagues of any concerns you may have about a particular patient ahead of time so that they may be vigilant. Do not leave the building with an agitated patient.
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BURNOUT

Coined by the psychologist, Herbert Freudenberger in the 1970s, burnout describes a severe stress condition that leads to severe physical, mental, and emotional exhaustion. Much worse than ordinary fatigue, burnout makes it challenging for people to cope with stress and handle day-to-day responsibilities.

People experiencing burnout often feel like they have nothing left to give and may dread getting out of bed each morning. They may even adopt a pessimistic outlook toward life and feel hopeless. Burnout doesn't go away on its own and, if left untreated, it can lead to serious physical and psychological illnesses like depression, heart disease, and diabetes.

Burnout is not a disorder. However, if it is unrecognized, burnout can become chronic. Burnout is more than just job dissatisfaction and more than just physical fatigue from which one can recover more quickly. It is not synonymous with job stress, since some individuals thrive under stressful conditions; however, if the stress becomes overwhelming or leads to maladaptive coping, the risk for burnout increases.

Empathy and Burnout

Empathy is being able to put yourself in someone else's shoes, or being able to sense the emotions of the other person, and convey that understanding to them. While undoubtedly important for many aspects of life, being empathetic is especially useful for those working in healthcare.

Empathy helps ensure people receive the best quality healthcare, helps clients from all backgrounds and cultures receive care that works best for them, and helps clients feel safe about their healthcare procedures. But all too often, those working in healthcare can become burnt out – which may have a serious impact on their ability to relate to, and be empathetic, with clients. Not surprisingly, research shows that as either empathy or burnout increases, the other one decreases – that is, they are negatively associated to each other.

Discussion: What are some signs of burn out? *Answer: Signs of burnout can include exhaustion, detachment, cynicism and a reduced sense of achievement, all of which makes quality client care more difficult.*

Three Stages of Burnout

Because prevention and treatment are possible, particularly in the earlier stages, it is important to recognize the stages.

Stage 1 consists of milder signs and symptoms that are episodic, such as experiencing mental fatigue at the end of the workday; feeling unappreciated, frustrated, or tense; and having physical aches and pains. Often individuals feel that they are falling behind

on goals and deadlines and are not meeting status quo requirements, and they experience growing dread at facing the next workday.

Stage 2 consists of longer-lasting symptoms that are more challenging to reverse, such as disillusionment about the job; pervasive feelings of boredom, apathy, or frustration; feelings of being ruled by a schedule; and intermittent periods of psychological or physical symptoms that persist even when the provoking situation subsides. Psychological symptoms include irritability, aggression, anxiety, depression, substance use (eg, caffeine, nicotine), and suicidal thoughts; physical symptoms include fatigue, sleep disturbance, changes in weight, and GI distress.

Stage 3 is severe burnout. The signs and symptoms have become more chronic and if left untreated can evolve into psychiatric and physical health disorders, such as depression, myocardial infarcts, and peptic ulcers. Often there are expensive personal consequences, such as divorce, high job turnover, substance dependence, shorter life expectancy, and completed suicide

Discussion: What are the reasons you think burnout happens? *Answer: Burnout happens for a range of reasons, including high-pressure workplaces, lack of support, poor work-life balance or feeling a lack of control over, overwhelmed by, or in conflict with the work itself.*

Discussion: How can we prevent burnout? *Answer: Manageable case-loads, debriefing, peer and organisational support may all help people avoid (or recover from) burnout and low empathy. Some advice for those working in healthcare might be to set boundaries in your relationships with clients. Healthcare professionals might also engage in self-care, and make time to regularly debrief with a colleague about difficult experiences.*

Cultivating empathy can be difficult for those working in the healthcare sector, especially when the stressful environment can make burnout common. But there is some research that higher empathy levels might protect against burnout.

While this link needs to be studied more, the researchers involved speculate that healthcare workers able to better understand the perspective of their clients might feel more connected - and useful - to their clients. This could alleviate some of the stresses of the work.

Stress may be unavoidable, but burnout is preventable. Following these steps may help you thwart stress from getting the best of you:

- **Exercise**

  Not only is exercise good for our physical health, but it can also give us an emotional boost. Stretched for time? You don’t need to spend hours at the gym to reap these

benefits. Mini-workouts and short walks are convenient ways to make exercise a daily habit.

- **Eat a balanced diet**

  Eating a healthy diet filled with omega-3 fatty acids can be a natural antidepressant. Adding foods rich in omega-3s like flaxseed oil, walnuts, and fish may help give your mood a boost.

- **Practice good sleep habits**

  Our bodies need time to rest and reset, which is why healthy sleep habits are essential for our well-being. According to the National Sleep Foundation, avoiding caffeine before bedtime, establishing a relaxing bedtime ritual, and banning smartphones from the bedroom can help promote sound sleep hygiene.

- **Ask for help**

  During stressful times, it's important to reach out for help. If asking for assistance feels difficult, consider developing a self-care "check-in" with close friends and family members so that you can take care of each other during trying times.

Sources:

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BURNOUT HANDOUT

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