Mental Health Commission of Canada | Commission de la santé mentale du Canada

Mental Health First Aid Canada

Mental Health First Aid - Supporting Older Adults Reference Guide

Can Anyone Help My Mind?

The artist is in the middle of a crowd and feeling envious that other people have such full lives with work, families and happiness. He feels like an outcast. All the faces look the same because the artist was reflecting his desire to fit in and be like everyone else.

Source: Paintings in this document

The painting on the front cover, along with the paintings at the beginning of sections 1, 2.1, 2.2 and 2.3, were reproduced with permission from the "Out of the Shadows" artist's program in Edmonton, which offers community arts opportunities to individuals living with mental health concerns. The artist wishes to remain anonymous.

Published by the Mental Health Commission of Canada, 2020 (4th edition)

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Disclaimer

The information provided in this course is for mental health and substance use first aid use only and is not intended to be and should not be relied upon as a substitute for professional mental health and substance use advice.

Welcome to Mental Health First Aid (MHFA) - Supporting Older Adults

In any given year, one in five people in Canada are living with a mental health or substance use problem (Mental Health Commission of Canada, 2013; Smetanin et al., 2011). Some mental health and substance use problems are more common than many physical health problems. While people often know a lot about physical illness, most people have little knowledge about mental illness. This lack of understanding promotes fear and stigma. It prevents people from seeking help early and from seeking the most effective help. It also keeps people from providing support to friends, colleagues, family members and people around them simply because they do not know how.

Our mental health (also referred to as mental wellness or well-being) allows us to realize our potential, cope with stress effectively, bounce back from life challenges and be active, productive members of our communities. How each of us defines our mental health/wellness/well-being can be very different and quite individualized, it is about living well and feeling capable despite life's challenges (Minister of Public Works and Government Services Canada, 2006).

Note: In this MHFA course, we'll use the term "mental well-being."

The Mental Health First Aid (MHFA) - Supporting Older Adults training course was developed to help people provide initial support to older adults who may be experiencing a decline in their mental well-being or may be in crisis. The philosophy behind MHFA is that mental health and substance use crises, such as suicidal and self-harming actions, may be avoided through early intervention. If crises do arise, then members of the public can take action that may reduce the harm that could result.

Course participants will learn how to recognize the range of changes that may be a sign of declining mental well-being or crisis, how to offer and to provide help, and how to guide an older adult towards appropriate treatments and supports.

This guide has been developed to accompany the MHFA Canada course. The "Contents" page provides a snapshot of the topics addressed. Please note that the contents of this guide, including all wording, graphics, images and other material, are not intended to replace consultations with a doctor or professional, or to provide medical advice, diagnosis or treatment. Don't use this information to diagnose or develop a treatment plan for a mental health or substance use problem without consulting a qualified health care provider.

We appreciate your interest in supporting others who may be experiencing mental distress. And, we encourage you to use what you'll learn for your own mental well-being.

Enjoy the course!

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Background

Mental Health Commission of Canada

Who We Are

The Mental Health Commission of Canada (MHCC) leads the development and dissemination of innovative programs and tools to support the mental health and wellness of Canadians. Through its unique mandate from the Government of Canada, the MHCC supports federal, provincial and territorial governments as well as organizations in the implementation of sound public policy.

The MHCC's current mandate aims to deliver on priority areas identified in the Mental Health Strategy for Canada in alignment with the delivery of its strategic plan. The MHCC's staff, Board and Advisory Committees all share the same goal—creating better systems for mental well-being.

How We Work

Funded by Health Canada, the MHCC convenes stakeholders, develops and influences sound public policy, and seeks to inspire collective action in a range of areas that impact the lives of Canadians living with a mental health or substance use problem as well as their families. Examples include, among others, the justice system, primary health care, workplaces and housing.

Each of MHCC's initiatives and projects is led by experts from across the country who bring a range of experience and a variety of perspectives to the table. Consulting with people who have experience living with a mental health or substance use problem as well as their families is a key aspect in all of the MHCC's work. This work includes offering a host of resources, tools and training programs aimed at increasing mental health and substance use literacy and improving the mental well-being of all people living in Canada.

MHFA Program

This program is run by MHFA International, trading as Mental Health First Aid Australia, which is a not-for-profit company. MHFA training has been licenced to operate in numerous countries: Bermuda, Canada, Denmark, England, Finland, Hong Kong, India, Ireland, Japan, Malta, Nepal, Netherlands, New Zealand, Northern Ireland, Pakistan, Saudi Arabia, Scotland, Singapore, Sweden, UAE, USA and Wales. When the MHFA Program was adopted in these countries, either a mental health government agency or a nongovernment mental health organization tailored the MHFA Australia course materials to their own culture and health care system and worked out the method of dissemination best suited to local conditions. The MHFA Canada program came under the leadership of the Mental Commission of Canada (MHCC) in February 2010.

An important factor in the MHFA Program's international spread has been the continuing attention to research and evaluation. The MHFA course has been thoroughly evaluated using randomized controlled trials and a qualitative study and been found to be effective at:

- Improving course participants' knowledge of mental health and substance use problems
- Reducing stigma
- Increasing the amount of help provided to others

Acknowledgements

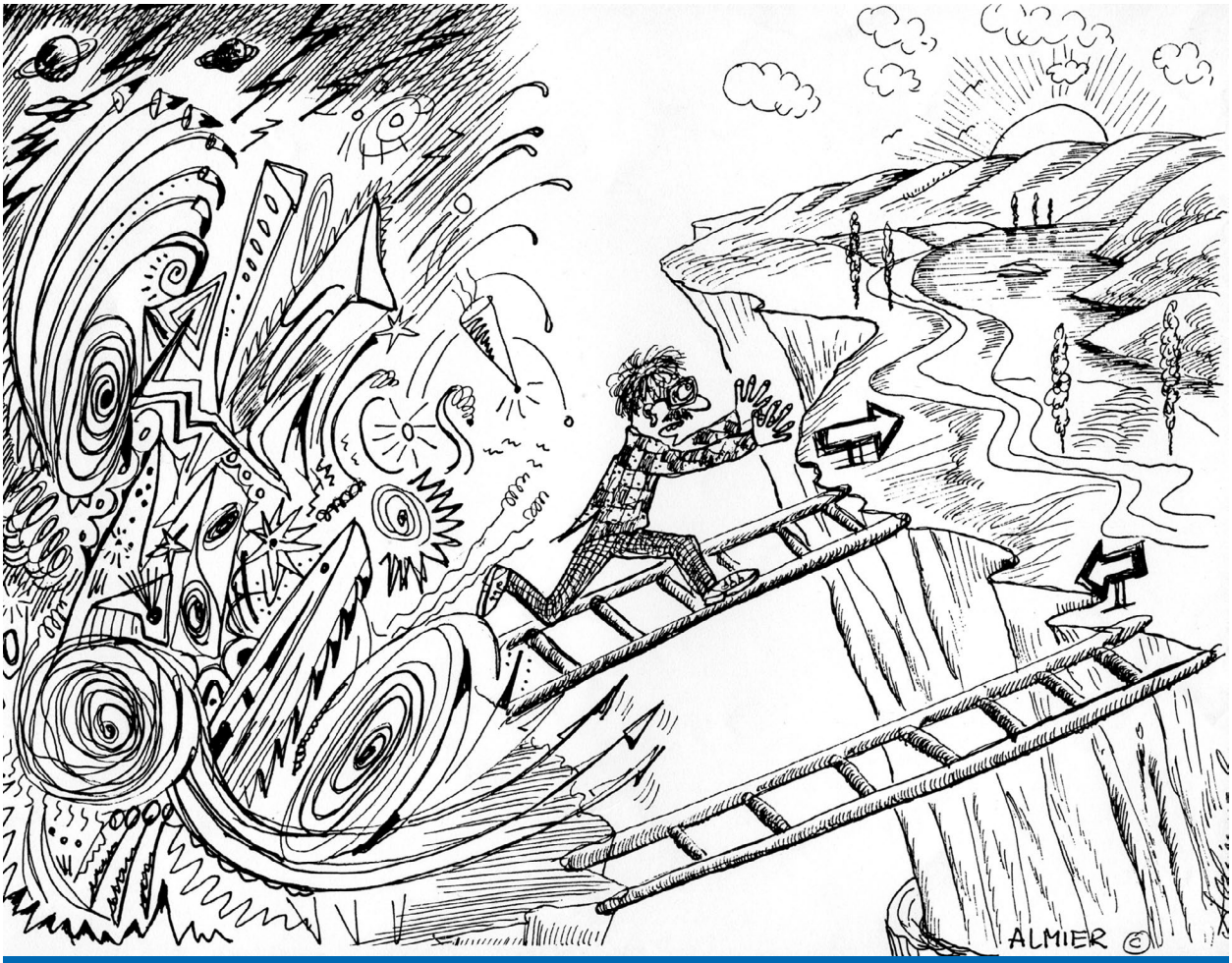
The MHFA course was originally developed in Canberra by Betty Kitchener, an educator and mental health consumer, in partnership with Professor Tony Jorm, a mental health researcher. The aim in creating the program was to extend the concept of first aid training to include mental health and substance use problems so that community members were empowered to provide better initial support to someone who is developing a mental health and/or substance use problem, has experienced a worsening of an existing mental health and/or substance use problem, or is in a mental health and/or substance use crisis.

The first aid information in this Participant Reference Guide is based on guidelines developed by the Australian Mental Health First Aid® Training and Research Program from 2006 to 2008, using the consensus of international expert panels involving mental health and substance use consumers, caregivers and professionals. The following people worked on the development of these guidelines: Claire Kelly, Robyn Langlands, Anna Kingston and Laura Hart. Further details of the guidelines may be found at www.mhfa.com.au.

The Canadian edition was compiled by the Mental Health Commission of Canada (MHCC) and reviewed by experts in mental health and substance use disorders. This reference guide is based on the Australian version, referred to as "MHFA Manual, version 4." Content was modified, adapted and edited for Canada.

The MHCC thanks the following people who were involved in the development of the original version of the course from which this updated version was developed:

- Dr. Doug Watson (Alberta Health Services),
- Dr. Roger Bland (University of Alberta),
- Dr. Stephen Newman (University of Alberta),
- Dr. Scott B. Patten (University of Calgary),
- Betty Kitchener (MHFA Australia),
- Dr. Anthony Jorm (MHFA Australia),
- Julie Peacock (Alberta Health Services),
- Richard Ramsay (LivingWorks),
- MHFA Canada instructors Karen Kyliuk, Anthony Prime, Marion Cooper, John Mitchell and Yvonne Walsh for providing feedback
- ALMIER for permission to reproduce his artwork. Artwork was provided through the "Out of the Shadows" artists' program, which offers community arts opportunities to individuals living with mental health and substance use concerns in Alberta's Capital Health region.



Section 1: Introduction to MHFA

Real and Unreal

The artist is constantly shifting between his real world and his unreal world. He goes back and forth and sometimes loses touch with what is real and what is unreal. Sometimes he feels he may not really exist. Space and time disappear.

Older adult mental health and substance use problems in Canada

Older adults

Age 65 marks the line between adulthood and old age. An older adult who is 65 years or older is commonly referred to as "a senior", "an older adult" or "an older person."[1] In many countries, including Canada, age 65 is when an individual may be expected to retire and begin to receive a government pension.[2]

While the term "older adult" can be used to identify an older adult who is at least age 65, it does not automatically identify an older adult as old. There is no clear biological definition of old age,[5] or accepted agreement on the age at which an older adult is said to become physically or psychologically old.[6,7] Older adults' rate of change with aging varies amongst individuals such that the age of an older adult is a poor predictor of the aging process. Rather than defining an older adult by age alone, a better approach requires taking into account the physical, mental, social and spiritual aspects of the person.[8]

Social health and older adults

The overall health and wellness of older adults is influenced by their social health. Social health refers to an individual's ability to positively interact with others. Socially healthy older adults gain a sense of well-being, belonging and group identity through social networks: the web of supportive and rewarding social connections that surrounds an older adult.[14] Social networks provide access to advice, contacts, and information.

As people get older, the size of their social networks tends to decrease. The absence of mutually rewarding relationships and lack of significant interaction with others causes older adults to become socially isolated[16] and more susceptible to loneliness.[17] Older adults are more frequently challenged with the need to adapt to losses and/or major life transitions like moving to a retirement home or nursing home.

Socially unhealthy older adults can become anxious and/or depressed and find it hard to maintain a social network and supports. Socially isolated older adults may become more at risk for mental health disorders and suicide.[20] Mental health disorders can also contribute to social isolation in older adults, reinforcing their discomfort around other people and further eroding social skills and healthy interactions with others.[21]

What is mental health?

There are different ways of defining the term "mental health." Some definitions emphasize positive psychological well-being, whereas others see it as the absence of mental health and substance use problems.

For example, the World Health Organization has defined "mental health" as:

"…a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community" (World Health Organization, 2018).

For many, mental health also incorporates a spiritual dimension along with the physical, mental and social aspects of wellness. Mental health influences how we think and feel about ourselves and others and how we interpret events. It affects our capacity to learn, communicate, and form, sustain or end relationships. Good mental health buffers us from stresses and hardships that are part of life for us all. It can help reduce the risk of

developing mental health and substance use problems or disorders. Even when someone develops a problem or disorder, they can nonetheless experience good mental health, and this can contribute to their journey of recovery (Provencher & Keyes, 2011).

Mental well-being or mental wellness

These two terms are often used interchangeably with mental health when referring to positive mental health. Our mental health/wellness/well-being allows us to realize our potential, cope with stress effectively, bounce back from life challenges and be active, productive members of our communities. How each of us defines our mental health/wellness/well-being can be very different and quite individualized. It is about living well and feeling capable despite life's challenges (Canadian Mental Health Association, 2014).

Note: In this MHFA course, we'll use the term "mental well-being."

Mental and physical well-being

It is important to be aware that physical and mental health problems can occur at the same time in older adults. For example, older adults tend to report physical symptoms rather than say they are depressed. Symptoms may include musculoskeletal pain, abdominal pain, fatigue, dizziness and weakness. This can lead to older adults not always receiving treatment for a mental health problem. Medical psychiatry is the specialty that takes a coordinated approach to assessing and treating both mental and physical problems. Psychiatrists specializing in the field assess the older adult for medically unexplained symptoms.

What are mental health disorders?

A mental disorder or mental illness is a diagnosable illness that affects an older adult's thinking, emotional state and behaviour, and disrupts the person's ability to work or carry out other daily activities and engage in satisfying personal relationships (American Psychiatric Association, 2013).

Some people have only one episode of mental illness in their lifetime, while others have multiple episodes and periods of wellness in between. Only a small minority have ongoing mental health problems.

There are different types of mental illnesses, some of which are common, such as depression and anxiety disorders, and some which are not common, such as schizophrenia and bipolar disorder. However, mental illnesses, as with any health problem, cause disability, which is sometimes severe. In Canada, most health professionals will use the Diagnostic Statistical Manual 5 (DSM 5) or International Classification of Diseases (ICD 10) to determine whether or not an older adult meets the criteria for diagnosis of a mental disorder.

Concurrent Disorders

(Centre for Addiction and Mental Health, n.d.-a)

Mental health problems can often occur in combination with substance use or addiction disorder. Research shows that more than 50% of those seeking help for a substance use disorder or addiction also have a mental illness, and 15-20% of those seeking help from mental health services are also living with an addiction or substance use disorder (Centre for Addiction and Mental Health, n.d.-a).

Concurrent disorders is a term used to refer to co-occurring addiction and mental health problems. This term covers a wide array of combinations of problems, such as: anxiety disorder and an alcohol problem,

schizophrenia and cannabis dependence, borderline personality disorder and heroin dependence, and bipolar disorder and problem gambling. These problems can co-occur in a variety of ways. They may be active at the same time or at different times, in the present or in the past, and their symptoms may vary in intensity and form over time. People often ask, "Which came first: the mental health problem or the substance use problem?" This is a hard question to answer. It's more useful to think of them as independent problems that interact with each other.

What are "problems"?

A mental health or substance use problem is a broader term including both mental health- and substance use-related illnesses and symptoms that may not be severe enough to warrant the diagnosis of a disorder.

A variety of terms are used to describe mental health and substance use problems: mental illness, mental ill-health, mental health and substance use condition, psychiatric illness, nervous exhaustion, mental breakdown, nervous breakdown and burnout. Slang terms such as crazy, psycho, mad, loony, nuts, cracked-up and wacko promote stigmatizing attitudes and should not be used.

These terms do not give much information about what the older adult is really experiencing. Worse, slang terms reinforce negative attitudes about mental health and substance use problems and can be hurtful. Myths, misinformation and lack of knowledge lead to stigma around mental health and substance use problems and discrimination that prevents people from accessing help and hinders recovery.

Older adults living with mental illness

There are four distinct populations of older adults living with mental illnesses:24

1. Those growing older with a recurring, persistent or chronic mental illness.
2. Those experiencing mental illnesses that appear for the first time later in life (after the age of 65).
3. Those living with behavioral and psychological symptoms associated with dementia.
4. Those living with chronic medical problems with known correlations with mental illness (for example, Parkinson's disease, stroke and chronic obstructive and lung disease).

This guide provides information on how to assist older adults with mental health and substance use problems and not only those with diagnosable disorders. There are so many different types that it is not possible to cover them all in this guide. The most common problems, as well as the most severe problems, are covered. However, it is important to note that the MHFA principles in this guide can be usefully applied to other mental health and substance use problems.

Why is MHFA needed?

There are many reasons why people need training in MHFA.

1. Mental health and substance problems are common

   Over the course of any person's life, it is highly likely that they will develop a mental health or substance use problem themselves or have close contact with someone who does. In any given year, one in five people in Canada are living with a

mental health or substance use problem or illness (Mental Health Commission of Canada, 2013; Smetanin et al., 2011).

However, there are many older adults that do not reach out for help. Others seek help from sources that are not tracked by statistics, such as private therapy. Mental health and substance use problems are a common reason for people consulting their physician.

Over 1 million Canadians with a mental health-related disability say they require counselling services from a psychologist, psychiatrist, psychotherapist, or social worker (Statistics Canada, 2019). These results reflect the general population. Research on subpopulations may show higher or lower rates of mental health and substance use problems.

ESTIMATED 12-MONTH PREVALENCE OF ANY MENTAL ILLNESS IN CANADA, 2011		
	Total Number of People	**Percentage of the Population**
ALL MAJOR DISORDERS (not including childhood disorders, such as ADHD)	6,797,627	19.8%
MOOD AND ANXIETY-RELATED DISORDERS	4,016,700	11.75%
SUBSTANCE USE DISORDERS	2,029,200	5.9%
COGNITIVE IMPAIRMENT & DEMENTIAS	747, 100	2.17%
SCHIZOPHRENIA	210,540	0.61%

Figure 1: Estimated 12-Month Prevalence of Any Mental Health Illness in Canada (Mental Health Commission of Canada, 2013; Smetanin et al., 2011)

2. Professional help is not always on hand

Family doctors/physicians, counsellors, psychologists, psychiatrists and other professionals can all assist older adults with mental health and substance use problems. However, as with injuries and other medical emergencies, such assistance is not always available when a problem first arises. This is when members of the public who are trained in MHFA can offer immediate aid and support the older adult until appropriate professional help is received.

3. Members of the general public often do not know how to respond

Even in an emergency, an older adult wishing to give assistance at a motor vehicle crash may be reluctant to help for fear of doing the "wrong thing." Similarly, in a mental health and substance use situation, the first aider's actions may determine how quickly the older adult with the problem gets help and/or recovers. In any first aid course, participants learn how to help someone who is injured or ill. The first aider learns how to remain calm and confident and

to respond in an appropriate way to give the best help until the crisis is resolved or professional help is obtained.

4. There is stigma associated with mental health and substance use problems

Stigma refers to negative attitudes (prejudice) and negative behaviour (discrimination) toward people with mental health and substance use problems. Stigma means having fixed ideas and judgments about people, as well as fearing and avoiding what we don't understand (Centre for Addiction and Mental Health, 2007).

The stigma attached to mental health and substance use problems presents a serious barrier to assessment, diagnosis, treatment and support needed for recovery as well as acceptance in the community (Minister of Public Works and Government Services Canada, 2006).

Stigma results in the exclusion of people with mental health and substance use problems from activities that are open to other people, such as getting a job, finding a safe place to live, participating in social activities and having relationships (Centre for Addiction and Mental Health, 2007).

The prejudice and discrimination older adults face often becomes internalized. They begin to believe the negative things that other people and the media say about them (self-stigma) and they have lower self-esteem because they feel guilt and shame. As a result, they often do not seek the help they need (Centre for Addiction and Mental Health, 2007).

Stigma mental health and older adults

Although for many Canadians, the term "older adult" (or older adult) signifies a sense of wisdom acquired through life experience or a well-deserved retirement from paid work,6 for others "older adult" is considered a negative label associated with inaccurate assumptions based on age alone.

Ageism has many of the same characteristics as mental illness related stigma. It is defined as stereotypes and prejudices applied to older adults based solely on their age.[7] Ageism occurs when people believe that promoting healthy living among older adults is unimportant or too late to make a difference.[8]

Ageism is particularly prevalent in health care settings. It can result in a lack of timely medical diagnosis and treatment, fewer checkups, overmedication, and a lack of attention to cognitive and mental impairments.[9]

According to the MHCC's Guidelines for Comprehensive Mental Health Services for Older Adults in Canada (2011), "Older adults who experience a mental health problem or illness may face a "double whammy" of stigma: the stigma of being older in addition to the stigma of mental illness" (p.6). As a result, "When older adults seek help from healthcare providers, they can experience stigma and discrimination in the form of ageism, as well as mental illness-related stigma" (MHCC, Eliminating Stigma, 2014). In this way, mental health stigma functions as "a significant barrier to help-seeking" which deters older adults from seeking care (Conner, 2010, p.531).

It is also important to note that there are two forms of stigma at work; there is public stigma (external) and self-stigma (internal). However, self-stigma is the internalization of public stigma (Conner, 2010, p.531). Conner (2010) contends that "an individuals' perception about

society's attitudes and beliefs about their mental health status often leads to negative attitudes about mental health treatment and thus becomes a barrier to help-seeking" (p.538).

In fact, a Health Canada survey reported that 54 per cent of respondents (who met the criteria for anxiety-related disorder, mood-related disorder or substance dependence) felt embarrassed about their mental health and substance use problems, and 54 per cent reported facing discrimination for their mental health and substance use problems. Not everyone with a mental health or substance use problem seeks treatment (Minister of Public Works and Government Services Canada, 2006).

5. Many people are not well informed

Not all mental health and substance use problems require professional help. However, people who do require treatment may not seek professional help for a variety of reasons, such as an inability to recognize their mental health and substance use problems, a lack of health professionals, or a lack of knowledge about what services are available.

People may lack the insight to realize that they need help or that help is available. Some mental health and substance use problems cloud clear thinking and good decision-making. An older adult experiencing such problems may not realize that they need help or that effective help is available. They may be in such a state of distress that they are unable to think clearly about what they should do.

Although the general public's knowledge about mental health and substance use problems is slowly improving, there is still a widespread lack of understanding about how to recognize these problems and what effective treatments are available (Jorm et al., 1997).

There are many myths about mental health and substance use problems, such as older adults that live with these problems are violent, that they can make themselves better if they wanted to or that these problems are contagious. As a result, some older adults may not know when or where to seek help or what kind of help might be useful.

With greater community awareness, older adults will be able to recognize their own problems, or those of others, and feel more comfortable about seeking professional help.

Impacts

How disabling are mental health and substance use problems?

Mental health and substance use problems can be more disabling for an older adult than many chronic physical illnesses. "Disability" refers to the amount of disruption that a health problem causes to an older adult's ability to work, look after themselves and carry on their relationships with family and friends.

Research in the Netherlands has looked at the amount of disability caused by a large number of both physical and mental health and substance use problems (Stouthard et al., 1997). It helps to understand the amount of disability that mental health and substance use problems can cause by comparing them to physical health problems that cause the same amount of disability. Here are some examples:

- The disability caused by moderate depression is similar to the disability from relapsing multiple sclerosis, severe asthma, chronic hepatitis B or deafness.
- The disability from severe post-traumatic stress disorder is comparable to the disability from paraplegia.
- The disability from severe schizophrenia is comparable to the disability from quadriplegia.

Global Burden of Disease studies have highlighted mental and substance use disorders as the leading cause of disability globally (Whiteford et al., 2016), and The World Health Organization (2019) described how mental, neurological, and substance use disorders make up 10 % of the global burden of disease and 30% of the non-fatal disease burden.

Impact of mental health and substance use problems

Mental health and substance use problems affect people of all ages, cultures, and education and income levels. “Mental illnesses have the potential to impact every aspect of an individual’s life, including relationships, education, work, and community involvement” (Public Health Agency of Canada, 2015. p.3). They also indirectly affect all Canadians through illness in a family member, friend or colleague, and they are costly to the individual, their family, the health care system and the community.

It is important to realize that many mental health and substance use problems are time limited and people are able to take up their lives as before. Even when older adults experience more serious, long-term or recurring problems, they are still able to live meaningful and satisfying lives. This may mean making some adjustments to accommodate the effects of their mental health and substance use problem.

Mental health and substance use and specific populations

Physical illness and physical disability

The extra pressures that physical disability brings can contribute to mental health and substance use problems. Similarly, the strain of having a long-term physical illness can make older adults more vulnerable to developing mental health and substance use problems. Older adults living with poor mental well-being are at increased risk of developing a range of physical health problems, including diseases of the immune system and cardiovascular system.

Age/gender

People of all ages can experience poor mental health and/or substance use problems. The way these problems are experienced, as well as their signs and symptoms, is influenced by an older adult’s age. Some mental health and substance use problems are more common than others at different stages in life.

Research conducted by Canadian Mental Health Association, Centre for Addiction and Mental Health and the Canadian Coalition for Older adults’ Mental Health reveal that up to 20% of older adults in the community experience mild or severe depression. Rates of depression in long-term care facilities can be as high as 40% and the rate of

depression in older adults within hospitals range from 12-45%. Women experience nearly twice the reported rates of depression than men (CMHA, 2005).

Men and women experience mental health and substance use disorders at different rates and seek different treatments. Women are more likely than men to use health services for a mental illness, especially those between the ages of 25 to 39 years (Public Health Agency of Canada, 2015). Women are 1.5 times more likely to have mood or anxiety-related disorders than men. Men are 2.6 times more likely to be diagnosed with substance use disorders (Minister of Public Works and Government Services Canada, 2006). According to a 2017 profile of Canadians with mental health-related disabilities, women were more likely to report requiring counselling and support group services, while men were more likely to report requiring addiction services (Statistics Canada, 2020).

Sexuality

Members of the 2SLGBTQ+ (two-spirited, lesbian, gay, bisexual, transgendered and transsexual, and questioning) community may encounter a range of difficulties that can contribute to mental health and substance use problems. Although society is becoming more accepting, many 2SLGBTQ+ people still experience feelings of isolation and rejection (Minister of Public Works and Government Services Canada, 2006).

Individuals are more likely to experience higher rates of depression, anxiety, suicidal thoughts and acts, self-harm, and substance use disorders than their heterosexual peers. Meta-analysis studies have found that members of the 2SLGBTQ+ community are 1.5 times more likely to develop depression and anxiety disorders and 2.5 times more likely to attempt suicide (Rainbow Health Ontario, 2012). The high risk for mental health and substance use disorders can be connected to experiences of stigma, prejudice, discrimination, internalized feelings of negativity and expectations of rejection (Gilmour, 2019), as well as interpersonal violence, childhood maltreatment and personal loss (Rainbow Health Ontario, 2012).

Indigenous people

Many factors contribute to the mental health and substance use problems among Indigenous people. Some communities see high rates of mental health and substance use problems and suicide, while others do not. Services available to the general Canadian population do not always reflect the most appropriate approach to healing for respective cultures within Indigenous populations.

Cultural diversity

Racism and discrimination place extra pressures on those from immigrant, refugee, ethnocultural and racialized communities. Language and cultural differences also make it more difficult for older adults to access appropriate help. Services that are helpful to the general population may not be equally effective for those from different cultural backgrounds, especially if there are language or geographic barriers. Any successful communication recognizes the uniqueness of every culture, relationship and individual. Some forms of verbal and nonverbal communication are appropriate, and others are not. For instance, older adults from some cultures may regard prolonged eye contact as rude. When an individual does not speak English at all, has limited English or chooses to communicate their distress in their primary language, the ideal solution is to use a professional interpreter.

The choice to use a trained interpreter or a family member to interpret must be made by the individual who is experiencing problems. Being able to do so will help the older adult to feel that they are in control of the situation.

A good interpreter will concentrate on accurately conveying equivalent meaning as well as reporting the direct answers to questions and other responses offered. Everyone has different ways of communicating fears and needs when becoming unwell. If the opportunity is available, exploring the older adult's life experiences, value and belief systems, and their reactions to illness, care and support may help establish what is realistic for the individual and what is culturally acceptable.

It is important to recognize both individual and cultural differences. For example, refugees have similar problems to those of settled minority ethnic communities but may face additional challenges if they have experienced torture and political oppression.

Recovery and resilience

Older adults can, and do, improve with treatment for severe mental health problems. Remission, which occurs when all the symptoms disappear, is not common in treating severe mental illnesses in older adults. Rather, the goal is to aim for recovery, which is the pursuit of a meaningful life in which mental illness does not prevail.

"Recovery" in the context of mental health and substance use problems refers to the lived experiences of people as they accept and overcome the challenge of their problem or disorder. Recovery is much more than

achieving the absence of symptoms and means different things to different people. Although most older adults with chronic persistent mental illness may not achieve complete recovery, many show significant improvements in psychological and social functioning as they age. This reflects the older adult's resilience; the ability to successfully adapt in response to adversity.[25]

Some of the cornerstones of recovery are hope, education, self-advocacy, support, and willingness and responsible action by both the ill person and their helpers (Mental Health Commission of Canada, 2015).

- **Individual factors –** satisfaction with one's life, nutrition, and physical activity
- **Family and social factors –** social activity, friendships, living in close proximity to family, friends and/or social networks, access to caregiving
- **Life events and situations –** economic security, general physical health and fitness and history of positive life experiences
- **Community and cultural factors –** access to community support services and meaningful participation and feeling of belonging

Other factors such as early intervention and access and availability of appropriate services and treatments can have positive impacts on an older adult's mental health. An older adult's resilience and willingness to pursue professional assessment and participate in treatment will help determine the degree of recovery.

On the other hand, biological (physical, such as decreased hearing, inability to walk), psychological (the emotional aspects associated with a loss), and social losses (loss of job, ability to drive) can negatively impact the mental well-being of older adults.

Newer, more effective treatments mean that people with mental health and substance use problems experience fewer side effects and are able to do more while in treatment or recover more quickly and completely.

Older adults are encouraged to work closely with their health care providers to get the best results possible.

For older adults with dementia recovery is not possible since dementia is a progressive and terminal condition. The focus of assessment and treatment is to maintain the highest possible quality of life and well-being for both the older adult and caregivers.

It is important to recognize that mental health and substance use problems can develop over a long time, and recovery may also take time. The holistic interpretation of recovery found in "Guidelines for a Recovery-Oriented Practice," primarily developed and promoted internationally by the Mental Health Commission of Canada (MHCC), offers guidelines to help improve understanding about recovery and to promote the application of recovery principles in practice (Mental Health Commission of Canada, 2015).

MHFA Actions

The MHFA Program provides an action plan on how to help an older adult who is experiencing a decline in mental well-being or a mental health or a substance use crisis. Its mnemonic is ALIFES (see page 21). These actions are not necessarily to be followed in a fixed order. The first aider has to use good judgment about the order and the relevance of these actions and needs to be flexible and responsive to the older adult they are helping. Listening and communicating nonjudgmentally is an action that occurs throughout the giving of first aid.

Who are mental health first aiders for older adults likely to be?

Mental health first aiders for older adults are quite likely to fall into one of the groupings below:

- Informal caregivers
  - Spouse/partner
  - Child
  - Other family
- Friends
- Neighbours / Community Members
- Staff in caregiving settings

As with all first aiders, responders will vary in a number of ways, including:

- Age/Gender
- Ethnic and cultural background
- Education
- Social/economic status
- Support network

There is a difference between a first aider and a caregiver:

- First aider is the person who provides initial help to an older adult until appropriate professional assistance is received.
- Caregivers are those individuals who provide longer term care and support to an older adult with a physical or mental health problem.

It is important to recognize that first aiders providing initial help and support to older adults who may be developing a mental health disorder or experiencing a mental health crisis, may also be that older adult's informal caregiver.

Personal Reflection: What are some of the benefits and burdens associated with being a caregiver for an older adult?

Caregiving

Caring refers to a feeling that accompanies an older adult's commitment to the welfare of another. Caregiving refers to the help or assistance provided by one person towards another who is unable to fully care for him or herself. In any well-established relationship where people are committed to each other's welfare, ("husbands and wives," or "children and parents" are two examples), care and caregiving routinely occur. Not only do people in these relationships care for each other, but they also assist each other. However, this balance of caregiving can change over time; with the balance of assistance provided by each member of a relationship becoming unequal.[13]

Caregiving Activities

Caregiving activities commonly include assisting with activities of daily living (ADLs)[14] – conceptualized by the actions required to commence the day: to rise and transfer out of bed, walking, toileting, grooming, bathing, selecting proper attire, dressing, and feeding; as well as instrumental activities of daily living (IADLs)[15] which include: telephone use, shopping, food preparation, housekeeping, laundry, transportation, responsibility for medications, and ability to handle finances. Caregiving activities vary in the level of intensity, caregivers' abilities to perform these activities, as well as the degree of physical and emotional demands on the caregivers.

Benefits of Caregiving

When measured across Canada, the Canadian Community Health Survey (2009) estimated that 3.8 million Canadians aged 45 or older were providing informal care to an older adult with a short or long term condition.[16] In addition to reducing the social costs associated with health services and institutionalization, the unpaid labor provided by caregivers annually saves the Canadian health care system over $25 billion annually.[17]

Providing care can have many benefits. In addition to enabling the receiver of care to maintain a better quality of life, caregiving can provide positive benefits to the caregiver including becoming aware of inner strengths, becoming more self-confident, growing as an older adult, and learning.18 Deriving positive experiences are important because they can also contribute to better health and wellbeing in the caregiver.[19,20]

Caregiver Burden

The term "caregiver burden" is used to refer to the physical, psychological, social and financial problems that can be experienced by caregivers.[21] It is commonly used to capture the degree to which the caregiving role has impacted the life, health, and well-being of the caregiver.

Caring for a family member or friend can be a major source of stress; caregivers often report lacking the required resources to meet the needs of their care receiver.[22] Many caregivers are also working while they manage their caregiving responsibilities. Historically, caregivers have disproportionally been women, who tend to provide care for activities that must be completed on

a regular or set schedule.[23] Female caregivers report a higher level of caregiving burden than male caregivers.[24] Unsurprisingly, caregivers commonly report poorer mental health as compared to non-caregiving populations.25 Financial strain is another source of concern for caregivers.[26]

Adults Providing Informal Caregiving

Along with increasing life expectancies also comes an increased risk for chronic ailments that may impair the ability of an older adult to take care of him or herself.[27] Caregivers of older adults report many challenges. Responsibilities for caregiving can come on suddenly (as in the case of medical conditions that occur quickly, for example a stroke) and gradually increase over time (for example aging parents). Caregivers of older adults are often unaware of appropriate information about the mental illness of the older adult being cared for, what to expect, how to manage symptoms, and how to cope with the role of caregiving.[28] Caregivers who care for older adults with a mental health issue have reported a higher caregiver burden compared with caregivers to care recipients with physical illness only.[29]

Older Adults Providing Informal Caregiving

Older adults (aged 65 years and older) are the smallest group of caregivers, but they are most likely to spend the most hours providing care. Older caregivers are considered to be at greater risk of injury, or exacerbation of pre-existing issues. Older adults who provide informal caregiving often report feeling worried, anxious or tired. In particular, older women are more likely than older men to report that they sometimes or nearly always feel stressed between helping others, trying to meet other responsibilities and finding time fojr themselves.[30]

MHFA Actions – ALIFES

A Assess safety: risk of suicide, serious physical deterioration, and/or harm to others

L Listen and communicate nonjudgmentally

I Information and reassurance

F Facilitate the older adult getting appropriate professional help

E Encourage support for the older adult and caregiver

S Self-care for the first aider

Although assessing safety is the highest priority, other actions may need to occur first. The mental health first aider must use judgment about the order of the actions and be flexible and responsive to the needs of the older adult they are helping and the caregiver, if applicable.

Action: Assess safety: risk of suicide, serious physical deterioration and/or harm to others

There are lots of ways in which an older adult who is dealing with a mental health problem can be at risk for harm. So, it is very important that each time mental health first aid is provided, the first aider assess the risk for suicide and harm in the older adult.

In mental health first aid, "assess" is a general term that requires first evaluating a situation before undertaking a course of action. It does not refer to clinical assessments used by professionals.

Assessing the risk of suicide includes reducing or removing any risk that is present while at the same time ensure one's own personal safety.

Assessing the risk of **serious physical deterioration** is a component of this action because although the older adult may not be threatening harm to them self or others, the older adult may not be caring for themselves resulting in risk of malnutrition, weight loss and dehydration which can lead to a medical emergency.

Assessing risk of harm to others acknowledges the involvement of caregivers for older adults with mental illness and the need to ensure their safety and physical and mental well-being. It is important that the mental health first aider takes appropriate action and arrange for professional help, either with a mental health professional or by contacting emergency medical services, if the older adult is threatening harm to themselves or others, even if the older adult does not want help. Confidentiality does not apply when an older adult is at risk of suicide, self-harm or harming others.

If there is low to no risk, the mental health first aider will continue with – or return to – the basic actions. In this course, crisis first aid outlines the actions a first aider can take to reduce the risk of harm for:

- Overdose
- Suicidal behaviour
- Panic attack
- Reaction to traumatic events
- Psychotic episode

Action: Listen and communicate non-judgmentally

Non-judgmental listening means adopting a set of attitudes, communication, and listening skills (verbal and non-verbal) that allow the listener to hear and understand what is being said and enable the older adult to talk freely and comfortably about their problems or concerns without feeling they are being judged.

Attitudes

The attitudes involved in non-judgmental listening are acceptance, genuineness and empathy. They are sometimes referred to as the "core conditions" because all are necessary to create a safe, comfortable environment in which the older adult can talk openly.

- Acceptance – means respecting the older adult's feelings, experiences and values, even though they may be different from the listener's.
- Genuineness – means that what the listener says and does shows the older adult that they are accepted.
- Empathy – is the ability to put oneself in the older adult's place and to demonstrate to the older adult that they are truly being heard and understood.

An older adult is being non-judgmental if they can:

- Accept the older adult as they are
- Make no moral judgment about the older adult's situation
- Demonstrate empathy

If a first aider can do these things, they can create an environment in which the older adult feels safe and can express their feelings.

The effective listener

Although the first aider is asked to focus their attention on the feelings of the older adult, it is important to be aware of your feelings and thoughts. Helping an older adult who is distressed may lead to a number of responses in a first aider like fear, irritation, sadness and a sense of being overwhelmed. These are normal responses to a difficult situation.

However, it is important that the first aider continues to listen respectfully and avoids reacting to what is being shared. That means focusing on the distressed older adult and understanding how it feels to be in their place. This may be difficult, depending on the relationship between the first aider and the older adult. Remember, a first aider is offering the distressed older adult a place of safety based on respect, acceptance and understanding.

Verbal skills

It is easy for an older adult to show that they are listening:

- Listen to what is being said without interrupting
- Pay attention to what is being said
- Ask questions to make sure you and the older adult are clear on what is being said
- Listen to the words and the tone of voice and look at the body language – all will give clues about how the older adult is feeling
- Confirm your understanding by repeating what the older adult has said
- Summarize facts and feelings

Slight prompts such as "mm," "ah" or "I see" may be all that is necessary to keep the conversation going and to help demonstrate that you are listening and trying to empathize. It is okay to have pauses in the conversation. The older adult may simply be thinking or lost for words.

Non-verbal skills (body language):

- Be attentive
- Keep eye contact comfortable (don't stare but don't avoid eye contact)
- Keep a relaxed body position (e.g., try not to cross your arms across your body)
- Sit close to the older adult if s/he is hearing impaired so that you do not have to shout to communicate – if hearing impaired, enquire if the older adult has hearing aids that may assist with communication
- Sit down even when the older adult is standing – it seems less threatening
- Try not to sit directly opposite and facing the older adult to reduce the appearance of intrusiveness or invasion of personal space – however, if the older adult is hearing impaired, face the older adult when talking with them since this helps communication through lip reading and body language

Action: Information and reassurance

Help the older adult understand that they have a real medical condition and that professional help is available. Reassure the older adult that obtaining help is a positive and safe thing to do.

Because older adults with mental health problems may also be experiencing an

impairment in their thinking, providing information and reassurance may not be enough. Distraction is an additional strategy31 that may be used to help shift the older adult's focus to a non-threatening source of interest to reduce fear. The goal is to intentionally direct the attention of an older adult experiencing a mental health problem or crisis away from the source of worry by discussing a more positive or neutral topic. In older adults, distraction can also be accomplished by presenting the older adult with a physical task that draws away their attention from the source of worry. Distraction is not asking the older adult to try not to think, feel, or express something.

Action: Facilitate the older adult getting appropriate professional help

Facilitate means to help the older adult identify the most appropriate professional person/service that can help them with their particular mental health problem. Older adults with mental illness may not be able to independently obtain appropriate professional services and supports. This may be due to factors such as impaired mobility, language constraints, or lack of access to satisfactory transportation.

Older adults experiencing a mental health problem should be referred immediately to a healthcare professional. These individuals may include:

- Family physician / Nurse practitioner
- Geriatric Team and/or Memory Clinic
- Geriatric Psychiatrist Team
- Community Mental Health Services

It is important to be aware that older adults displaying symptoms of a mental health problem may also be experiencing an underlying physical health problem and that older adults displaying symptoms of a physical health problem may also be experiencing a mental health problem. It is essential that older adults be taken immediately for assessment.

Action: Encourage supports for the older adult and caregiver

Older adult

Encourage support for older adults and their informal caregivers, (family members, friends and neighbours)[32] is a vital element of an all-inclusive approach to mental health care for older adults.[33] Support may involve ensuring that older adults are:

- Socially connected within their family, friends and communities
- Remain physically active
- Follow a healthy diet
- Mentally active

Caregiver

Informal caregivers can experience their own physical and emotional problems while caring for an elderly relative with a disability or chronic deterioration, which may include feelings of loss, depression, stress and anxiety.[34] Challenges caregivers experience in obtaining support include: a lack of appropriate information about the mental illness of the older adult being cared for, what to expect and how to manage symptoms and a lack of support to cope with adjusting to the role of caregiving.[35]

Support for family caregivers is a vital element of a comprehensive integrated mental health system for older adults.36 Support commonly includes both emotional comfort as well as tangible assistance in the form of help in obtaining services and receiving training to optimize performance of caregiving activities.[37] Support can come from a variety of sources including health care

providers, family members, friends and other caregivers.

Action: Self-Care for the first aider

Understanding your own situation and feelings as you go through the MHFA process is important. Because MHFA may take place over days or even weeks, practicing self care is necessary. Discussing someone else's problems or experiences may trigger your own personal memories. It is important that you take care of your own mental well-being.

After providing MHFA to an older adult who is in distress, you may feel worn out, frustrated or even angry. You may also need to deal with the feelings and reactions you set aside during the encounter. It can be helpful to find someone to talk to about what has happened.

If you do this, you need to remember to respect the older adult's right to privacy. If you talk to someone, don't share the name of the person you helped or any personal details which might make them identifiable to the person you choose to share with.

There are many ways that a family member, friend, volunteer, staff member or passerby can provide care, support or mental health first aid. Providing help can be deeply rewarding, but it can also cause physical and mental stress.

Tips for self-care

Self-care is anything physical, emotional, social or spiritual that helps you to manage everyday life (with all its joys and sorrows). Often people reject the need to take care of themselves because they feel they need to care for others first. This is not a good idea. To be most effective as a first aider, you need to be strong, optimistic and confident in yourself.

An older adult can develop a plan of self- care by pursuing healthy coping strategies to continually renew themselves and reduce stress.

Are you taking care of yourself?

Some things to consider when thinking about self-care include:

- Are you eating healthy meals every day?
- Do you belong to a social group that meets regularly?
- Do you do something to relax at least three times a day?
- Are you keeping your mind stimulated?
- Do you exercise and/or get out on the land regularly like three times a week?
- Are you keeping your appointments and obligations?
- Do you sleep six to eight hours each night?
- Are you kind to yourself?
- Do you say no when you need and want to?
- Are you forgiving of yourself?
- Are you engaged in social activities?
- Are you balancing between feeling your feelings and keeping busy?

Not all of these activities will appeal to everyone.

Develop a self-care plan

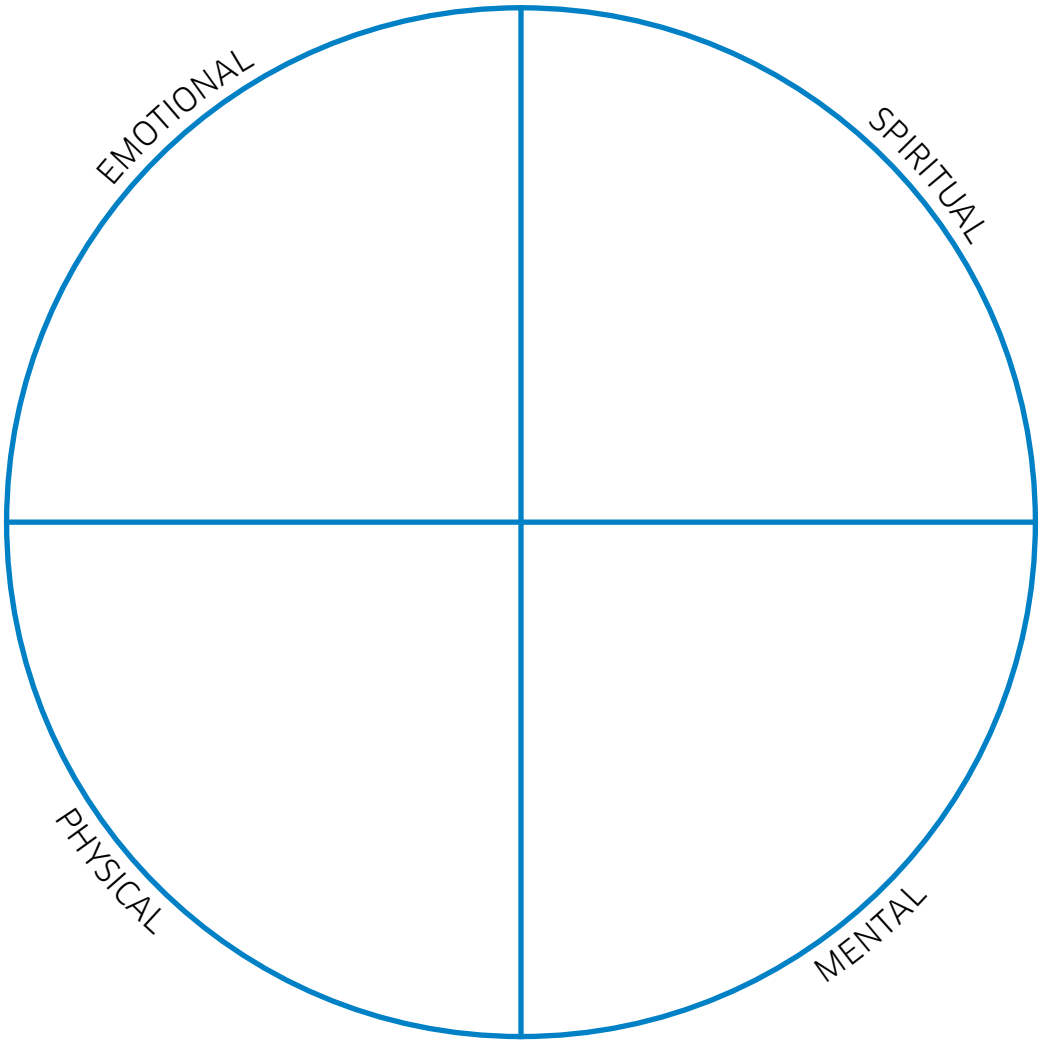
Take some time to do something just for yourself every day. Some ideas of things to do include:

- Reading
- Listening to music
- Watching a movie
- Enjoying a bath or shower
- Finding ways to laugh

- Keeping your environment bright and cheerful with plants or flowers
- Visiting with friends
- Having a pet
- Writing personal feelings in a journal or sharing them with a trusted person
- Reflecting, meditating

Self-care wheel

A self-care wheel is another way to identify ways to take care of yourself. There are lots of different ways to full out a self-care wheel. One way is to identify emotional, spiritual, mental and physical things you can do to keep yourself healthy.



Applying MHFA Actions

Section 2 in this guide gives a detailed explanation of how to apply the MHFA actions to an older adult who may be developing or experiencing a worsening of one or more of the following:

- Depression
- Anxiety problems
- Psychosis
- Substance use problems
- Dementia
- Delirium

Section 3 in the guide describes the best ways to assess and assist an older adult who is experiencing a mental health or substance use crisis. The following crises are covered:

- Suicidal thoughts and behaviours
- Non-suicidal self-injury
- Panic attacks
- Following a traumatic event
- Severe psychotic states
- Severe effects from alcohol use
- Severe effects from drug use
- Agitated behaviours

There are other problems and crises which are not covered in the MHFA course and guide, including personality disorders. However, the skills learned are useful when assisting anyone who is distressed or in crisis, regardless of the underlying problem.

Providing MHFA to diverse cultures and populations

When providing MHFA to an older adult who is from a culture or population that is different from your own, it is important to:

- Be aware that culture shapes each individual's understanding of health and ill health
- Learn about specific cultural beliefs that surround mental health and substance use problems in the older adult's community
- Learn how these terms are described in the older adult's community (i.e., become familiar with the words and ideas used to talk about symptoms or behaviours related to these problems)
- Be aware of taboo concepts, behaviours or language (i.e., learn what might cause shame)
- Do not make assumptions about beliefs, practices or preferences.

This involves:

- Respecting the culture of the community by using the appropriate language and behaviour
- Never doing anything that causes the older adult to feel shame
- Supporting the older adult's right to make decisions about seeking culturally based care.

Providing MHFA to a 2SLGBTQ+ person

Guidelines for communicating with a 2SLGBTQ+ (Two-Spirit person, Lesbian, Gay, Bisexual, Transgender, Transsexual, Queer, Questioning) about mental health and substance use problems are available in the Appendix.

Spectrum of interventions for mental health and substance use problems

Society has a wide range of interventions for preventing mental health and substance use problems, and for helping older adults that live with them. MHFA is just one part of the spectrum of intervention. The diagram below illustrates different states of mental well-being, ranging from being well to developing mental health and substance use problems, to having a mental illness and to recovery. There are different types of interventions that are appropriate at these states of mental health and substance use. For the older adult who is well or has some mild symptoms, prevention programs are appropriate. For the older adult who is moving from mild mental health and/or substance use problems to a mental illness, early intervention programs such as MHFA can be used. For an older adult who is very unwell, a range of treatment and support approaches are available, which will assist them in their recovery process.

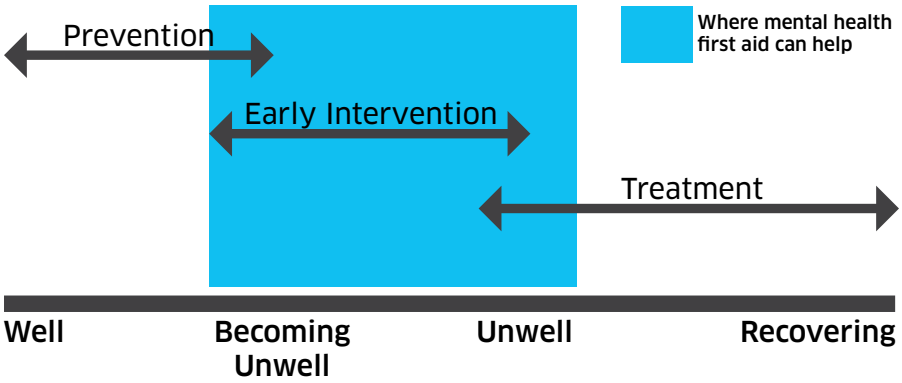
Prevention

Prevention programs are available to help everyone in the community, as well as targeted programs for older adults who are particularly at risk. Examples include parenting skills training, drug education and resilience training programs in schools, promotion of physical exercise to improve mood, stress management courses and policies to reduce stress in the workplace.

Early intervention

Early intervention programs target older adults living with mental health and/or substance use problems and those who are just developing these problems. They aim to prevent problems from becoming more serious and reduce the likelihood of secondary effects such as loss of employment, relationship breakup and drug and alcohol problems. Many older adults have a long delay between developing a mental illness and receiving appropriate treatment and support. The longer people delay getting help and support, the more difficult their recovery can be.

It is important that older adults are supported by their family, friends and work colleagues during this time. People are more likely to seek help if someone close to them suggests it (Cusack et al., 2004; Vogel et al., 2007). It is during this early intervention phase that helping with MHFA actions can play an important role.



Treatment and supports

There are many different types of treatment and supports that can help older adults in their recovery to improved mental well-being. Once the older adult has made the decision to seek help, they may choose from a number of sources of help, treatment approaches and service settings. There is no "one-size-fits-all" approach.

Medical Treatments

These include various types of prescribed medications and other treatments given by a doctor.

Psychological treatments

Psychological treatments provide a supportive relationship and seek to change the way the older adult thinks or behaves. Usually, treatment involves talking individually, or sometimes in a group, with a mental health or addictions professional to address issues and to promote personal growth and coping skills. Self-help books and computerized psychological treatments are also available.

Complementary treatment and lifestyle changes

These involve using natural or alternative therapies and changing the way one lives. These can be used under the guidance of a health professional or as self-help. Care should be taken to ensure that the self-help strategies employed are evidence based or have been recommended by an appropriate professional.

Support groups

These groups bring people with common problems together to share experiences and help each other. Participation in mutual-aid self-help groups can help reduce feelings of isolation, increase knowledge, enhance coping skills and bolster self-esteem.

Rehabilitation programs

These programs help older adults regain skills and confidence to live and work in their community.

Family and friends

Family and friends are a very important source of support for recovery to improved mental well-being. Family and friends can help by having an understanding of the problem and providing the same support as they would if the older adult has a physical illness.

MHFA can continue to play an important role in this period if relapses or crises occur. At such times, older adults need to be supported by those around them, in particular when no expert help is immediately available.

Professionals who can help

A variety of health professionals can help older adults to improve their mental well-being:

Family doctors

For many older adults developing a mental health and/or substance use problem, their family doctor will be the professional they first turn to for help. A family doctor can recognize symptoms and provide the following types of help:

- Look for a possible physical cause
- Explain the problem and how the older adult can best be helped
- Prescribe medication if needed
- Refer the older adult to a psychologist or allied health professional who can help the person learn ways to cope with and overcome the illness
- Refer the older adult to a psychiatrist, particularly if the symptoms are severe or long lasting
- Link the older adult to community supports.

Psychologists

A psychologist is someone who has studied human behaviour at university and has had supervised professional experience in the area. Psychologists are registered with a national registration board. Some psychologists provide treatment to older adults with mental illnesses. Psychologists do not have a medical degree, so they do not prescribe medication. Some psychologists work for health services, while others are private practitioners.

A clinical psychologist is a psychologist who has undergone additional specialist training in how to treat people with mental health and/or substance use problems. They are particularly skilled at providing cognitive behaviour therapy and other psychological treatments.

Psychiatrists

Psychiatrists are medical doctors who specialize in the treatment of mental health and/or substance use problems. Psychiatrists mostly focus on treating people with severe or long-lasting problems. They are experts in medication and can help people who are having side effects from their medication or interactions with other medications. It is possible to see a psychiatrist by getting a referral from a family doctor. A family doctor might refer a patient to a psychiatrist if they are very ill or are not getting better quickly. Most psychiatrists work in private practice, but some work in clinics or hospitals.

Mental health and substance use nurses

Mental health and substance use nurses are registered nurses who are specialized in caring for people with mental illnesses. They generally care for people with more severe illnesses who are treated in hospitals or in the community. They can provide assistance with medication, practical support and counselling.

Occupational therapists and social workers

Most occupational therapists and social workers work in health or welfare services. However, some have additional training in mental health and substance use and are registered by Medicare. They can provide treatments similar to psychologists.

Counsellors

Counsellors can provide psychological support. However, counsellors are not a profession registered by the government, so anyone, even those without qualifications, can call themselves a “counsellor.” A well-qualified counsellor may also be a psychologist or other registered professional. Some counsellors may have specific training and skills in an area such as drug and alcohol counselling.

Resources

AMERICAN PSYCHOLOGICAL ASSOCIATION
www.apa.org

The American Psychological Association provides information, links and resources on a variety of mental health and substance use topics.

CANADIAN INSTITUTE FOR HEALTH INFORMATION
www.cihi.ca/en

The Canadian Institute for Health Information provides health-related information, data and reports.

CANADIAN MENTAL HEALTH ASSOCIATION
www.cmha.ca

The Canadian Mental Health Association is a nationwide charitable mental health organization. Its website has a variety of information on mental health and mental illness.

CANADIAN PSYCHIATRIC ASSOCIATION
www.cpa-apc.org

The Canadian Psychiatric Association provides downloadable brochures on a variety of mental health topics.

CANADIAN PSYCHOLOGICAL ASSOCIATION
www.cpa.ca

The Canadian Psychological Association provides downloadable information sheets on a variety of mental health topics.

CENTRE FOR ADDICTION AND MENTAL HEALTH
www.camh.ca

The Centre for Addiction and Mental Health (CAMH) is an addiction and mental health teaching hospital in Toronto. Under "About Addiction and Mental Health," there are resources on mental health and substance use problems.

CENTRE FOR INTERNATIONAL MENTAL HEALTH

www.cimh.unimelb.edu.au
https://mspgh.unimelb.edu.au/research-groups/centre-for-mental-health

The Global and Cultural Mental Health Unit works to improve mental health and reduce mental illness in low-resource settings and among vulnerable populations in Australia and internationally.

COMMUNITY ADDICTIONS PEER SUPPORT ASSOCIATION (CAPSA)
www.capsa.ca

CAPSA is a non-profit organization of people affected by addiction. Based in Ottawa, Ontario, CAPSA strives to empower individuals impacted by addiction by providing opportunities to integrate into the broader community through peer-support initiatives and community engagement projects. We support all pathways to recovery and endeavour to collaborate with other organizations that provide services for those in need of help.

MENTAL HEALTH COMMISSION OF CANADA
www.mhcc.ca

The MHCC offers many tools and guidelines on a wide range of mental health topics, including on peer support, caregiving and recovery.

NATIONAL INSTITUTE OF MENTAL HEALTH
www.nimh.nih.gov

The National Institute of Mental Health (NIMH) is a scientific organization dedicated to research focused on the understanding, treatment and prevention of mental disorders and the promotion of mental well-being.

NATIONAL NETWORK FOR MENTAL HEALTH
www.nnmh.ca

The National Network for Mental Health is run by and for mental health consumer/survivors. Its purpose is to advocate, educate and provide expertise and resources that benefit the Canadian consumer and survivor community. (Go to "Get Informed" and click "Helpful People and Places" to find helpful resources.)

PUBLIC HEALTH AGENCY OF CANADA
www.phac-aspc.gc.ca

The Human Face of Mental Health and Mental Illness in Canada 2006 (Look in "Publications," under "H" for "The Human Face of Mental health and substance use and Mental Illness in Canada.")

WORLD HEALTH ORGANIZATION
www.who.int/mental_health/en/

The World Health Organization has international information on mental health. (Look in "Health Topics" under "M." www.who.int/health-topics/mental-health#tab=tab_1)

MENTAL HEALTH ATLAS 2017
www.who.int/gho/mental_health/reports/en/

The Mental Health Atlas, series produced by WHO, is considered the most comprehensive resource on global information on mental health and an important tool for developing and planning mental health services within countries and regions

ROYAL COLLEGE OF PSYCHIATRISTS
www.rcpsych.ac.uk

The Royal College of Psychiatrists provides information, links and resources on a variety of mental health topics.

ADVANCE CARE PLANNING
www.advancecareplanning.ca/making-your-plan/how-to-make-your-plan/provincialre-sources.aspx

A Canadian website designed to assist seniors and their families discuss advance care planning; to reflect on values and wishes, and to let others know a senior's future health and personal care preferences, with links to assistance with decision making resources in every province and territory.

CANADIAN CAREGIVER COALITION
www.ccc-ccan.ca

A national organization of diverse partner organizations who work to identify and respond to the needs of caregivers in Canada.

CANADIAN COALITION FOR SENIORS' MENTAL HEALTH (CCSMH)
www.ccsmh.ca/en/default.cfm

The mission of the CCSMH is to promote the mental health of seniors by connecting people, ideas and resources. The CCSMH has user-friendly educational guides for seniors and their families regarding delirium, depression, mental health issues in long-term care homes, and suicide prevention available for download free of charge.

THE CANADIAN GERIATRICS SOCIETY
www.canadiangeriatric.ca

Goal is to promote excellence in the medical care of older Canadians.

CENTRE FOR STUDIES IN AGING & HEALTH

www.sagelink.ca

A resource for geriatric patients, their caregivers and health professionals.

SENIORS.GC.CA
www.seniors.gc.ca/eng/

A Canadian government website launched in 2013 with a great deal of information about resources for seniors, separated by region.

THE CANADIAN ALLIANCE ON MENTAL ILLNESS AND MENTAL HEALTH (CAMIMH)
www.camimh.ca

CAMIMH established in 1998, is a non-profit volunteer run organization comprised of health care providers as well as organizations which represent individuals with lived experience of mental illness that provides mental health education to the public. The objective of CAMIMH is to engage Canadians in a national conversation about mental illness to reduce stigma associated with mental illness and provide insight into the services and support available to those living with mental illness.

MENTAL HEALTH FIRST AID CANADA

www.mentalhealthfirstaid.ca/EN/Pages/default.aspx

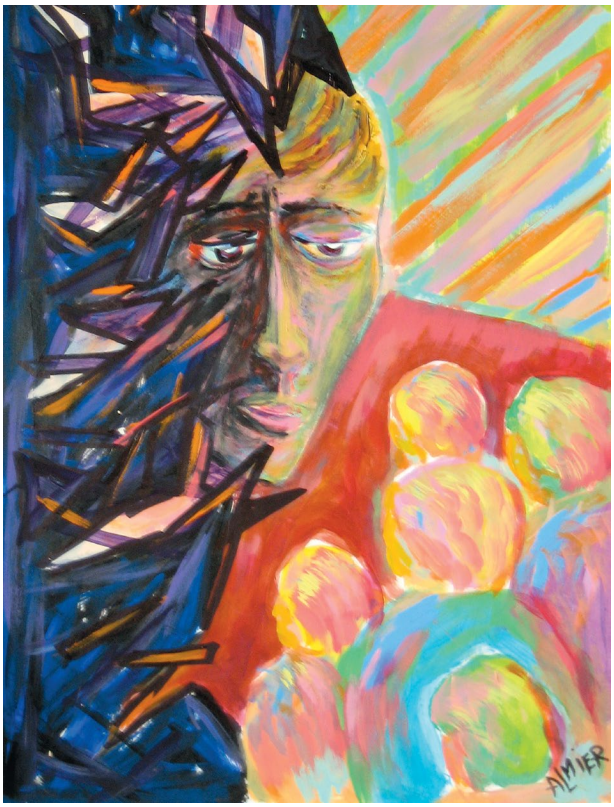
Mental Health First Aid (MHFA) is the help provided to a senior developing a mental health problem or experiencing a mental health crisis. Just as physical first aid is administered to an injured senior before medical treatment can be obtained, MHFA is given until appropriate treatment is found or until the crisis is resolved. The MHFA Canada program aims to improve mental health literacy, and provide the skills and knowledge to help people better manage potential or developing mental health problems in themselves, a family member, a friend or a colleague.

Section 2: MHFA for Declining Mental Well-being

Girl-Woman Lights Her Way Home
By Michelle Hosking

"This painting is about the journey into madness (or illness) and somehow finding my way out back to myself or home."

2.1 Depression



Living in My Painful World
The artist is depressed and feels as though something is blocking him from others. He is feeling lost, dreadful, tormented and so different from everyone else. He is longing for people to help him and to understand him. He is looking for a way out and waits, feeling isolated.

What is depression?

The word "depression" is used in many different ways. People feel sad or blue when bad things happen. However, everyday "blues" or sadness is not a depressive disorder. Older adults with the "blues" may have a short-term depressed mood, but they can manage to cope and soon recover without treatment. The depression we are talking about in this chapter is major depressive disorder. Major depressive disorder lasts for at least two weeks and affects an older adult's ability to carry out their work and usual daily activities, and to have satisfying personal relationships. This chapter also covers bipolar disorder, another illness in which depression can be a feature.

Depression often co-occurs with anxiety disorders and substance use disorders (Canadian Centre on Substance Abuse, 2009; Teesson et al., 2009). Depression is more common in females than males. It is often recurrent (that is, people recover but develop another episode later on). Once an older adult has had an episode of depression, they are more likely to have other episodes during their life (Post, 2010).

Grief

What is Grief and Bereavement?

Many older adults must contend with loss. This may include the loss of a loved one, but it also can refer to the challenge in coping with physical and/or functional losses imposed by illness. Situations of loss are often accompanied by grief, the reaction or response to the loss, and bereavement, the period after loss during which grief is experienced.

Distinguishing between grief over physical, social or psychological losses and major depressive disorder can be difficult because of overlapping symptoms including sadness, tearfulness, sleep disturbance, decreased socialization and decreased appetite.[1]

Although they contain a significant emotional component, neither grief nor bereavement is considered a mental health disorder. Grief is a universal human experience; it is seen as a normal and expected emotional response to loss, with the majority of people being able to

work through their grief over a course of 2 to 6 months without treatment.[2]

For older adults, there is no "typical way" to grieve. Successful grieving enables an older adult to come to terms with a loss. While some older adults will grieve "successfully" (ultimately returning to a previous level of functioning) for others the death of a loved one can precipitate a major depressive disorder.

In situations of bereavement, the main feelings of grief relate to a sense of sorrow, emptiness and loss. These feelings are likely to decrease in intensity over days to weeks. They often occur in waves, typically associated with thoughts or reminders of the deceased.

In bereavement complicated by a major depressive disorder, older adults experience persistently depressed mood that is not necessarily tied to specific thoughts or reminders of the deceased loved one. Major depressive disorder results in an inability to experience happiness or pleasure. Feelings of worthlessness, self-loathing and self-critical or pessimistic thoughts are common which are not consistent with bereavement.
In bereavement complicated by major depressive disorder, suicidal thoughts may arise in part because of feelings of being unable to cope with the emotional pain of the loss such that urgent professional assessment is required.

Grief and Depression

It can be difficult to differentiate between grief and major depressive disorder because of the overlapping symptoms. However, older adults experiencing a persistently depressed mood that is not necessarily tied to specific thoughts or reminders of the specific loss may be suffering from depression.

Signs and symptoms of major depressive disorder

Depressive disorders affect how the older adult feels, acts and thinks. An older adult having five or more of the following symptoms (including at least one of the first two) nearly every day for at least two weeks is categorized as having a depressive disorder:

- A depressed mood
- Loss of enjoyment and interest in activities that used to be enjoyable
- Lack of energy and tiredness
- Feeling worthless or feeling guilty when they are not really at fault
- Thinking about death a lot or of suicide
- Difficulty concentrating or making decisions
- Moving more slowly or sometimes becoming agitated and unable to settle
- Having sleeping difficulties or sometimes sleeping too much
- Loss of interest in food or sometimes eating too much. Changes in eating habits may lead to either loss of weight or putting on weight.

Note that not every older adult who is depressed has all these symptoms. People differ in the number of symptoms they have and also how severe the symptoms are. Even if an older adult does not have enough symptoms to be diagnosed with a depressive disorder, the impact on their life can still be significant. These symptoms will cause distress to the older adult and will interfere with their day-to-day routine and their relationships with family and friends.

A first aider cannot diagnose depression. However, a first aider may be able to recognize the cluster of symptoms which indicate that depression may be the problem.

Symptoms of depression affect thinking, feeling, behaviour and physical well-being. Some examples are listed below:

Thinking

Individuals living with depression commonly have a negative view of themselves, the world and the future. Their thoughts often follow themes of hopelessness and helplessness. Other thoughts common to depression include frequent self-criticism, self-blame, worry, pessimism, impaired memory and concentration, indecisiveness and confusion, a tendency to believe others see you in a negative light, and thoughts of death and suicide.

Older adults who are depressed may say things, such as:

- "I'm a failure."
- "I have let everyone down."
- "It's all my fault."
- "Nothing good ever happens to me."
- "I'm worthless."
- "No one loves me."
- "I am so alone."
- "Life is not worth living."
- "Things will always be bad."

Feeling

Feelings associated with depression include sadness, anxiety, guilt, anger, mood swings, lack of emotional responsiveness, feelings of helplessness, hopelessness and irritability.

Behaviour

Behaviours related to depression include crying spells, withdrawal from others, neglect of responsibilities, loss of interest in personal appearance, loss of motivation, being slowed down, non-suicidal self-injury, sleeping too much or too little, over-eating, and using drugs and alcohol.

Physical

A range of physical symptoms are associated with depression: chronic fatigue, lack of energy, loss of appetite, constipation, weight loss or gain, headaches, irregular menstrual cycle, loss of sexual desire, and unexplained aches and pains.

Depression in older adults that goes unrecognized and untreated is associated with poor outcomes resulting in prolonged suffering, increased use of health care resources and increased risk of death by suicide, but also increased likelihood of death by physical illness within 15 months.[4] The connection between physical and mental health is exemplified well by depression in older adults. The supporting evidence for this includes:

1. Only a minority of older adults with depression receive mental health care or treatment with an antidepressant medication in primary care settings in part because of the difficulty primary care physicians have in recognizing depression in older adults who report physical symptoms only.[5]
2. Coronary artery disease is associated with a high rate of depression as up to 40% of patients with coronary artery disease have clinically significant depressive symptoms with half of those meeting criteria for major depressive disorder.[6]
3. Depression may be a stronger risk factor for a heart attack then traditional medical risk factors such as obesity, high blood pressure and second-hand smoke.[7]
4. Following a heart attack, those with depression have higher rates of sudden cardiac death and worse outcomes.[8] Similar findings have been found in

patients with mild depression[9] as well as following coronary artery bypass surgery.[10] Those with coronary artery disease without history of a heart attack also have worse outcomes when suffering from depression.[11]

5. Depression after stroke is also associated with higher mortality.[12] The effectiveness of antidepressants in post-stroke depression[13] is so important that their appropriate use has been incorporated into the clinical guidelines on post-stroke rehabilitation published by the U.S. Public Health Service.[14]
6. Depression is a risk factor for the development of type II diabetes, the more common type of diabetes which makes up about 90% of all cases and whose onset tends to occur after age 40.[15] Similarly diabetes is a risk factor for developing depression.[16]
7. Depression is associated with increased complications from diabetes with higher rates of disability and death.[17]
8. Depression is related to Geriatric Failure to Thrive (GFTT), a syndrome of poor overall physical and mental health. The syndrome is often described in terms of physical deterioration with weight loss, malnutrition and even dehydration accompanied by decreased appetite, depressed mood, and cognitive decline.[18,19,20,21] GFTT results in worsened prognosis (the likely course and outcome of a disease) for older adults with any illness.[22,23]

How a depressed person may appear

An older adult who is depressed may be slow in moving and thinking, although agitation can occur. Even speech can be slow and monotonous. There can be a lack of interest and attention to personal hygiene and grooming. The person usually looks sad and depressed and is often anxious, irritable and easily moved to tears. However, in its milder forms, they may be able to hide their depression from others, while with severe depression the older adult may be emotionally unresponsive and describe themselves as "beyond tears."

GOLDBERG DEPRESSION SCALE

(Goldberg et al., 1988)

The Goldberg Depression Scale is an internationally known scale used to screen for depression. The scale contains key questions that might help an older adult recognize that they or someone else may be having symptoms of depression. This is just a screening tool and is not intended to diagnose depression. If an older adult rates high on this scale, a professional assessment can accurately diagnose whether or not the person has a clinical depressive disorder.

Depression Scale

(Score one point for each "Yes" if the symptom occurs most of the time over the past 2-4 weeks)

1. Have you had low energy?
2. Have you had loss of interests?
3. Have you lost confidence in yourself?
4. Have you felt hopeless? (If you answered "yes" to any of questions 1-4, continue to 5-9).
5. Have you had difficulty concentrating?
6. Have you lost weight (due to poor appetite)?
7. Have you been waking early?
8. Have you felt slowed up?
9. Have you tended to feel worse in the mornings?

People with a score of two (2) have a 50 per cent chance of having a mental health problem. With higher scores, the probability rises sharply.

Bipolar disorder

People living with bipolar disorder (previously called manic depressive disorder) have extreme mood swings. They can experience periods of depression, periods of mania and long periods of normal mood in between. An older adult with bipolar disorder will usually have more episodes of depression than mania. The time between these different episodes can vary greatly from person to person, but usually episodes last days or weeks, distinguishing bipolar disorder from moodiness, which may cause mood switches that occur on a daily basis or several times a day (Merikangas et al., 2011).

The depression experienced by an older adult with bipolar disorder includes some or all of the symptoms of depression listed previously. Mania appears to be the opposite of depression. An older adult experiencing mania will have an elevated mood, be overconfident and full of energy. The person might be very talkative, full of ideas, have less need for sleep and take risks they normally would not. Although some of these symptoms may sound beneficial (e.g., increased energy and full of ideas), mania often gets people into difficult situations (e.g., they might spend too much money and get into debt, become angry and agitated, get into legal trouble or engage in sexual behaviour they otherwise wouldn't). These consequences may play havoc with their work, education and personal relationships. The older adult can have grandiose ideas and may lose touch with reality (i.e., become psychotic). In fact, it is not unusual for people with this disorder to become psychotic during depressive or manic episodes (Forty et al., 2008). Additional information on bipolar disorder with psychosis is discussed in Section 2.3 *Psychosis.*

An older adult is not diagnosed with bipolar disorder until they have experienced an episode of mania. It may, therefore, take many years before they are diagnosed correctly and get the most appropriate treatment.

Bipolar disorder most commonly starts earlier in life. Among older adults newly diagnosed in late-life there are two subgroups:

- those diagnosed for the first time with a manic or hypomanic episode despite a long-standing depressive mood-related disorder, and
- those who develop an initial manic episode as a result of an underlying neurological or medical illness.

The main risk factors for bipolar disorder beginning in older adults are neurological and medical illnesses (including some medications) that influence brain function.[29]

Signs and Symptoms of Mania

An older adult with bipolar disorder will experience periods of mania. Mania is characterized by a distinct period of abnormally elevated, expansive, or irritable mood and persistently increased goal-directed activity or energy. The symptoms last at least one week and are present most of the day, nearly every day (or any duration if hospitalization is necessary).

The start of a manic episode is usually sudden and can increase rapidly over a few days. Untreated, mania can last for days and sometimes as long as several months. Older adults with a manic episode typically do not realize they are ill and have poor judgment.

During the period of mood disturbance and increased energy or activity, some of the following signs and symptoms are present:

- Inflated self-esteem or grandiosity. The older adult may believe that he or she is especially talented, or may develop

delusions of being superhuman or of being an important religious figure (however delusions are not required diagnostic criteria).

- Decreased need for sleep (the older adult feels rested after only three hours of sleep or so).
- Racing thoughts and speech. The older adult may talk too much, too fast or too loud. Racing thoughts may be subjectively perceived as their thoughts are going faster than they are able to speak.
- Distractibility (attention too easily drawn to unimportant or irrelevant stimuli). The older adult may keep changing subjects while talking due to being easily distracted.
- Increase in goal-directed activity or psychomotor agitation (purposeless non-goal directed movement).
- Poor judgment in activity choice (e.g., engaging in unrestrained buying sprees, or foolish business investments).

Older adults with Bipolar disorder suffer significant impairment in psychosocial functioning and have substantially higher rates of cognitive dysfunction[30,31,32,33] These older adults tend to have substantially higher rates of neurological and medical illnesses including diabetes, lung disease, cardiac disease and cerebrovascular (stroke) disease.[34] This results in older adults with bipolar disorder having higher rates of disability[35] and death compared to those with depression.[36,37]

Risk factors for depressive disorders

Depression has no single cause and often involves the interaction of many diverse biological, psychological and social factors (Joyce, 2000; Souery et al., 2000).

The following factors increase an older adult's risk of developing depression:

- A history of depression in close family members
- Being female
- Being a more sensitive, emotional and anxious person
- Adverse experiences in childhood, such as lack of care or abuse
- Poverty, poor education and social disadvantage
- Recent adverse events in the older adult's life, such as a death or serious illness in the family, having an accident, or being a victim of crime, bullying or other form of mistreatment
- Separation or divorce
- Lack of a close confiding relationship with someone
- Long-term or serious physical illness
- Having another mental illness such as anxiety disorder, psychotic disorder or substance use disorder
- Caring full-time for an older adult with a long-term disability (Schulz & Sherwood, 2008).

Depression can also result from:

- the direct effects of medical conditions, for example, Parkinson's disease, Huntington's disease, stroke, Vitamin B12 deficiency, hypothyroidism, systemic lupus erythematous, hepatitis, glandular fever, HIV and some cancers;
- the side effects of certain medications or drugs;
- intoxication or withdrawal from alcohol or other drugs; and
- lack of exposure to bright light in the winter months.

These risk factors are thought to produce changes in the brain that lead to the symptoms of depression. Older adults who are depressed have a loss of connections between nerve cells in some areas of the brain (the hippocampus and prefrontal cortex) that are important in mood and memory. Antidepressants are thought to work by helping the production of new nerve cells and the formation of connections between nerve cells in these brain areas (Andrade & Rao, 2010). Other types of treatment, such as psychological therapy and exercise, possibly affect the brains of depressed people in a similar way.

Risk factors for bipolar disorder

The risk factors for depression and bipolar are not the same.

The main factors for bipolar disorder in older adults are neurological and medical illnesses that influence brain function. The causes of bipolar are not fully understood. However, the following factors can increase older adults' risk of developing bipolar disorder:[38]

- Family history – Although bipolar disorder is not directly inherited, people who have a parent who is affected, or who have a family history, have higher rates of this disorder compared to the general population.
- Chemical changes in the brain – Mania and depression are believed to be associated with chemical imbalances in the brain.
- Stress – Stress may play a part in triggering symptoms in vulnerable people.
- Medications – Episodes of mania may occur after illness as a result of using drugs and after taking certain medications used in the treatment of physical illness.

Interventions for depressive disorders

Professionals who can help

A variety of health professionals can provide help to an older adult with depression. They are:

- Family doctors
- Psychologists
- Psychiatrists
- Counsellors
- Mental health nurses
- Occupational therapists and social workers with mental health training

Only in the most severe cases of depression, or where there is a danger an older adult might harm themselves, is a depressed person admitted to a hospital. Most older adults with depression can be effectively treated in the community.

Treatments available for depressive disorders

Most people recover from depression and lead satisfying and productive lives. There is a range of treatments available for both depression and bipolar disorder. There is good evidence that the following treatments are effective for most people with depression (Jorm et al., 2013).

Psychological therapies

The following psychological therapies are effective in the treatment of depression:

- **Cognitive behaviour therapy (CBT)**
  CBT is based on the idea that how we think affects the way we feel. When people get depressed they think negatively about most things.

  An older adult may think their situation is hopeless and they may feel helpless. They may also have a negative view of themselves, the world and the future.

Cognitive behaviour therapy helps the person recognize such unhelpful thoughts and to change them to more realistic ones. CBT also helps people to change depressive behaviours by scheduling regular activities and engaging in pleasurable activities. It can include components such as stress management, relaxation techniques and sleep management. To get the full benefit of cognitive behaviour therapy, it is recommended that an older adult has 16-20 sessions of this treatment (Crome & Baillie, 2016).

- **Mindfulness-based cognitive therapy**
  This involves learning a type of meditation that teaches people to focus on the present moment. The older adult just notices what they are experiencing, whether pleasant or unpleasant, without trying to change it.
- **Interpersonal psychotherapy**
  Interpersonal psychotherapy helps older adults to resolve conflict with other people, deal with grief or changes in their relationships, and develop better relationships. To get the full benefit of interpersonal psychotherapy, it is recommended that an older adult has 16-20 sessions of treatment (Crome & Baillie, 2016).
- **Behaviour therapy**
  This is also called behavioural activation and is often part of cognitive behaviour therapy. It focuses on increasing an older adult's level of activity and pleasure in their life.
- **Marital therapy**
  This is also called couple's therapy. It can help where depression is accompanied by relationship problems. Marital therapy focuses on helping an older adult who is depressed by improving their relationship with their partner.
- **Problem-solving therapy**
  This involves meeting with a therapist to clearly identify problems, think of different solutions for each problem, choose the best solution, develop and carry out a plan, and then see if this solves the problem.
- **Psychodynamic psychotherapy**
  This involves discovering how the unconscious patterns in an older adult's mind might play a role in their problems.
- **Reminiscence therapy**
  This is used with older people. It involves encouraging the older adult to remember and review the events in their life. The therapy might help resolve conflicts and regrets associated with past experiences and help the older adult to have a more positive and realistic view of themselves.
- **Self-help books**
  Books that are based on cognitive behaviour therapy can be effective (see Helpful resources at the end of this chapter). These are more effective when used under the guidance of a health professional, with 5-7 sessions recommended (Crome & Baillie, 2016).

Medical treatment

The following medical treatments are known to be effective:

- **Antidepressant medications** have been found effective with older adults who have moderate to severe depression.
- **Antipsychotic medications** may be used to treat older adults with bipolar disorder. They are also sometimes used to treat people with severe depression in combination with antidepressants, where other treatments have not worked.
- **Mood stabilizers** can help older adults with bipolar disorder by reducing the swings from one mood to another. They are also sometimes used in long-term depression.

- **Electroconvulsive therapy (ECT)** can be effective for older adults with severe depression that has not responded to other treatments. However, it has also been known to cause some negative side effects, such as memory loss.
- **Transcranial magnetic stimulation (TMS)** is sometimes used to treat severe depression or depression that has not responded to other treatments. It involves holding a strong magnet over the scalp in order to stimulate some areas of the brain.

Complementary therapies and lifestyle changes

There is some scientific evidence supporting the effectiveness of the following strategies in improving symptoms related to depression (Jorm et al., 2013):

- **Exercise** including both aerobic (e.g., jogging, brisk walking) and anaerobic (e.g., weight training).
- **SAMe** (S-Adenosylmethionine) which is a compound made in the body and available as a supplement in health food stores.
- **Light therapy** which involves bright light exposure to the eyes, often in the morning. This is most useful for older adults whose depression is associated with lack of light in winter. It is best used under the guidance of a health professional.

There are a number of other complementary therapies and lifestyle changes that have weaker evidence for their effectiveness in treating depression. These include avoiding alcohol for older adults who have a drinking problem, massage, omega-3 fatty acids (fish oil), relaxation training, St John's wort and yoga.

As well as looking at scientific evidence of which treatments and supports work for depression, it is also important to look at what older adults who have experienced depression find to be helpful. A large Internet survey of people who had received treatment for a depressive disorder asked them to rate the effectiveness of any treatment they had had. The treatments they rated as most effective were some antidepressant medications, cognitive behaviour therapy, interpersonal psychotherapy, other types of psychotherapy, and exercise.

Bipolar disorder treatments

There is evidence that the following treatments help people with bipolar disorder (Yatham et al., 2013):

- **Medications.** There is a range of medications that can help people with bipolar disorder. These include mood stabilizers, antipsychotics and antidepressants.
- **Psychoeducation** involves providing information to the person about bipolar disorder, its treatment and managing its effect on their life. Psychoeducation has been found to reduce relapses when used together with medication.
- **Psychological therapies.** Two therapies that research has found to be helpful are cognitive behaviour therapy and interpersonal and social rhythm therapy. Cognitive behaviour therapy helps people to monitor mood swings, overcome thinking patterns that affect mood, and function better. Interpersonal and social rhythm therapy covers potential problem areas in the person's life (grief, changes in roles, disputes, and interpersonal deficits), and helps them regulate social and sleep rhythms.
- **Family therapy** educates family members on how they can support the person with bipolar disorder and avoid negative interactions that can trigger relapses.

Importance of early intervention for depression

Early intervention is very important. People who wait a long time before getting treatment for depression tend to have a worse outcome (Ghio et al., 2014). Once an older adult has had an episode of depression, they become more prone to subsequent episodes. They fall into depression more easily with each subsequent episode (Post, 2010). For this reason, some people go on to have repeated episodes throughout their life. To prevent this pattern occurring, it is important to intervene early in the first episode of depression an older adult experiences to make sure it is treated quickly and effectively.

Crises associated with depression

Two main crises that may be associated with depression are:

- The person has **suicidal thoughts and behaviours.**
- The person is engaging in **non-suicidal self-injury.**

Suicidal thoughts and behaviours

Suicide is a significant risk for people with depression. An older adult may feel so overwhelmed and helpless that the future appears hopeless. The older adult may think suicide is the only way out. Sometimes an older adult becomes suicidal very quickly, perhaps in response to a trigger (such as a relationship breakup or arrest), and acts on their thoughts quickly and impulsively. The risk is increased if they have also been using alcohol or other drugs. However, not every older adult who is depressed is at risk for suicide and nor is everyone who is at risk of suicide necessarily depressed.

Non-suicidal self-injury

(Klonsky & Muehlenkamp, 2007)

Non-suicidal self-injury is also a significant risk for people with depression (Martin et al., 2010). People who engage in self-injury report more intense experience of emotional distress. They may also struggle to express these emotions. For these people, self-injury may alleviate their distress temporarily. Adults who engage in self-injury typically started doing so during adolescence, and it may have become a very difficult habit to break.

Suicide in older adults

Although not all depressed older adults are suicidal, the great majority of older adults who report suicidal ideation or who die by suicide experience depression.[43] Despite evidence that antidepressant treatment protects older adults from death by suicide, only a minority of older adults with depression receive mental health care or treatment with an antidepressant medication.[44,45]

In Canada, men aged 80 and older have the highest suicide rate, particularly if they have physical or mental health problems and are socially isolated.[46]

MHFA Actions for Depression

MHFA Actions – ALIFES

A Assess safety: risk of suicide, serious physical deterioration, and/or harm to others

L Listen and communicate nonjudgmentally

I Information and reassurance

F Facilitate the older adult getting appropriate professional help

E Encourage support for the older adult and caregiver

S Self-care for the first aider

Action: Assess safety: risk of suicide, serious physical deterioration and/or harm to others

Assess safety: risk of suicide

The warning signs of suicide may include:[47]

- Evidence, expression, or threat of a suicide plan
- Seeking access to means for suicide: seeking pills, weapons, or other means
- Expressing thoughts about a wish to die, or be dead, or die in one's sleep
- Expressions of hopelessness
- Expressions of no reason for living, no sense of purpose or meaning in life
- Expressions of rage or anger
- Expressing feelings of being trapped with no way out
- Expressions of excessive sadness, anxiety or agitation
- Increasing or excessive substance use
- Withdrawing from family, friends, society

As you talk with the person, be on the lookout for any indications that the person may be in crisis. If you have concerns that the person may be having **suicidal thoughts,** find out how to **assess and assist** this person in Section 3.1 *MHFA for Suicidal Thoughts and Behaviours.*

If you have concerns that the person may be engaging in **non-suicidal self-injury,** find out how to **assess and assist** this person in Section 3.2 *MHFA for Non-Suicidal Self-Injury.*

Assess safety: risk of serious physical deterioration

Older adults with depression are at risk for serious physical deterioration due to non-compliance with medical treatments, lack of exercise (walking), reduced attention to personal care needs, reduced appetite, weight loss, malnutrition and dehydration. Untreated depression is associated with:

- Increased risk of heart disease

- Increased risk of Type II diabetes
- Increased risk of death by physical illness in 15 months

What to do if the older adult who is not considering suicide does not want help?

When an older adult is having psychological and physical symptoms related to depression, they may nevertheless lack insight or awareness of their illness and see no reason to seek mental health care. There is no easy solution for an older adult who is unwilling to seek professional help and is not an immediate danger to themselves or others, but may be at risk of serious physical deterioration. The older adult may be incapable of making a decision about the need for treatment. In this scenario, investigate if the local provincial laws permit a justice of the peace or court application for an older adult to undergo an emergency psychiatric evaluation.

Assess safety: risk of harm to others

Older adults suffering from depression are rarely a danger to others. Those with mania may experience grandiosity, irritability and psychosis (loss of reality) with no insight into their condition. In this scenario, confrontation is unhelpful and may provoke aggressiveness. Calling 911 for emergency medical assistance is warranted.

Action: Listen and communicate nonjudgmentally

If you believe that the older adult is not in a crisis that needs immediate attention, you can engage the person in conversation, such as asking the older adult about how they are feeling and how long they have been feeling this way. Listening and communicating nonjudgmentally is important at this stage as it can help the older adult to feel heard and understood, while not being judged in any way. This can make it easier for the person to feel comfortable to talk freely about their problems and to ask for help.

It is very difficult to be entirely nonjudgmental all of the time. We automatically make judgments about people from the minute we first see or meet them, based on their appearance, behaviour and what they say. **There is more to nonjudgmental listening than simply trying not to make those judgments—it is about ensuring that you do not express your negative judgments, as this can get in the way of helping.**

If you have decided to approach someone with your concerns about them, it is a good idea to spend some time reflecting on your own state of mind first. It is best to talk to the older adult when you are feeling able to express your concerns without being judgmental.

You can be an effective nonjudgmental listener by paying special attention to two main areas:

- Your **attitudes,** and how they are conveyed, and
- Effective **communication skills**—both verbal and nonverbal.

Attitudes: Acceptance, Genuineness and Empathy

The key attitudes involved in nonjudgmental listening are acceptance, genuineness and empathy.

Acceptance

Adopting an attitude of acceptance means respecting the older adult's feelings, personal values and experiences as valid, even if they are different from your own or you

disagree with them. You should not judge, criticize or trivialize what the older adult says because of your own beliefs or attitudes. Sometimes, this may mean withholding any and all judgments that you have made about the older adult and their circumstances, e.g., listen to the person without judging them as weak—these problems are not due to weakness or laziness—and recognize that the person is trying to cope. An important way to show acceptance is to avoid communicating stigmatizing attitudes about mental illness. Be careful in applying labels to the older adult that they may find stigmatizing, e.g., "mentally ill" or "drug addict." Choose your words carefully so as to avoid causing offence. Also be aware that the older adult may hold stigmatizing attitudes towards mental illness and that you can model acceptance, making it easier for them to accept help.

Genuineness

Genuineness means that what you say and do shows the older adult that they are accepted. This means not holding one set of attitudes while expressing another. Your body language and verbal cues should reinforce your acceptance of the older adult. For example, if you tell the person you accept and respect their feelings but maintain a defensive posture or avoid eye contact, the person will know you are not being genuine.

Empathy

Empathy means being able to imagine yourself in the other person's place, showing them that they are truly heard and understood by you. This doesn't mean saying something glib such as "I understand exactly how you are feeling"—it is more appropriate to say that you can appreciate the difficulty that they may be going through. Remember that empathy is different from sympathy, which means feeling sorry for or pitying the person.

Verbal skills

Using the following simple verbal skills will show that you are listening:

- Ask questions that show you genuinely care and want clarification about what they are saying
- Check your understanding by restating what they have said and summarizing facts and feelings
- Listen not only to what the older adult says but also how they say it; their tone of voice and nonverbal cues will give extra clues about how they are feeling
- Use minimal prompts such as "I see" and "Ah" when necessary to keep the conversation going
- Be patient, even when the older adult isn't communicating well, is repetitive or is speaking slower and less clearly than usual
- Do not be critical or express your frustration at the older adult for having such symptoms.
- Avoid giving unhelpful advice such as "pull yourself together" or "cheer up." If this were possible the older adult would do it
- Do not interrupt the older adult when they are speaking, especially to share your opinions or experiences
- Avoid confrontation unless necessary to prevent harmful or dangerous acts.

Remember that pauses and silences are okay. Silence can be uncomfortable for many people, but the older adult may need time to think about what has been said or may be struggling to find the words they need. Interrupting the silence may make it difficult for them to get back on track and may damage the rapport you have been building. Consider whether the silence is awkward, or just awkward for you.

Nonverbal skills

Nonverbal communications and body language express a great deal. Good nonverbal skills show that you are listening, while poor nonverbal skills can damage the rapport between you and the older adult you are assisting and negate what you say.

Keep the following nonverbal cues in mind to reinforce your nonjudgmental listening:

- Pay close attention to what the older adult ays.
- Maintain comfortable eye contact, i.e., the level of eye contact that the older adult seems most comfortable with. Avoid staring.
- Be aware of the older adult's body language as this can provide clues as to how they are feeling or how comfortable they feel talking with you. Try to notice how much personal space the older adult feels comfortable with and do not intrude beyond it.
- Maintain an open body position. Don't cross your arms over your body as this may appear defensive.
- If it is safe, sit down, even if the older adult is standing. This may seem less threatening.
- It is best to sit alongside the older adult and angled towards them, rather than directly opposite them.
- Avoid distracting gestures such as fidgeting with a pen, glancing at other things or tapping your feet or fingers as they could be interpreted as a lack of interest.

Although your conversation with the older adult you are helping should be focused on their feelings, thoughts and experiences, you need to be aware of your own as well. Helping someone who is in distress may evoke an unexpected emotional response in you; you may find yourself feeling fearful, overwhelmed, sad or even irritated or frustrated.

In spite of any emotional response you might have, you need to continue listening respectfully and avoid expressing a negative reaction to what the older adult says. This is sometimes difficult and may be made more complex by your relationship with the older adult or your personal beliefs about their situation. **You need to set aside these beliefs and reactions in order to focus on the needs of the older adult you are helping—their need to be heard, understood and helped.** Remember that you are providing the older adult with a safe space to express themselves, and a negative reaction from you can prevent them from feeling that sense of safety.

Cultural considerations for nonjudgmental communication

If you are assisting someone from a cultural background that is different from your own, you may need to adjust some of your verbal and nonverbal behaviours. For example, the older adult may be comfortable with a level of eye contact different from what you are used to or may be used to more personal space.

If these differences are interfering with your ability to be an effective helper, it may be helpful to explore and try to understand the older adult's experiences, values or belief systems. Be prepared to discuss what is culturally appropriate and realistic for the older adult or seek advice from someone from their cultural background before speaking to them.

Action: Information and reassurance

After you have listened attentively and sensitively to the older adult and given them a chance to fully express and explore their issue, you can begin to discuss possible courses of action. Spending time talking and

listening means you are less likely to offer ill-considered or inappropriate advice, or to minimize or dismiss the problem based on only "half the picture."

Treat the older adult with respect and dignity

Each older adult's situation and needs are unique. It is important to respect the older adult's autonomy while considering the extent to which they are able to make decisions for themselves. Equally, you should respect the older adult's privacy and confidentiality unless you are concerned that the older adult is at risk of harming themselves or others.

Do not blame the older adult for their illness

Depression is a real health problem and the older adult is not in control of how and whether depression affects them. It is important to remind the older adult that they have a health problem and that they are not to blame for feeling "down."

Have realistic expectations for the older adult

Accept the older adult as they are and have realistic expectations for them. Everyday activities like cleaning the house, paying bills or feeding the dog may seem overwhelming to the older adult. You should let them know that they are not weak or a failure because they have depression, and that you don't think less of them as an older adult. You should acknowledge that the older adult is not "faking," "lazy," "weak" or "selfish."

Offer consistent emotional support and understanding

It is more important for you to be genuinely caring than for you to say all the "right things." The older adult genuinely needs additional care and understanding to help them through their illness so you should be empathetic, compassionate and patient. People with depression are often overwhelmed by irrational fears; you need to be gently understanding of someone in this state. It is important to be patient, persistent and encouraging when supporting someone with depression. You should also offer the person kindness and attention, even if it is not reciprocated. Let the older adult know that they will not be abandoned. You should be consistent and predictable in your interactions with the person.

Give the older adult hope for recovery

You need to encourage the older adult to maintain hope by saying that, with time and treatment, they will feel better. Offer emotional support and hope for a more positive future in whatever form the person will accept.

Provide practical help

Ask the older adult if they would like any practical assistance with tasks but be careful not to take over or encourage dependency.

Offer information

Ask the older adult if they would like some information about depression. If they do want information, it is important that you give them resources that are accurate and appropriate to their situation. Don't assume that the person knows nothing about depression as they, or someone else close to them, may have experienced it before.

What isn't supportive

- There's no point in just telling an older adult with depression to get better. They cannot "snap out of it" or "get over it."
- Do not be hostile or sarcastic when their responses are not what you usually expect of them. Rather, accept these responses as the best the person has to offer at that time.
- Do not adopt an over-involved or overprotective attitude towards an older adult who is depressed.

- Do not nag the older adult to try to get them to do what they normally would.
- Do not trivialize the older adult's experiences by pressuring them to "put a smile on their face," to "get their act together" or to "lighten up."
- Do not belittle or dismiss the older adult's feelings by attempting to say something positive like, "You don't seem that bad to me."
- Avoid speaking with a patronizing tone of voice and do not use overly compassionate looks of concern.
- Resist the urge to try to cure the older adult's depression or to come up with answers to their problems.

Action: Facilitate the older adult to get appropriate professional help

Facilitating getting professional help frequently involves arranging a visit to the older adult's family physician. If the older adult is suicidal, facilitate getting professional help even if it is not wanted.

Everybody feels down or sad at times, but it is important to be able to recognize when depression has become more than a temporary experience for an older adult and when to encourage that person to seek professional help. Professional help is warranted when depression lasts for weeks and affects an older adult's normal ability to function in daily life. Many older adults with depressive disorders do not seek professional help.

In Canada, older adults with depressive symptoms are more likely to be treated by a family physician than from a psychiatrist.[48] In fact, family physicians provide the majority of care to older adults in Canada.[49] Timely and appropriate treatment of depressive illness has been identified as the most effective way to prevent suicide in older adults.[50] Unfortunately, depression often goes under-treated in older adults.[51] However, the influence of others' views can play a crucial role in help seeking; recommendations from significant others is an important factor for those older adults seeking professional help.[52]

Discuss options for seeking professional help

Ask the older adult if they need help to manage how they are feeling. If they feel they do need help, discuss the options that they have for seeking help and encourage them to use these options. If the older adult does not know where to get help, offer to help them seek assistance. It is important to encourage the person to reach out to appropriate professional help and effective treatment as early as possible. If the older adult would like you to support them by accompanying them to an appointment with a health professional, you must not take over completely; an older adult with depression needs to make their own decisions as much as possible.

Depression is not always recognized by health professionals; it may take some time to get a diagnosis and find a healthcare provider with whom the older adult is able to establish a good relationship. Encourage the person not to give up seeking appropriate professional help.

What if the older adult doesn't want help?

The person may not want to seek professional help. Find out if there are specific reasons why this is the case. For example, the older adult might be concerned about the cost of the service or about not having a doctor they like, or they might be worried they will be sent to hospital.

These reasons may be based on mistaken beliefs and you may be able to help the person overcome their worries about seeking help. If the older adult still doesn't want help

after you have explored their reasons with them, let them know that they can contact you if they change their mind in the future about seeking help. You must respect their right not to seek help unless you believe that they are at risk of harming themselves or others.

Action: Encourage supports for the older adult and the caregiver

Older adults

- Assist the older adult to reach out to others
- Foster a sense of belonging through strengthening cultural, spiritual and religious connections
- Support the older adult in pursuing a hobby/interests
- Encourage activities that instill a sense of purpose
- Support the older adult to engage in a healthy lifestyle (exercise, diet and sleep)

Additional strategies for older adults to reduce suicide risk are telephone help/crisis lines and homevisiting services.[53]

Caregivers

Providing care and treatment for older adults with suicide-related behaviour is emotionally demanding and care providers should keep in mind that they too may require support. Understanding one's own personal views on suicide and self-harm will assist in maintaining a caring, respectful and non-judgmental attitude. Do not neglect to take care of yourself.

Tragically, sometimes despite competent care, an older adult dies by suicide. Losing someone to suicide is extremely painful. Blaming yourself is unnecessary and counter-productive. Surround yourself with supports to help you work through the pain of such a loss.

Self-help strategies

Self-help strategies are frequently used by people with depression (Jorm et al., 2004). The person's ability and desire to use self-help strategies will depend on their interests and the severity of their depression. Therefore, you should not be too forceful when trying to encourage an older adult to use self-help strategies.

Self-help strategies may be useful in conjunction with other treatments and may be suitable for older adults with less severe depression. It is important that severe or long-lasting depression be assessed by a health professional.

Action: Self-Care for the first aider

Supporting a suicidal older adult can be unsettling and stressful. Do not underestimate the effect on your own well-being. Find ways of reducing the immediate stress. While maintaining confidentiality, find someone to talk to about your experience.

Remember to take care of yourself in your role as a mental health first aider. You may find yourself in the position of being both the caregiver and the mental health first aider, but keep in mind that each fulfils a different need for the older adult.

Refer back to MHFA Actions in Section 1 of this Reference Guide for a reminder about the importance of taking care of yourself as the older adult's first aider, and for a list of how-to suggestions for good self care practices.

Resources

CANADIAN MENTAL HEALTH ASSOCIATION
www.cmha.ca

The Canadian Mental Health Association is a nationwide charitable organization that promotes mental well-being.

CANADIAN PSYCHOLOGICAL ASSOCIATION
www.cpa.ca

The Canadian Psychological Association provides downloadable information sheets on a variety of mood-related disorders.

CANADIAN NETWORK FOR MOOD AND ANXIETY TREATMENTS (CANMAT)
www.canmat.org

Canadian Psychiatric Association and Canadian Network for Mood and Anxiety Treatments (CANMAT) have published Canadian guidelines on treating depression.

www.canmat.org/2019/03/31/choice-d/

A guide for patients and their families, written by patients and people with lived experience, to understand the different evidence-based treatments available for depression, adapted from CANMAT's 2016 depression treatment guidelines.

COGNITIVE BEHAVIOUR THERAPY ONLINE
www.moodgym.com.au

This is an interactive site that teaches people to use ways of thinking that will help to prevent depression. It is based on cognitive behaviour therapy.

CENTRE FOR ADDICTION AND MENTAL HEALTH
www.camh.ca

The Centre for Addiction and Mental Health is a substance-related disorder and mental health teaching hospital in Toronto. Under "Health Info/Mental Health and Addiction Index," there are resources on mood-related disorders, concurrent disorders and substance use.

CLINICAL RESEARCH UNIT FOR ANXIETY AND DEPRESSION
www.crufad.org

This site is Australian. The "This Way Up" section includes a depression quiz, information about effective treatments, suggestions for planning activities and problem solving, a list of pleasant activities, and cognitive behaviour therapy materials and links. The downloadable fact sheets on depression are particularly useful.

LIVINGWORKS EDUCATION INC.
www.livingworks.net

LivingWorks Education provides training courses around the world that teach people how to intervene when someone is suicidal. This organization provides ASIST training and also provides a variety of other workshops on suicide and suicidal behaviour to people across Canada and beyond.

MOOD DISORDERS SOCIETY OF CANADA
www.mdsc.ca

The Mood Disorders Society of Canada (MDSC) is a national, not-for-profit, volunteer-driven organization that is committed to improving quality of life for people affected by depression, bipolar disorder and other related disorders.

ASIST: APPLIED SUICIDE INTERVENTION TRAINING
www.livingworks.net

A workshop for caregivers who want to feel more comfortable, confident and competent in helping to prevent the immediate risk of suicide. Created by LivingWorks, its website lists two-day workshops that are offered through a variety of organizations across Canada.

BAYCREST
www.baycrest.org/educate/mental-health/depression/

An academic health sciences centre fully affiliated with the University of Toronto. Baycrest offers this educational website for seniors with depression and their caregivers.

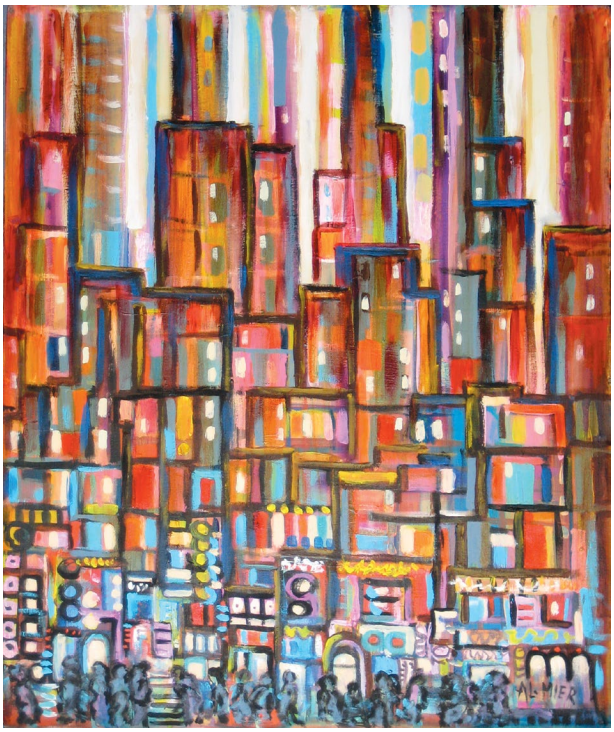
THE CANADIAN ASSOCIATION FOR SUICIDE PREVENTION (CASP)
www.suicideprevention.ca

The CASP provides information and resources to reduce the suicide rate and minimize the harmful consequences of suicidal behaviour.

CANADIAN COALITION FOR SENIORS' MENTAL HEALTH (CCSMH)
www.ccsmh.ca/pdf/ccsmh_depressionBooklet.pdf
www.ccsmh.ca/pdf/ccsmh_suicideBooklet.pdf

Helpful resource booklets for seniors suffering from depression and their caregivers available from the CCSMH are "Depression in Older Adults: a guide for seniors and their families" and "Suicide Prevention among Older Adults: a guide for family members" both available for free via downloading.

2.2 Anxiety Problems



Lost in a Crowd

The artist is feeling non-existent and lost in the world with no attachment to anyone. The city is overwhelming and creating tension and he wants to escape. He is lost in a dark crowd and the anxiety in his mind is moving his thoughts upward, looking for an open space.

What are anxiety problems?

Everyone experiences anxiety at some time. When older adults describe their anxiety, they may use such terms as anxious, stressed, uptight, nervous, frazzled, worried, tense or hassled. Although anxiety is an unpleasant state, it can be quite useful in helping an older adult to avoid dangerous situations and motivate solving everyday problems. Anxiety is mostly caused by perceived threats in the environment, but some older adults are more likely than others to react with anxiety when they are threatened. Anxiety can vary in severity from mild uneasiness through to a terrifying panic attack.

Anxiety can also vary in how long it lasts, from a few moments to many years. Anxiety problems differ from normal anxiety in the following ways:

- more severe
- longer lasting
- interfere with the person's work, other activities or relationships.

Anxiety can affect an older adult's thinking, feeling, behaviour and physical well-being.

Anxiety and anxiety-related disorders in older adults

Older adults tend to worry about health, family, finances, disability and eventual death. These worries are more likely to arise when older adults feel that their physical and mental abilities are diminishing and that they are losing their independence and autonomy. This is also considered normal anxiety. Yet sometimes the anxiety is so intense that it causes significant impairment in an older adult's daily functioning and becomes an important source of distress. This kind of anxiety is not normal and it is called an anxiety-related disorder.[2]

Anxiety-related disorders are mental disorders characterized by excessive anticipation of future events causing muscle tension and cautious or avoidant behaviour that remains present regardless of the situation.[3]

It is important to recognize that what might be considered a "normal reaction" can be different depending upon family context, cultural beliefs and expectations.

Anxiety-related disorders tend to develop between childhood and young adulthood and are less common in older adults than in younger adults. However, development of an anxiety-related disorder for the first time late in life is less common and is typically related to another mental health problem such as an underlying depression,[4] neurological or medical illness.[5] This also explains why it can be difficult to diagnose anxiety in older adults.

Prevalence of anxiety-related disorders in older adults is high. For example:

- 5.5 – 10% of older adults
- 24% of medically ill older adults
- Rates are higher for older adults living in retirement homes
- Women are twice as likely as men to experience an anxiety-related disorder

Signs and symptoms of anxiety

When someone feels extremely anxious, they may experience changes in their thinking and emotions. Anxiety in older adults may present as psychological symptoms and/or as physical symptoms.[6]

Psychological symptoms include:

- Excessive inappropriate worry
- Fear of impending doom or danger
- Fear of dying or "going mad"
- Fear of falling[7]
- Trouble concentrating and maintaining focus
- Thoughts seem to be sped up or slowed down
- Irritability
- Insomnia, and/or vivid dreams
- Specific phobias

They may also experience physical symptoms:

- Chest pain, heart palpitations, and rapid heart rate
- Hyperventilation or shortness of breath
- Dizziness, headache, vertigo, tingling or numbness of the skin
- Choking sensation, dry mouth, nausea, vomiting and diarrhoea
- Muscle aches, tenseness and restlessness

Types of anxiety disorders

Older adults with anxiety problems may be diagnosed with different types of anxiety disorders. These disorders differ from each other by the types of situations or things that the person feels anxious about and by the sorts of beliefs they have that exacerbate their anxiety. The main types of disorders where anxiety is a major feature are post-traumatic stress disorder, social anxiety disorder (social phobia), agoraphobia, generalized anxiety disorder, panic disorder and obsessive-compulsive disorder. It is not unusual for an older adult to have more than one of these disorders.

Post-traumatic stress disorder (PTSD)

Post-traumatic stress disorder can occur after an older adult is exposed to actual or threatened death, serious injury or sexual violation. Examples of traumas include involvement in war, accidents, assault (including physical or sexual assault, mugging or robbery, or family violence), and witnessing something terrible happen. Mass traumatic events include terrorist attacks, mass shootings, warfare and severe weather events.

A major symptom is re-experiencing the trauma. This may be in the form of recurrent dreams of the event, flashbacks, intrusive memories or unrest in situations that bring

back memories of the original trauma. There is avoidance behaviour, such as persistent avoidance of things associated with the event, which may continue for months or years. Also, persistent symptoms of increased emotional distress occur (constant watchfulness, jumpiness, being easily startled, irritability, aggression, insomnia). The older adult may also overly blame themselves or others, show reduced interest in others and the outside world, and may not be able to fully remember the event.

It is common for older adults to feel greatly distressed immediately following a traumatic event. If their distress lasts longer than a month, they may have post-traumatic stress disorder. Only some older adults who are distressed following a traumatic event will go on to develop a mental illness such as post-traumatic stress disorder or depression.

Social anxiety disorder (social phobia)

This involves extreme discomfort or fear in a variety of social situations. Commonly feared situations include speaking or eating in public, dating and social events. These are situations where public scrutiny may occur, usually with the fear of behaving in a way that is embarrassing or humiliating. The key fear is that others will think badly of the person. The anxiety about social situations must persist for six months or longer. Social anxiety disorder often develops in shy children as they move into adolescence.

Generalized anxiety disorder (GAD)

Some older adults experience long-term anxiety across a whole range of situations, and this interferes with their life. These people have generalized anxiety disorder. The main symptoms of generalized anxiety disorder are overwhelming, unfounded anxiety and worry (about things that may go wrong or one's inability to cope) accompanied by multiple physical and psychological symptoms of anxiety or tension occurring most days, for at least six months. Older adults with generalized anxiety disorder worry excessively about money, health, family and work, even when there are no signs of trouble.

The anxiety appears difficult to control. Other characteristics can include an intolerance of uncertainty, belief that worry is a helpful way to deal with problems and poor problem-solving abilities. Generalized anxiety disorder can make it difficult for older adults to concentrate, function at home, and generally get on with their lives.

Panic disorder

Some older adults have short periods of extreme anxiety called a panic attack. A panic attack is a sudden onset of intense apprehension, fear or terror. These attacks can begin suddenly and develop rapidly. This intense fear is inappropriate for the circumstances in which it is occurring. Other symptoms—many of which are similar to those of a heart attack—can include racing heart, sweating, shortness of breath, chest pain, dizziness, feeling detached from oneself and fears of losing control. Once an older adult has had one of these attacks, they often fear having another attack and may avoid places where attacks have occurred. The older adult may avoid exercise or other activities that can produce physical sensations similar to those of a panic attack.

It is important to distinguish between a panic attack and a panic disorder. Having a panic attack does not necessarily mean that an older adult will develop panic disorder. An older adult with panic disorder experiences recurring panic attacks and, for at least one month, is persistently worried about possible future panic attacks and the possible consequences of panic attacks, such as a fear of losing control or having a heart attack.

Some older adults may develop panic disorder after only a few panic attacks, while others may experience many panic attacks without developing a panic disorder. Some older adults with panic disorder also develop agoraphobia (described below), where they avoid places where they fear they may have a panic attack.

Agoraphobia

An older adult with agoraphobia avoids situations such as being outside of the home alone, using public transport, being in either open spaces (e.g., a parking lot or bridge) or in an enclosed space (e.g., a shopping mall or a theatre). The focus of the older adult's anxiety is that it will be embarrassing or difficult to get away from the place if a panic attack or other symptoms occur, or that there will be no one present who can help. Although agoraphobia can occur without panic attacks, this is less common.

Obsessive-compulsive disorder (OCD)

This disorder is not common but is very disabling. Obsessive-compulsive disorder often begins in adolescence and may be a lifelong illness. Obsessive thoughts and compulsive behaviours accompany feelings of anxiety.

Obsessive thoughts are recurrent thoughts, impulses and images that are experienced as intrusive, unwanted and inappropriate, and cause marked anxiety. Most obsessive thoughts are about fear of contamination, symmetry and exactness, safety, sexual impulses, aggressive impulses and religious preoccupation.

Compulsive behaviours are repetitive behaviours or mental acts that the older adult feels driven to perform in response to an obsession in order to reduce anxiety. Common compulsions include washing, checking, repeating, ordering, counting, hoarding or touching things repeatedly.

Specific phobias

An older adult with a phobia avoids or restricts activities because of fear. This fear appears persistent, excessive and unreasonable. Specific phobias are common but are less disabling than other anxiety disorders. The older adult may have an unreasonably strong fear of specific places, events or objects and often avoid these completely. The most common fears are of spiders, insects, mice, snakes and heights. Other feared objects or situations include an animal, blood, injections, storms, driving, flying or enclosed places.

Mixed anxiety, depression and substance use problems

Many older adults with anxiety problems do not fit neatly into a particular type of anxiety disorder. It is common for people to have some features of several anxiety disorders. A high level of anxiety over a long period will often lead to depression, and thus many older adults have a mixture of anxiety and depression.

People with anxiety disorders frequently use substances as a form of self-medication to help them cope. This can lead to substance use problems. Furthermore, heavy use of alcohol and drugs can lead to increased anxiety (Jorm et al., 2004).

Risk factors for anxiety disorders

People most at risk are those who (Canadian Psychiatric Association, 2006; Woodward & Fergusson, 2001):

- Have a more sensitive emotional nature and who tend to see the world as threatening

- Have a history of anxiety in childhood or adolescence, including marked shyness
- Are female
- Misuse alcohol
- Experience a traumatic event.

There are some family factors that increase risk for anxiety disorders:

- A difficult childhood (for example, experiencing physical, emotional or sexual abuse, neglect or over-strictness)
- A family background which involves poverty or a lack of job skills
- A family history of anxiety disorders
- Parental alcohol problems
- Separation and divorce

Anxiety symptoms can also result from:

- Some medical conditions such as hyper-thyroidism, arrhythmias, respiratory conditions such as chronic obstructive pulmonary disorder, metabolic conditions such as vitamin B12 deficiency
- Side effects of certain prescription and non-prescription medications
- Intoxication with alcohol, amphetamines, caffeine, cannabis, cocaine, hallucinogens and inhalants
- Withdrawal from alcohol, cocaine, sedatives and anti-anxiety medications.

Some older adults develop ways of reducing their anxiety that cause further problems. For example, people with phobias avoid anxiety-provoking situations. This avoidance reduces their anxiety in the short term but can limit their lives in significant ways. Similarly, people with compulsions reduce their anxiety by repetitive acts such as washing hands. The compulsions then become problems in themselves. Some older adults will use drugs and alcohol to cope with anxiety, which can increase anxiety in the long term.

Interventions for anxiety disorders

Professionals who can help

A variety of health professionals can provide help to an older adult with an anxiety disorder:

- GPs
- Psychologists
- Mental health nurses
- Counsellors
- Psychiatrists
- Occupational therapists and social workers with mental health training.

If the older adult is uncertain about what to do, encourage the person to consult a GP first, as they can check whether there is an underlying physical health problem causing this anxiety and refer the older adult to the appropriate specialist.

Treatments available for anxiety disorders

Research shows that a wide range of treatments can help with anxiety disorders (Reavley et al., 2014).

Psychological therapies

Various psychological therapies are used for anxiety disorders, but the following have the strongest evidence for effectiveness:

- **Cognitive behaviour therapy** is the best treatment for anxiety disorders of all types. It involves working with a therapist to look at patterns of thinking (cognition) and acting (behaviour) that are making the person more likely to have problems with anxiety or are making their anxiety worse. Once these patterns are recognized, the person can make changes to replace these patterns with new ones that reduce anxiety

and improve coping. To get the full benefit of cognitive behaviour therapy, an older adult needs to have a sufficient number of sessions. As a guide, it is recommended that an older adult has 12-15 sessions of treatment for generalized anxiety disorder, 14-16 for social anxiety disorder, 4-14 for panic disorder, 8-12 for post-traumatic stress disorder and 10 for obsessive-compulsive disorder (Crome & Baillie, 2016).

- **Behaviour therapy** (also known as exposure therapy) is often a component of cognitive behaviour therapy. It involves exposing the person to the things that make them anxious. The person might be exposed to feared situations in real life or using their imagination, usually in a gradual way. This type of therapy teaches the person that their fear will diminish without the need to avoid or escape the situation, and that their fears about the situation often do not come true or are not as bad as they thought
- **Self-help books** which are based on cognitive behaviour therapy or behaviour therapy can be useful. These books are more effective when used under the guidance of a health professional.
- **Computerized therapy** is self-help treatment delivered over the Internet or on a computer. Some are available for free (see Helpful resources at the end of this chapter). These treatments are more effective when used under the guidance of a health professional (Cuijpers et al., 2010).

Medical treatments

Scientific evidence supports the effectiveness of a number of medications:

- **Antidepressant medications** are effective for most anxiety disorders as well as for depression.
- **Other types of medication** can also be of help, particularly for generalized anxiety disorder. These include benzodiazepines, anticonvulsants, antihistamines, antipsychotics and azapirones. However, these medications can involve risks as well as benefits. For example, benzodiazepines should be restricted to short-term use because of concerns about possible side effects of dependency, sedation, rebound anxiety and memory impairment.

Complementary therapies and lifestyle changes

Relaxation training has good scientific evidence for effectiveness in helping people with anxiety disorders. Relaxation training involves learning to relax by tensing or relaxing specific groups of muscles, or by thinking of relaxing scenes or places. Relaxation training is most useful when learned under the guidance of a health professional.

Crises associated with anxiety problems

There are several crises that may be associated with anxiety problems:

- Experiencing an extreme level of anxiety such as a **panic attack.**
- Experiencing severe anxiety following a **traumatic event.**
- Having **suicidal thoughts and behaviours.**
- Engaging in **non-suicidal self-injury.**

Panic attack

More than one in four people have a panic attack at some time in their lives (Kessler et al., 2006). Few go on to have repeated attacks, and fewer still go on to develop panic disorder or agoraphobia. Although anyone can have a panic attack, older adults with anxiety disorders are more prone to them.

Traumatic event

A traumatic event is one that causes an individual or group to experience intense feelings of terror, horror, helplessness or hopelessness. The older adult could directly experience the event, witness it happen to others or learn that it has happened to someone close to them. Most people who experience a traumatic event do not develop a mental illness. Others experience symptoms of severe stress and may go on to develop post-traumatic stress disorder, another anxiety disorder or depression.

Suicidal thoughts and behaviours

Extreme levels of anxiety are the most obvious crisis seen in older adults with anxiety disorders. However, there is also the possibility of suicidal thoughts. The risk of suicide for older adults with anxiety disorders is not as high as for some other mental illnesses (Arsenault-Lapierre et al., 2004). However, the risk increases if the older adult also has a depressive or substance use disorder. Of people who have had an anxiety disorder in the past 12 months, approximately 2% attempt suicide (Johnston et al., 2009). Therefore, in any interaction with an older adult with an anxiety disorder, be alert to any warning signs of suicide.

Non-suicidal self-injury

Anxiety disorders greatly increase the risk for non-suicidal self-injury. Non-suicidal self-injury may be a coping mechanism for feelings of unbearable anxiety. Almost 60% of people who engage in non-suicidal self-injury have been diagnosed with an anxiety disorder at some time in their lives (Martin et al., 2010).

MHFA Actions for Anxiety Problems

MHFA Actions – ALIFES

A Assess safety: risk of suicide, serious physical deterioration, and/or harm to others

L Listen and communicate nonjudgmentally

I Information and reassurance

F Facilitate the older adult getting appropriate professional help

E Encourage support for the older adult and caregiver

S Self-care for the first aider

Action: Assess safety: risk of suicide, serious physical deterioration, and/or harm to others

If you notice new or sudden changes in an older adult's thinking or behaviour accompanied by inattentiveness, get medical help right away.

Assess safety: risk of suicide

As in the mood-related disorders chapter, ask about suicide risk because of the common connection of anxiety in older adults to unrecognized or untreated depression.

- Ask about suicidal thoughts
- Ask about risk factors
- Ask about suicidal plans

How to assess and assist in a crisis

As you talk with the older adult, be on the lookout for any indications that the person may be in crisis.

If the older adult has experienced a **traumatic event,** find out how to **assess and assist** this person in Section 3.4 *MHFA Following a Traumatic Event*.

If you have concerns that the older adult may be having **suicidal thoughts,** find out how to **assess and assist** this person in Section 3.1 *MHFA for Suicidal Thoughts and Behaviours.*

If you have concerns that the older adult may be engaging in **non-suicidal self-injury**, find out how to **assess and assist** this person in Section 3.2 *MHFA for Non-Suicidal Self-Injury.*

Assess safety: risk of serious physical deterioration

Risk of serious physical deterioration can be assessed by considering the older adult's social health. Enquire if the anxious older adult is socially isolated by asking who their social supports are and what social connections they have.[20]

Assess safety: risk of harm to others

Risk of harm to others is exceedingly rare in anxiety-related disorders in older adults and may only be an uncommon concern in those with acute stress disorder or PTSD.

Action: Listen and communicate nonjudgmentally

See Section 2.1 *Depression* for more tips on nonjudgmental listening and communication. Some main points to remember are:

- Engage the older adult in discussing how they are feeling and listen carefully to what they say.
- Do not express any negative judgments about the older adult's character or situation.
- Be aware of your body language, including posture, eye contact and physical position in relation to the older adult.
- To ensure you understand what the older adult says, reflect back what you hear and ask clarifying questions.
- Allow silences. Be patient, do not interrupt the older adult, and use only minimal prompts such as "I see" and "Ah."
- Do not give flippant or unhelpful advice such as "pull yourself together."
- Avoid confrontation unless necessary to prevent harmful acts.

Social support and social engagement are critical components of mental health promotion. Assessment of the social health of an older adult requires listening. It is important to listen to what the older adult feels about the quality of connections, how he/she perceives the support that is available to them (quality of relationships/ satisfaction

with relations) and do they perceive themselves as lonely.

If anxiety is related to poor social health:

- Ask about the social network: who are the significant and rewarding contacts for companionship and assistance.
- Ask about social supports: what kinds of supports the older adult needs and actually gets and by whom.
- Ask about risk factors for social isolation such as living arrangements, family structure, physical health changes, major losses and life transitions.

Action: Information and reassurance

See Section 2.1 *Depression* for more advice about giving support and information. The support and information that is helpful to someone with an anxiety problem is very similar to that given to someone experiencing depression.

You can support the person in the following ways:

- Treat the older adult with respect and dignity
- Do not blame the older adult for their illness
- Have realistic expectations for the older adult
- Offer consistent emotional support and understanding
- Give the older adult hope for recovery
- Provide practical help
- Offer information

What isn't supportive

It is important for the first aider to know that recovery from anxiety problems requires facing situations which are anxiety provoking. Avoiding such situations can slow recovery and make anxiety worse. Sometimes, family and friends think they are being supportive by facilitating the older adult's avoidance of anxiety-provoking situations but can inadvertently slow down the recovery process. Other actions that are also not supportive include dismissing their fears as trivial (for example, by saying, "That is nothing to be afraid of"), telling them to "toughen up" or "don't be so weak," and speaking to them in a patronizing tone of voice.

Action: Facilitate the older adult getting appropriate professional help

For older adults with anxiety and trauma-related disorders, the family doctor is the first to turn to for professional assessment. Facilitating a medical assessment is important because an anxiety or trauma-related disorder in an older adult can significantly impact an older adult's health by increasing the risk of death due to heart disease.[21]

Discuss options for seeking professional help

Ask the older adult if they need help to manage how they are feeling. If they feel they do need help, respond as follows:

- Discuss appropriate professional help and effective treatment options
- Encourage the older adult to use these options
- Offer to help them seek out these options
- Encourage the older adult not to give up seeking appropriate professional help.

What if the older adult doesn't want help?

The older adult may not want to seek professional help. You should find out if there are specific reasons why this is the case. For example, the older adult might be concerned about the cost of the service or about not

having a doctor they like. You may be able to help the person overcome their worries about seeking help. If the older adult still doesn't want help after you have explored their reasons with them, let them know that they can contact you if they change their mind in the future about seeking help. You must respect the older adult's right not to seek help unless you believe that they are at risk of harming themselves or others.

Action: Encourage support for the older adult and caregiver

Older adult

Encourage the older adult to reach out to others who can provide support and share feelings. Encourage the older adult to talk with family, friends and work colleagues.

Facilitate social engagement for the older adult including:[22]

- Educational/cultural events such as theatre, concerts, courses, museums
- Inter-generational activities such as attending sporting events, playing games like cards or bingo and going on pleasurable trips
- Volunteering and civic participation (unpaid work)
- Religious activities (attendance, choirs)
- Paid work
- Community/recreational clubs

If possible, encourage older adults to engage in the community by providing them with transportation and accompany them to social activities.[23] There are several types of social support for older adults including supports that are:

- Instrumental (daily and household chores)
- Physical (personal care)
- Financial (government assistance, subsidies)
- Emotional (companionship)[24]

Social supports for older adults are provided formally (by community services, government agencies, and/or religious organizations), or informally (by family, friends, neighbours, and/or colleagues).[25]

Caregiver

However, supporting an anxious person can be stressful. Do not underestimate the effect on the caregiver's well-being. The caregiver also requires ways of reducing stress (exercise, relaxation techniques, sleep etc.). The caregiver also may require someone to talk to about their experience. Community mental health services can give general support and counseling to not only the older adult but also to their family or caregivers.

Contact local community mental health services to determine types of programs available and how to access them.

Self-help strategies

People who are troubled by anxiety frequently use self-help strategies. The older adult's ability and desire to use self-help strategies will depend on their interests and the severity of their symptoms. Therefore, you should not be too forceful when trying to encourage the person to use self-help strategies.

Older adults wishing to use self-help strategies should discuss them with a professional. Some self-help strategies may not be suitable for every person with an anxiety problem and people with more severe anxiety problems may need to use self-help strategies in conjunction with medical or psychological treatments.

Action: Self-Care for the first aider

Remember to take care of yourself in your role as a mental health first aider. You may find yourself in the position of being both the caregiver and the mental health first aider, but keep in mind that each fulfils a different need for the older adult.

Refer back to MHFA Actions in Section 1 of this Reference Guide for a reminder about the importance of taking care of yourself as the older adult's first aider, and for a list of how-to suggestions for good self care practices.

Resources

MACANXIETY RESEARCH CENTRE

www.macanxiety.com

MacAnxiety Research Centre website has information and resources about anxiety-related disorders.

ANXIETY CANADA
www.anxietycanada.ca

This website provides information on anxiety-related disorders, links to provincial societies and other useful organizations and pharmaceutical companies.

MINDYOURMIND.CA
www.mindyourmind.ca

Mindyourmind.ca is an innovative award-winning internet resource for youth who are looking for relevant information on mental health and creative stress management.

CANADIAN MENTAL HEALTH ASSOCIATION
www.cmha.ca

The Canadian Mental Health Association is a nationwide charitable organization that promotes the mental well-being and recovery of people experiencing mental health or substance use problems.

Canadian Network for Mood and Anxiety Treatments (CANMAT)
www.canmat.org/di-anxiety.php

CANMAT, a federally incorporated academically based not-for-profit research organization, links healthcare professionals from across Canada with a special interest in mood and anxiety-related disorders. CANMAT offers a variety of information for the public as well.

CANADIAN PSYCHOLOGICAL ASSOCIATION

www.cpa.ca

The Canadian Psychological Association provides downloadable information sheets on a variety of anxiety and panic disorders.

COGNITIVE BEHAVIOUR THERAPY ONLINE
www.moodgym.com.au

CBT Online is an interactive site that teaches people to use ways of thinking that will help to prevent depression. It is based on cognitive behaviour therapy.

CENTRE FOR ADDICTION AND MENTAL HEALTH
www.camh.ca

The Centre for Addiction and Mental Health (CAMH) is an addiction and mental health teaching hospital in Toronto. Under "Health Info/ Mental Illness and Addiction Index," there are resources on anxiety-related disorders, concurrent disorders and substance use.

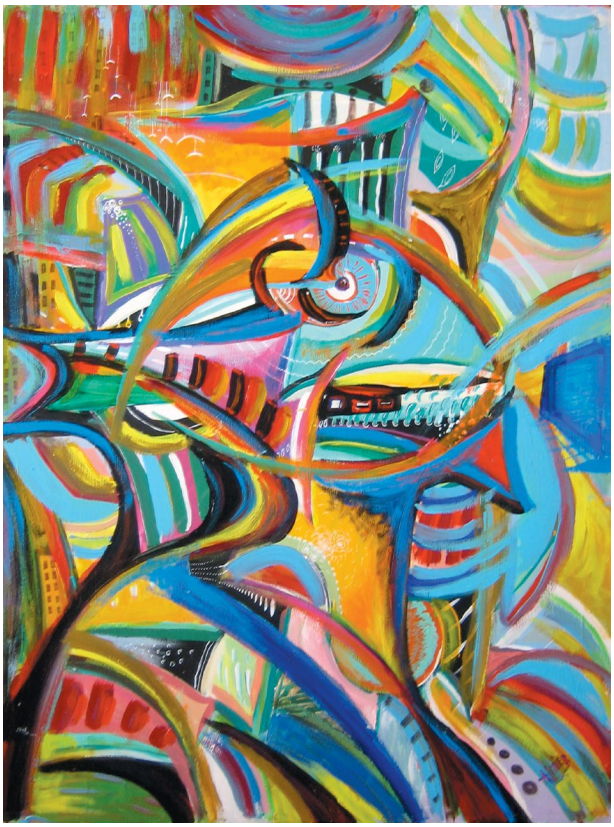
SELF-HELP BOOKS

Bourne, E. J. (2020). *The anxiety and phobia workbook* (7th edition). New Harbinger Publications.

A self-help book based on cognitive behaviour therapy.

Benson, H. (1985). *Beyond the relaxation response: How to harness the healing power of your personal beliefs.* Berkley Mass Market.

2.3 Psychosis



Metamorphosis of the Kselotia

The artist feels someone is looking at him and that he is under surveillance by outside, alien forces that are hunting him, stalking him and changing his brain. His thinking is very fragmented and he feels perplexed and frustrated. Something is projecting a strange energy that is influencing his perceptions. (Note: there is a touch of mania influencing the art as well.)

What is psychosis?

Psychosis is a general term to describe a mental health problem in which an older adult has lost some contact with reality. It is characterized by severe disturbances in thinking, emotion and behaviour. Psychosis can severely disrupt an older adult's life. Relationships, work, self-care and other usual activities can be difficult to initiate or maintain.

Psychotic disorders are less common than other mental illnesses, affecting around 0.45% of adults in any one year (V. A. Morgan et al., 2012).

When older adults experience the onset of new symptoms of psychosis, it is most likely to be the result of a mental health problem:

- Neurocognitive disorders (delirium and the various dementias)
- Mood-related disorders (depression and mania)
- Drugs/substances (for example, levodopa for Parkinson's disease, alcohol withdrawal)
- Schizophrenia

Older adults usually experience psychosis in episodes. An episode can involve the following phases, which vary in length from person to person.

- **Premorbid (at risk phase) –** the person does not experience any symptoms but has risk factors for developing psychosis.
- **Prodromal (becoming unwell phase) –** the person has some changes in their emotions, motivation, thinking and perception or behaviour as described in the box below. The prodrome cannot be diagnosed and is only identifiable in retrospect. During the prodromal phase, it may be uncertain whether the person is developing a psychotic disorder or another more common mental illness.
- **Acute (psychotic phase) –** the person is unwell with psychotic symptoms such as delusions, hallucinations, disorganized thinking and reduction in ability to work, study or maintain social relationships.

- **Recovery –** this is an individual process the person goes through to attain a level of well-being.
- **Relapse –** the person may only have one episode in their life or may go on to have other episodes.

Some people have a single episode of psychosis. However, most people have multiple episodes with either full recovery between episodes or partial recovery between episodes. Around a third have a continuous illness (V. A. Morgan et al., 2012).

Signs and symptoms when psychosis is developing

Abrupt onset of symptoms of psychosis in older adults, particularly visual hallucinations that are frightening with lack of understanding of their unreality, requires immediate medical assessment because of the high likelihood of an underlying acute medical condition or new medication causing the psychotic symptoms as symptoms of a delirium.[6]

Changes in emotion and motivation
(Edwards & McGorry, 2002)

Depression; anxiety; irritability; suspiciousness; blunted, flat or inappropriate emotion; change in appetite; reduced energy and motivation.

Changes in thinking and perception

Difficulties with concentration or attention; sense of alteration of self, others or outside world (e.g., feeling that self or others have changed or are acting differently in some way); odd ideas; unusual perceptual experiences (e.g., a reduction or greater intensity of smell, sound or colour).

Changes in behaviour

Sleep disturbance; social isolation or withdrawal; reduced ability to carry out work or social roles.

Although these signs and symptoms may not be very dramatic on their own, when they are considered together, they may suggest that something is not quite right. It is important not to ignore or dismiss such warning signs and symptoms, even if they appear gradually and are unclear. It should not be assumed that the person is just going through a phase or misusing alcohol or other drugs, or that the symptoms will go away on their own.

The signs and symptoms of psychosis may vary from person to person and can change over time. It is also important to consider the spiritual and cultural context of the person's behaviours, as what is interpreted as a symptom of psychosis in one culture may be considered to be normal in another culture.

People experiencing the early stages of psychosis often go undiagnosed for a year or more before receiving treatment. A major reason for this is that psychosis often begins in late adolescence or early adulthood and the early signs and symptoms involve behaviours and emotions that are common in this age group.

For 65% of people with psychosis, their first episode occurs before the age 25 years (V. A. Morgan et al., 2012). Many young people will have some of these symptoms without developing psychosis. Others showing these symptoms will eventually be diagnosed as having one of the following disorders.

Mental illnesses where psychosis can occur

Schizophrenia

The mental illness in which psychosis most commonly occurs is schizophrenia. Contrary to common belief, schizophrenia does not mean "split personality." The term schizophrenia comes from the Greek for "fractured mind" and refers to changes in mental function where thoughts and perceptions become disordered.

The major symptoms of schizophrenia include:

- **Delusions.** These are false beliefs, for example of persecution, guilt, having a special mission or being under outside control. Although the delusions may seem bizarre to others, they are very real to the person experiencing them.
- **Hallucinations.** These are false perceptions. Hallucinations most commonly involve hearing voices, but can also involve seeing, feeling, tasting or smelling things. These are perceived as very real by the person but are not actually there. The hallucinations can be very frightening, especially voices making negative comments about the person. The person may hear more than one voice or experience many types of hallucinations. Because their delusions and hallucinations are so real to them, it is common for people with schizophrenia to be unaware they are ill.
- **Thinking difficulties.** There may be difficulties in concentration, memory and ability to plan. These make it more difficult for the person to reason, communicate and complete daily tasks.
- **Loss of drive.** The person lacks motivation even for self-care. It is not laziness.
- **Blunted or inappropriate emotions.** The person does not react to the things around them or reacts inappropriately. Examples include speaking in a monotone voice, lack of facial expressions or gestures, lack of eye contact or reacting with anger or laughter when these are not appropriate.
- **Social withdrawal.** The person may withdraw from contact with other people, even family and close friends. There may be a number of factors that lead to this withdrawal such as loss of drive, delusions that cause fear of interacting, difficulty concentrating on conversations and loss of social skills.

Most people experience the onset of schizophrenia between the ages of 15 to 30 years, thus coinciding with the main period of social and educational achievement in life. For people with schizophrenia, onset of the disorder occurred before the age of 30 for 77% of people, before the age of 20 for 41%, and before the age of 10 for 4% (Häfner, 1998). The onset of the illness may be rapid, with symptoms developing over several weeks, or it may be slow and develop over months or years.

Psychotic depression

Sometimes depression can be so intense that it can cause psychotic symptoms. An older adult with psychotic depression will also experience delusions and hallucinations, the content of which is based around beliefs that the person is very inadequate, very guilty about something that is not their fault, severely physically ill, deserves punishment or is being persecuted or observed. Some people may also experience hallucinations, most commonly hearing voices.

Bipolar disorder with psychosis

(Müller-Oerlinghausen et al., 2002)

The depression experienced by an older adult with bipolar disorder has some or all of the symptoms of depression listed previously in Section 2.1 *Depression.* This section also

lists symptoms of mania. If in addition to these symptoms of mania an older adult experiences delusions and hallucinations, this is called psychotic mania. This involves grandiose beliefs about the person's abilities or invulnerability, e.g., the person has special powers or is an important religious figure. The person may also experience suspiciousness or paranoia, e.g., about other people doubting their powers. The person will also have a lack of insight. They may be so convinced that their manic delusions are real that they do not realize they are ill.

Schizoaffective disorder

Sometimes it is difficult to tell the difference between schizophrenia and bipolar disorder because the person has symptoms of both illnesses. An older adult with schizoaffective disorder has symptoms of psychosis and depression but does not meet the criteria for bipolar disorder.

Drug-induced psychosis

This is a psychosis brought on by intoxication with drugs or withdrawal from drugs or alcohol. The symptoms usually appear quickly and last a short time (from a few hours to a few days) until the effects of the drug wears off. The most common symptoms are visual hallucinations, disorientation and memory problems. Both legal and illegal drugs can contribute to a psychotic episode, including marijuana (cannabis), alcohol, cocaine, amphetamines (speed and ice), hallucinogens, inhalants, opioids, sedatives, hypnotics and anxiolytics (American Psychiatric Association, 2013).

Substance use and psychosis

People with psychotic disorders have very high rates of substance use. These problems with alcohol and illicit drugs contribute to poorer functioning, increased risk of relapse and increased risk of health problems (V. A. Morgan et al., 2012).

Risk factors for psychotic disorders

The following factors may predispose vulnerable older adults to developing psychosis.

- Increasing age – may be more pronounced in women
- Neurological[17] and medical illnesses causing dementia[18] and delirium[19] particularly in those who are more vulnerable due to:
  - sensory deficits[20] (impaired vision or hearing) and/or
  - social isolation[21]
- Medications – especially those with dopaminergic[22] (for Parkinson's disease) or anticholinergic activity (for overactive bladder)[23]
- Genetics

Risk factors for schizophrenia

(Tandon et al., 2008)

The most significant risk factors are:

- **Having a close relative with schizophrenia.** For someone with a parent or sibling with schizophrenia, the risk is around 10-15%. Although the risk is higher, it is important to note that 85-90% will not develop schizophrenia.
- **Male sex.** Biologically sexed boys and men are more likely to develop schizophrenia and tend to have an earlier age of onset.
- **Urban living.** People who are born and grow up in urban areas are at higher risk than people from rural areas. The reason is unknown but could be related to differences in the health of mothers during pregnancy, cannabis use or social stressors.

- **Migration.** People who are immigrants or the children of immigrants have increased risk. The reason is unknown, but social stress from feeling like an outsider could be a factor.
- **Cannabis use.** Cannabis use during adolescence increases risk, particularly in people who have other risk factors (Arseneault et al., 2004).

While there are a large number of possible risk factors for schizophrenia, these are thought to affect the development of the brain early in life and lead to changes in levels of the neurotransmitter (chemical messenger) dopamine (Di Forti et al., 2007). Antipsychotic medications that are used for schizophrenia work by altering dopamine levels in the brain.

Risk factors for bipolar disorder

The risk factors for bipolar disorder have been listed previously in Section 2.1 *Depression*.

Interventions for psychotic disorders

Professionals who can help

A variety of health professionals can provide help to an older adult with psychosis. They are:

- Family doctors
- Psychiatrists
- Mental health nurses
- Psychologists
- Occupational therapists and social workers with mental health training
- Counsellors
- Case managers.

Treatments available for psychosis

There are two aspects of professional help for psychosis that need to be considered. The first is medication and the second is treatments to improve outcomes and maximize quality of life.

Medication is very important to the management of a psychotic illness. Different psychotic illnesses require different medications, which are described below. An older adult with a psychotic illness will need to work closely with their doctors to determine the best medications to effectively manage the illness with a minimum of side effects. An older adult who is experiencing severe psychosis may benefit from a short stay in the hospital to get back on track.

Psychiatrists, psychologists, counsellors and other mental health and substance use professionals may be able to help improve quality of life by helping the older adult to learn to accept their illness, facilitate employment or education opportunities and help to maintain good family and social relationships. They may also be able to provide psychoeducation to the older adult and their family to promote good understanding and illness management strategies.

The pattern of recovery from psychosis varies from person to person. Some older adults recover quickly with intervention while others may require support over a longer period. Recovery from the first episode usually takes a number of months. If symptoms remain or return, the recovery process may be prolonged. Some older adults experience a difficult period that lasts for months or even years before effective management of psychotic episodes is achieved. Most people recover from psychosis and lead satisfying and productive lives.

Schizophrenia treatments

(Tandon et al., 2008)

In the past people with schizophrenia were considered to have a chronic illness with no hope of recovery. It is now known that people who get proper treatment can lead productive and fulfilling lives. In fact, research has demonstrated that recovery is possible for many people who are treated with medications and psychosocial rehabilitation programs. For those who are assisting people with schizophrenia and other psychotic disorders to recover, it is important that they approach this work in the spirit of partnership and with optimism. They need to live in a stable and secure social environment. This includes a pleasant home environment, support from family and friends, an adequate income and a meaningful role in society (McGorry et al., 2003). There is evidence that the following specific treatments help people with schizophrenia:

- **Antipsychotic medications**
  These are effective for psychotic symptoms such as delusions and hallucinations. However, they may have side effects such as lack of motivation, poor memory and problems with concentration. Antipsychotic medications can sometimes lead to weight gain and associated physical health problems such as diabetes, so an older adult taking this type of medication needs to have their physical health closely monitored.
- **Antidepressant medications.** People with schizophrenia may have depression symptoms as well. Antidepressants are effective for treating these symptoms.
- **Physical health checks.** People with schizophrenia often have poor physical health and may die prematurely as a result of preventable or treatable illnesses. It is important to have ongoing physical health checkups with a GP.
- **Psychoeducation** refers to education and empowerment of the person and their family about their illness and how best to manage it, which helps to reduce relapses. Family tension, a common result of trying to deal with a poorly understood disability, may contribute to a relapse in the person with schizophrenia, and psychoeducation can help to avoid this.
- **Cognitive behaviour therapy.** This type of psychological therapy can help reduce psychotic symptoms by helping the person to develop alternative explanations of the symptoms of schizophrenia, reducing the impact of the symptoms on their life, and encouraging the person to take their medication.
- **Social skills training** is used to improve social and independent living skills.
- **Assertive community treatment** is an approach for people experiencing more severe illness. The care of the person is managed by a team of various kinds of health professionals such as a psychiatrist, nurse, psychologist and social worker. Care is available 24 hours a day and is tailored to the person's individual needs. Support is provided to family members as well. Assertive community treatment has been found to reduce relapses and the need for hospitalization.

Bipolar disorder treatments

The treatments for bipolar disorder have been listed previously in Section 2.1 *Depression.*

Importance of early intervention for psychosis

Early intervention for older adults with psychosis is very important. Research has shown that the longer the delay between the onset of psychosis and the start of treatment, the less likely the older adult is to recover.

Other consequences of delayed treatment include (Edwards & McGorry, 2002):

- Poorer long-term functioning
- Increased risk of depression and suicide
- Slower psychological maturation and slower uptake of adult responsibilities
- Strain on relationships with friends and family and subsequent loss of social supports
- Disruption of study and employment
- Increased use of drugs and alcohol
- Loss of self-esteem and confidence
- Greater chance of problems with the law.

Shared decision-making about treatment for psychotic disorders

Antipsychotics are important for the management of psychotic disorders, in particular, for controlling hallucinations and delusions. However, they are strong medications that do have side effects. The most troubling side effects are weight gain and cardiovascular risk including the onset of metabolic syndrome and diabetes (Galletly et al., 2012). Other side effects include difficulty moving or difficulty staying still, and sleepiness.

Some of the side effects can be reduced with a change in medication or dose, or lifestyle changes (such as healthy diet and exercise), but side effects cannot be eliminated entirely. A recent Australian study showed over three-quarters of people using antipsychotic medications experienced side effects, and three out of five reported that those side effects impacted their ability to function normally in day-to-day life on daily functioning (Morrison et al., 2012).

Unfortunately, side effects are the main reason people stop taking medication. Choosing not to take medication is a major factor in relapse. There is some evidence to show that medications become less effective when people stop taking them and start again.

For this reason, it is important to negotiate the best treatments with a skilled clinician and discuss the various risks and benefits with them before making decisions about treatment. Choosing the right medication and reaching agreement on the right dose can take time and requires good communication.

Crises associated with psychosis

Crises that may be associated with psychosis are:

- Experiencing a **severe psychotic state.**
- Showing **aggressive behaviour.**
- Having **suicidal thoughts and behaviours.**

Severe psychotic states

Older adults who live with psychotic disorders can have periods when they become very unwell. They can have overwhelming delusions and hallucinations, very disorganized thinking and bizarre and disruptive behaviours. The older adult will appear very distressed or their behaviours may be disturbing to others. When an older adult is in this state, they can come to harm unintentionally because of their delusional beliefs or hallucinations, e.g., the person believes they have special powers to protect themselves from danger such as driving through red lights, or the person may run through traffic to try to escape from their terrifying hallucinations.

Aggressive behaviours

A very small percentage of people experiencing psychosis may become violent (Varshney et al., 2016). People with mental health or substance use problems are often portrayed in the media as potentially violent, dangerous or unpredictable. While there is

an increased risk of violence for people who experience psychosis, the use of alcohol or other drugs has a stronger association with violence than do psychotic illnesses (Arseneault et al., 2000; Noffsinger & Resnick, 1999). Many crimes are committed by people who are intoxicated with alcohol or other drugs. The risk of an older adult with a psychotic illness committing an act of violence is greater if they are not being adequately treated or are using alcohol or other drugs.

Suicidal thoughts and behaviours

Psychotic disorders involve a high risk of suicide. Around 67% of people with a psychotic disorder think about suicide at some point in their life and about 50% attempt suicide. Approximately 5% of people with schizophrenia die by suicide. About 6–19% of people with bipolar disorder die by suicide (Beyer & Weisler, 2016). Having concurrent depression or a substance use disorder increases this risk (Arsenault-Lapierre et al., 2004).

The main factors to be taken into account when assessing risk of suicide for people experiencing psychotic symptoms are (Beyer & Weisler, 2016; Hawton et al., 2005):

- Depression
- Previous suicide attempt
- Poor adherence to treatment
- Fears of the impact of the illness on one's mental functions
- Recent loss
- Family history of suicide
- Younger age of onset
- Drug use problems

MHFA Actions for Psychosis

MHFA Actions – ALIFES

A Assess safety: risk of suicide, serious physical deterioration, and/or harm to others

L Listen and communicate nonjudgmentally

I Information and reassurance

F Facilitate the older adult getting appropriate professional help

E Encourage support for the older adult and caregiver

S Self-care for the first aider

Action: Assess safety: risk of suicide, serious physical deterioration, and/or harm to others

Older adults with psychotic disorders are more likely than the general population to experience depressive symptoms, poorer quality of life, hospitalization, and suicide.[24,25] Two factors that may increase the risk of suicide in someone with psychosis are:

1. Hearing voices, which command the older adult to hurt and/or kill him or herself
2. Having multiple psychotic episodes and feeling unable to live with the illness

To help an older adult who is suicidal, refer to section 3.1 *MHFA for Suicidal Thoughts and Behaviours.*

An older adult having a psychotic episode is likely fearful and may become agitated. He or she may perceive the actions of others as threatening and may react in self-defence because of the fear caused by the psychotic experience. During these times, an older adult may be perceived by caregivers as threatening or aggressive. The goal of intervening is to de-escalate the situation by keeping the situation calm and trying to protect everyone's safety, including your own.

How to help an older adult having a psychotic episode

Try to create a calm, non-threatening atmosphere:

- Do not restrict the older adult's movements. Allow the older adult freedom to move around and not feel trapped or threatened.
- Ensure that both of you have easy access to exit the room.
- Make small, slow movements. Avoid nervous behaviour (shuffling feet, fidgeting).
- Talk slowly, quietly, firmly and simply.
- Do not respond to the older adult in an aggressive, hostile, disciplinary or challenging manner.
- Remove distractions (turn off radio, TV, etc.).
- Try to get the older adult to sit down. When people are seated they may feel more at ease and are less likely to lash out. It is best if you are both seated, preferably side-by-side rather than face- to-face (depending on their visual or hearing acuity, it may be better to face them, while still giving them space)).
- If the older adult sits down and you remain standing, the older adult can feel threatened or think that you are trying to be superior.
- Comply with reasonable requests. This will provide the older adult with a feeling that they are somewhat in control. Perhaps you can give or share something to help create some trust, such as food or a non-alcoholic drink.
- Make only promises you can keep. Lying can create an atmosphere of mistrust and add to the older adult's distress.

Express empathy for the older adult's emotional distress. Do not dismiss, minimize or argue with the older adult about their delusions or hallucinations. However, it is important that you do not pretend that the delusions or hallucinations are real for you. If you are part of the older adult's delusion, in a dangerous or unhelpful way, it is best to remove yourself from the situation and get another person to help.

How to assess and assist in a crisis

As you talk with the older adult, be on the lookout for any indications that the person may be in crisis. If you have concerns that the person is in a **severe psychotic state,** find

out how to **assess and assist** this person in Section 3.5 *MHFA for Severe Psychotic States.*

If you have concerns that the older adult is showing **aggressive behaviour,** find out how to **assess and assist** this person in Section 3.8 *MHFA for Aggressive Behaviours.*

If you have concerns that the older adult may be having **suicidal thoughts and behaviours,** find out how to **assess and assist** this person in Section 3.1 *MHFA for Suicidal Thoughts and Behaviours.*

Action: Listen and communicate nonjudgmentally

An older adult who is experiencing profound and frightening changes such as psychotic symptoms will often try to keep them a secret.

The older adult may be behaving and talking differently due to psychotic symptoms. They may also find it difficult to tell what is real from what is not.

What you should try to do:

- Understand the symptoms for what they are
- Empathize with how the older adult feels about their beliefs and experiences.

Things you should not do:

- Do not confront the older adult
- Do not criticize or blame them
- Try not to take their delusional comments personally
- Do not use sarcasm
- Do not use patronizing statements
- Do not state any judgments about the content of those beliefs and experiences.

See Section 2.1 *Depression* for more on nonjudgmental listening and communication.

Dealing with delusions and hallucinations

It is important to recognize that the delusions and hallucinations are very real to the older adult. Because of this, you should not do the following:

- Do not dismiss, minimize or argue with the older adult about their delusions or hallucinations
- Do not act alarmed, horrified or embarrassed by the older adult's delusions or hallucinations
- Do not laugh at the older adult's symptoms of psychosis
- Do not encourage or inflame the older adult's paranoia, if the person exhibits paranoid behaviour.

You can respond to the older adult's delusions without agreeing with them by saying something like: “That must be horrible for you” or “I can see that you are upset.”

Dealing with communication difficulties

Older adults experiencing symptoms of psychosis are often unable to think or communicate clearly. Ways to deal with communication difficulties include:

- Responding to disorganized speech by communicating in an uncomplicated and succinct manner
- Repeating things if necessary
- Being patient and allow plenty of time for the older adult to process the information and respond to what you have said
- Being aware that it does not mean that the older adult is not feeling anything, even if they are showing a limited range of feelings.

- Not assuming the older adult cannot understand what you are saying, even if their response is limited.

Action: Information and reassurance

Treat the older adult with respect and dignity.

It is important to respect the older adult's autonomy while considering the extent to which they are able to make decisions for themselves. Equally, you should respect the older adult's privacy and confidentiality unless you are concerned that the person is at risk of harming themselves or others. It is important that you are honest when interacting with the older adult.

Offer consistent emotional support and understanding

Reassure them that you are there to help and support them, and that you want to keep them safe.

Give the older adult hope for recovery

Convey a message of hope by assuring them that help is available, and things can get better.

Provide practical help

Try to find out what type of assistance they need by asking what will help them to feel safe and in control. If possible, offer the older adult choices of how you can help them so that they are in control. Do not make any promises that you cannot keep. This can create an atmosphere of distrust and add to the older adult's distress.

Offer information

When an older adult is in a severe psychotic state, it is usually difficult and inappropriate to give information about psychosis. When the person is more lucid and in touch with reality, you could ask them if they would like some information about psychosis. If they do want some information, it is important that you give them resources that are accurate and appropriate to their situation.

Action: Facilitate the older adult getting appropriate professional help

Discuss options for seeking professional help

It is important to get the older adult to medical help as early in the illness as possible. The sooner an older adult gets help, the better the outcomes.

You could ask the older adult if they have felt this way before and, if so, what they have done in the past that has been helpful. If the older adult decides to seek professional help, you should make sure that they are supported both emotionally and practically in accessing services. If the older adult does seek help, and either they or you lack confidence in the medical advice they have received, they should seek a second opinion from another medical or mental health professional.

What if the older adult doesn't want help?

The older adult may refuse to seek help even if they realize they are unwell. Their confusion and fear about what is happening to them may lead them to deny that anything is wrong. In this case you should encourage them to talk to someone they trust. It is also possible that an older adult may refuse to seek help because they lack insight that they are unwell. They might actively resist your attempts to encourage them to seek help. In either case, your course of action should depend on the type and severity of the older adult's symptoms.

It is important to recognize that unless an older adult with psychosis meets the criteria for involuntary committal procedures, they cannot be forced into treatment. If they are not at risk of harming themselves or others, you should remain patient, as people

experiencing psychosis often need time to develop insight regarding their illness. Never threaten the older adult with mental health legislation or hospitalization. Instead remain friendly and open to the possibility that they may want your help in the future.

Action: Encourage supports for the older adult and caregiver

Other people who can help

Try to determine whether the older adult has a supportive social network and, if they do, encourage them to utilize these supports.

Family and friends are an important source of support for an older adult experiencing a psychotic illness. An older adult is less likely to relapse if they have good relationships with family (Pharoah et al., 2010).

Family and friends can help by:

- Listening to the older adult without judging or being critical
- Keeping the older adult's life as stress free as possible to reduce the chance of relapse
- Encouraging the older adult to get appropriate treatment and support
- Checking if the older adult is feeling suicidal and taking immediate action if they are suicidal
- Providing the same support as they would for a physically ill person—this can include sending get-well cards, flowers, phoning or visiting the older adult, and offering help with basic chores
- Having an understanding of psychosis
- Looking for support from a carers' support group
- Helping the older adult to develop an Advance Care Directive, wellness plan, relapse prevention plan or personal directive (see below).

Support groups can be helpful to the older adult experiencing psychosis and to their friends and family.

What is an Advance Care Directive?

An Advance Care Directive is a document describing how the person wants to be treated when they are unable to make their own decisions due to their present state of illness. This is an agreement made between the person, their family, and hopefully their usual healthcare professional. It is not usually a legal document, but this varies between states and territories.

What is an Enduring Power of Attorney?

An Enduring Power of Attorney is a legal agreement where an older adult appoints someone of their choice to manage their legal and financial affairs. This is developed when an older adult is of sound mind. As the agreement is "enduring," it will continue to apply if the person becomes unable to make their own decisions (legally described as being of "unsound mind").

What is an Enduring Power of Guardianship?

An Enduring Power of Guardianship is a legal agreement where an older adult appoints someone of their choice to manage, where necessary, medical and welfare decisions on their behalf. It only comes into effect when the person becomes unable to make their own decisions.

Self-help strategies

Older adults experiencing psychosis should avoid the use of alcohol, cannabis and other drugs. Older adults sometimes take substances as a way of coping with a developing psychotic illness, but these drugs can make the symptoms worse, initiate relapse and make the disorder difficult to diagnose (Phillips & Johnson, 2001). The use

of cannabis can also slow down recovery (Linszen et al., 1994).

Many older adults experiencing psychosis also have a depressive or anxiety disorder. Many of the self-help strategies recommended for depression and anxiety are also appropriate for people with psychosis. However, they should not be used as the main form of assistance. Mental health professionals must be consulted.

Not all self-help strategies are suitable for all older adults with psychotic illnesses; for example, SAMe may trigger mania in people with bipolar disorder (Therapeutic Goods Administration, 2001). The benefits of exercise for depression have been well studied, but little research has been done on exercise for bipolar disorder. Older adults with bipolar disorder may benefit from an exercise regime but should be wary when there are warning signs of a manic episode. If exercise appears too stimulating during those times, decreasing the frequency or intensity of exercise may be a good idea.

Caregiver

Dealing with an older adult who experiences psychosis can be difficult. Caregivers should seek out emotional comfort from family and friends as well as tangible assistance in the form of help in obtaining services and receiving training to optimize performance of caregiving activities.

Caregivers should practice self-care.

Action: Self-Care for the first aider

Remember to take care of yourself in your role as a mental health first aider. You may find yourself in the position of being both the caregiver and the mental health first aider, but keep in mind that each fulfils a different need for the older adult.

Refer back to MHFA Actions in Section 1 of this Reference Guide for a reminder about the importance of taking care of yourself as the older adult's first aider, and for a list of how-to suggestions for good self care practices.

2.4 Substance Use Problems

Blown Away

"At certain times in my life it seemed that the only answer to problems and the way out of them was to use a substance. It was as though I was standing behind the thrusters of a rocket that could blow me away."

What are substance use problems?

Not all older adults who use a substance will have substance use problems. Substance use problems occur when an older adult is using alcohol or other drugs at levels that are associated with short-term or long-term harm. Substance use problems are not just a matter of how much of a substance an older adult uses, but how their use affects their life and those around them.

For an older adult to have a substance use disorder, their substance use problems must have an adverse effect on their life during the past year in two or more of the following areas (American Psychiatric Association, 2013):

- The substance is often taken in larger amounts or for a longer period than intended
- The person wants to cut down use but finds this difficult
- A lot of time is spent obtaining the substance, using it or recovering from its effects
- Craving (i.e., a strong urge) to use the substance
- Repeated use that affects their ability to fulfil their work, school or home responsibilities, e.g., repeated absences from work, poor work performance, neglect of children or household
- Repeated use despite this causing on-going problems with other people, e.g., arguments, fights
- Other important activities are neglected because of substance use
- Repeated use in situations where it is physically hazardous, e.g., driving a car or using machinery while affected by a substance
- Continued use despite knowing that the older adult has a mental or physical health problem caused by the substance
- Tolerance for the substance, i.e., the older adult needs to use increasing amounts to get the desired effect or they get less effect with the same amount of the substance
- Withdrawal symptoms or the substance is needed to avoid withdrawal symptoms.

Substance use disorders often co-occur with depressive, bipolar, anxiety and psychotic disorders. People with a psychotic disorder are over twice as likely to have an alcohol use disorder and six times as likely to have a drug use disorder compared to people without a psychotic disorder (V. A. Morgan et al., 2012). People with an anxiety or depressive disorder are three times as likely to have a substance use disorder (Teesson et al., 2009). One reason

for this is that many people use alcohol or other drugs to relieve unpleasant emotions (Gregg et al., 2007). However, alcohol or other drugs can also cause other problems in an older adult's life (e.g., relationship or financial problems), and heavy use may contribute to or exacerbate a mental illness.

Alcohol use problems

Alcohol makes people less alert and impairs concentration and coordination. Some older adults use alcohol to reduce anxiety, and, in the short term, it can be helpful in this regard. In small quantities, alcohol causes older adults to relax and lower their inhibitions. They can feel more confident and people often become more extroverted when using alcohol. However, alcohol use can produce a range of short-term and long-term problems.

Short-term problems caused by alcohol intoxication

(National Health and Medical Research Council, 2009)

When an older adult is intoxicated, they are at risk of a number of problems, such as:

- **Physical injuries.** People are more likely to engage in risky behaviour which can lead to injury or death. Alcohol is a big contributor to traffic accidents. Also, alcohol intoxication can in itself cause poor motor co-ordination resulting in staggering or falling and slurred speech, and even to medical emergencies such as continual vomiting or unconsciousness.
- **Aggression and antisocial behaviour.** People can become aggressive and are at a much higher risk of committing crimes.
- **Sexual risk taking and unplanned sexual contact.** People are more likely to engage in unsafe sex practices while affected by substances. People may engage in sexual activity that they wouldn't agree to while sober. Sexual risk taking may result in unwanted pregnancy or sexually transmitted infections.
- **Becoming a victim of crime.** While affected by alcohol and other drugs, people are at an increased risk of becoming victims of violent crime, including physical or sexual assault.
- **Suicide and self-injury.** When an older adult is intoxicated, they are more likely to act on suicidal thoughts or injure themselves. Alcohol increases risk in several ways. It acts as a mood amplifier, intensifying feelings of anxiety, depression or anger. It also reduces inhibitions and inhibits the use of more effective coping strategies.

Long-term problems caused by alcohol use

(National Health and Medical Research Council, 2009)

With heavy and prolonged use, alcohol can cause physical, psychological and social problems.

- **Alcohol use disorders.** People who regularly drink alcohol above the recommended levels (see below), particularly those who start at an early age, have an increased risk of developing an alcohol use disorder.
- **Other substance use disorders.** People who use alcohol are more likely to be introduced to other drugs.
- **Depression and anxiety.** Heavy alcohol use increases risk of depression and anxiety. If an older adult is feeling suicidal, they are more likely to attempt suicide when under the effect of alcohol.
- **Social problems.** Misuse of alcohol is associated with family conflict, dropping out of school, unemployment, social isolation and legal problems.
- **Physical health problems.** In the long term, heavy use of alcohol can produce problems

such as liver disease, brain damage, heart impairment, cancers, diabetes, muscle weakness, pancreatitis, ulcers and gastro-intestinal bleeding, nerve damage to hands and feet, weight gain and risks to unborn babies.

How much is too much?

Many people drink alcohol and, in low doses, doing so may not lead to any damage to their health (National Health and Medical Research Council, 2009).

For healthy men and women aged 18 years and over:

- Drinking no more than two standard drinks on any day reduces the lifetime risk of harm.
- Drinking no more than four standard drinks on a single occasion reduces the risk of alcohol-related injury arising from that occasion.

For women who are pregnant, are planning a pregnancy or are breastfeeding:

- Not drinking is the safest option.

Measuring drinks

A standard drink contains about 10 grams of alcohol. The average time taken by the human liver to break down 10 grams of alcohol is one hour.

Drinking Guidelines

Information on safe drinking can be provided by referring to *The Canadian Guidelines on Low-Risk Alcohol Drinking*[18,19] which provide a "low risk," but not a "no-risk" guideline for daily and weekly alcohol consumption. Low-risk drinking helps to promote a culture of moderation and supports healthy lifestyles.

The Canadian Guidelines on Low-Risk Alcohol Drinking recommend reducing long-term health risks by drinking no more than 10 drinks a week for women, with no more than 2 drinks a day most days; and 15 drinks a week for men, with no more than 3 drinks a day most days. However, the guidelines do not provide any specific recommendations for older adults.

In the United States, *The National Institute on Alcohol Abuse and Alcoholism Drinking Guidelines for Older Adults*[20] recommends that older adults who are healthy and not taking medications should have no more than 7 drinks in a week, and 3 drinks on a given day. If an older adult has a health problem or take certain medications, he/she may need to drink less or not at all, as these older adults may experience negative health consequences from even moderate quantities of alcohol consumption (e.g., 1-2 drinks on most days).[21,22,23]

Drug use problems

There is a wide variety of other drugs that can cause problems and lead to substance use disorders.

Cannabis (marijuana)

Cannabis is a mind-altering drug and is a mixture of dried, shredded leaves, stems, seeds, and flowers of the hemp plant. The main active chemical in cannabis is THC (delta-9-tetrahydrocannabinol). The effects of cannabis vary depending on how much THC a cannabis product contains. The THC content of cannabis has been increasing since the 1970s. Use of cannabis can interfere with performance at work or at school and lead to increased risk of accidents if used whilst driving. Long-term heavy use of cannabis has been found to produce abnormalities in certain parts of the brain (Yücel et al., 2008).

People who use cannabis are more likely to experience a range of other mental health and substance use problems, including anxiety and depression, but it is unclear which comes first. Also, cannabis use by adolescents and

young adults has been found to increase the risk of developing schizophrenia, particularly in older adults who are vulnerable because of a personal or family history of schizophrenia (Arseneault et al., 2004).

Opioid drugs (including heroin)

Opioid drugs include heroin, morphine, opium and codeine. Heroin is processed from morphine, which is a naturally occurring substance taken from the Asian poppy plant. Heroin produces a short-term pain relief and feelings of euphoria and well-being. Most people who are dependent on heroin also have associated problems such as depression, alcohol dependence and criminal behaviour. People who use heroin are at higher risk for suicide.

Pharmaceutical drugs used for nonmedical purposes

A number of prescription drugs, such as those used to treat anxiety and sleep problems, are used by some people for nonmedical purposes. Even when used under prescription, some people will become dependent on these medications after long-term use. Older people are the most likely to be affected. Long-term use of these medications can increase the risk of falls and cognitive impairment in older people.

Cocaine

Cocaine is a highly addictive stimulant drug. Although sometimes thought of as a modern drug problem, cocaine has been misused for more than a century, and the coca leaves from which it is made have been used for thousands of years. Cocaine gives very strong euphoric effects and people can develop dependence after using it for a very short time. With long-term use people can develop mental health and substance use problems such as paranoia, aggression, anxiety and depression. Cocaine can bring on an episode of drug-induced psychosis.

Amphetamines (including methamphetamine)

Amphetamines belong to a category of stimulant drugs and have the temporary effect of increasing energy and apparent mental alertness. However, as the effect wears off, an older adult may experience a range of problems including depression, irritability, agitation, increased appetite and sleepiness. Amphetamines come in many shapes and forms and are taken in many ways. They can be in the form of powder, tablets, capsules, crystals or liquid. **Methamphetamine** (meth) has a chemical structure similar to that of amphetamine, but it has stronger effects on the brain. The effects of methamphetamine can last 6-8 hours. After the initial "rush," there can be a state of agitation, which can lead to violent behaviour in some individuals.

A particular mental health and substance use risk is amphetamine psychosis or "speed psychosis," which involves symptoms similar to schizophrenia. The older adult may experience hallucinations, delusions and uncontrolled violent behaviour. The older adult will recover as the drug wears off but is vulnerable to further episodes of drug-induced psychosis if the drug is used again.

Some types of amphetamines have legitimate medical uses. They are used under prescription to treat attention-deficit/hyperactivity disorder and other medical conditions.

Hallucinogens

Hallucinogens are drugs that affect an older adult's perceptions of reality. Some hallucinogens also produce rapid, intense emotional changes. A particular problem associated with hallucinogens is flashbacks, where the older adult re-experiences some of

the perceptual effects of the drug when they have not been recently using it.

Ecstasy

Ecstasy (MDMA) (also known as "E") is a stimulant drug that also has hallucinogenic properties. Some people use it at dance parties. Users can develop an adverse reaction that in extreme cases can lead to death. To reduce this risk, users need to maintain a steady fluid intake and take rest breaks from vigorous activity. While intoxicated, ecstasy users report that they feel emotionally close to others. When coming off the drug they often experience depressed mood. The long-term effects of using ecstasy are of particular concern.

It is important to note that while ecstasy refers to the drug MDMA, the pills or powders people buying off the street may contain other substances–drugs or harmful chemicals.

Inhalants

Inhalants are breathable chemical vapours that produce mind-altering effects. The effects of inhalants range from an alcohol-like intoxication and euphoria to hallucinations, depending on the substance and the dosage. Use of inhalants also starves the brain of oxygen, causing a brief "rush." Typical Inhalants include solvents (e.g., paint thinners, petrol, glues), gases (e.g., aerosols, butane lighters), nitrites and other substances. Although people are exposed to volatile solvents and other inhalants in the home and in the workplace, many do not think of inhalable substances as drugs because most of them were never meant to be used in that way. Young people are the most likely to misuse inhalants, partly because inhalants are readily available and inexpensive.

The intentional misuse of common household products to get high can result in fatalities, through "sudden sniffing death" or as a result of long-term use. Addiction is another risk of inhalant use. Young people are usually unaware of the serious health risks and those who start using them at an early age are likely to become dependent on them. These agents destroy cells in the brain, liver and kidneys.

Tobacco

It is possible that tobacco is used as a type of self-medication by some people with mental illnesses in order to improve mood and cognitive functioning.

Signs and symptoms of substance-related disorders in older adults

Signs and symptoms of an alcohol and/or substance related disorder in older adults can include:[6,7]

- Drinking and/or using to calm nerves
- Hiding drinking and/or using habits (drinking or using secretly in isolation)
- Loss of interest in food due to drinking and/or using habits
- Feeling irritable, resentful or unreasonable when not drinking or using
- Medical, social or financial problems caused by drinking or using
- Poor personal care as a consequence of drinking or using

Alcohol and Aging

Aging influences the process by which any drug including alcohol is handled by the body. With aging there is a reduction in total body water, resulting in a potentially increased blood alcohol concentration in older adults for the same amount consumed by a younger adult.[24,25] Slower metabolism of alcohol by the liver results in both potentially increased concentrations and prolonged effects due to longer times required to clear alcohol from the body.[26]

Women are more susceptible than men to the effects of alcohol throughout their lives due to gender differences including less body water than men of similar weight, less muscle mass and lower levels of the enzyme that breaks down alcohol in the stomach. These differences result in a higher blood alcohol concentration in a woman as compared to a man for the same amount consumed. Thus, even at low quantities, older women are particularly sensitive to the effects of alcohol.[27]

Problem Alcohol Use and older adults

Excessive use of alcohol in older adults is often divided into early vs. late onset use. Early-onset refers to older adults who began using alcohol excessively in their youth and continued through life. Late-onset refer to those who drank moderately in adult life and began to drink excessively as older adults.[28] Late-onset drinking develops more commonly in women than men.[29]

Risk factors for substance use problems

Most of our knowledge about the risk factors of substance use disorders relates to alcohol, but the risk factors for drug use disorders are likely similar.

Risk factors for late-onset drinking amongst older adults, both men and women, are mostly social including:

- Living alone
- Lack of a supportive social network with few contacts with friends and family
- Few social activities
- Significant losses such as retirement, death of family/friends and widowhood all resulting in social isolation are particularly high-risk factors.[35]

Older adults are more likely to drink alone than people in other age groups. An older adult with an alcohol related disorder withdraws from others; at the same time others often withdraw from the older adult, compounding his or her social isolation. Older adults who are socially isolated and misusing alcohol or prescription medications likely know they need to get out and socialize, but may not feel able to do so.

Social interactions and attitudes of family and friends helps shape the values and beliefs an older adult holds about the acceptability of alcohol use.[36] Family members and friends may inadvertently support heavy drinking by wanting to avoid conflict thus "enabling" the inappropriate alcohol use. Therefore, without adequate social supports, the risk for heavy drinking increases.

Psychological risk factors for increased alcohol use include difficulty coping with stress whether it is financial, occupational and/or health related. Older adults tend to have more free time and reduced obligations which can also increase feelings of nervousness leading to increased alcohol or substance use.

Social and psychological risk factors for increased alcohol use, particularly amongst older women, include:

- Family conflicts
- History of depression and/or negative life events
- Difficulty coping with stress
- Increased feelings of nervousness[37]

Interventions for substance use problems

Professionals who can help

A variety of health professionals can provide help to an older adult with substance use

disorders. If the older adult is uncertain about what to do, encourage them to consult a GP first. The GP might refer the older adult to a drug or alcohol service, or to a mental health professional if there are other mental health problems.

Treatments available for substance use disorders

Treatments depend on the nature and severity of the problem, how motivated the older adult is to change and what other physical and mental health and substance use problems they also have. Treatment may need to do several things:

- Overcome any physiological dependence on alcohol or drugs
- Overcome any psychological dependence, e.g., use of alcohol or drugs to help the older adult cope with anxiety or depression
- Overcome habits that have been formed, e.g., a social life that revolves around drinking or drug use.

The following treatments are known to be effective (Enoch & Goldman, 2002; Pilling et al., 2007):

- **Brief intervention.** If an older adult is drinking at a level that could damage their health or using drugs, then brief counselling by a GP can help them reduce or stop using. If they have a substance use disorder, seeing a GP can help to motivate them to enter long-term treatment. This type of intervention generally takes four or fewer sessions, each lasting from a few minutes up to an hour. The GP looks at how much the older adult is using, gives information about risks to their health, advises them to cut down, discusses the advantages and disadvantages of changing and options for how to change, motivates the older adult to act by emphasizing personal responsibility and monitors progress. In doing these things, the GP adopts an empathic rather than a coercive approach.
- **Withdrawal management.** If the older adult is dependent on alcohol or drugs, they will have to withdraw from the substance before other treatments commence. This should be done under professional supervision. However, withdrawal is not enough and should be combined with other treatments to prevent the older adult from relapsing. It is only part of the recovery process and many lifestyle changes are required to change behaviours associated with drinking or drug use.
- **Psychological treatments.**
  - **Cognitive behaviour therapy** which teaches the older adult how to cope with craving and how to recognize and cope with situations that might trigger relapse. To get the full benefit of cognitive behaviour therapy, an older adult needs to have a sufficient number of sessions. As a guide, around 12 sessions are recommended (Crome & Baillie, 2016).
  - **Motivational enhancement therapy** which helps motivate and empower an older adult to change. It allows the older adult to consider the gains they receive from using substances, while helping to improve their awareness of the negative aspects and consequences of their use and to identify reasons to choose not to use.
  - **Contingency management** is used with people who have a drug use disorder and involves offering the older adult incentives such as shopping vouchers or privileges for negative drug test results or for harm reduction actions such as having a hepatitis or HIV test.
- **Medications.** There are a number of types of medications that can assist an older adult to stay off substances. For people with an alcohol use disorder, these include

anti-craving medications, medications that give an unpleasant effect if the older adult drinks or medications for the treatment of underlying anxiety and depression. For people dependent on opioid drugs, methadone maintenance therapy is available.

For an older adult with both a substance use disorder and other mental illness

Older adults with a substance use disorder often have another mental illness. Use of the substance may have started as a way to deal with emotional difficulties. This means that it is important that any other mental illness is treated as well, preferably at the same time.

Crises associated with substance use

The main crises that may be associated with substance use are:

- Experiencing severe effects from alcohol use.
- Experiencing severe effects from drug use.
- Showing aggressive behaviours.
- Having suicidal thoughts and behaviours.

Severe effects from alcohol use

If the older adult is using alcohol heavily, it is possible they will experience severe effects from alcohol intoxication, alcohol poisoning or alcohol withdrawal.

- **Alcohol intoxication** substantially impairs the older adult's thinking and behaviour. When intoxicated the older adult may engage in a wide range of risky activities such as having unprotected sex, getting into arguments or fights, or driving a car. The older adult may also be at higher risk of attempting suicide.
- **Alcohol poisoning** is a dangerous level of intoxication that can lead to death. The amount of alcohol that causes alcohol poisoning is different for every older adult.
- **Alcohol withdrawal** refers to the unpleasant symptoms an older adult experiences when they stop drinking or drink substantially less than usual. It is not simply a hangover. Unmedicated alcohol withdrawal may lead to seizures.

Severe effects from drug use

If the older adult is using drugs, it is possible they will experience acute effects from drug intoxication, drug overdose, or overheating or dehydration.

- **Drug intoxication** can lead to impairment or distress, e.g., the older adult may have poor judgment, engage in risky behaviours or become aggressive. The effects vary depending on the type and amount of drug and also vary from person to person. It can be difficult to make a distinction between the effects of different drugs. Illicit drugs can have unpredictable effects, as they are not manufactured in a controlled way.
- **Overdose** occurs when the intoxication level leads to risk of death.
- **Overheating or dehydration** can occur with prolonged dancing in a hot environment (such as a dance party) while on some drugs (e.g., ecstasy) without adequate water intake. This causes the older adult's body temperature to rise to dangerous levels.
- **Sudden sniffing death** may occur with inhalant use, due to heart failure. This is more likely if the older adult becomes agitated or engages in physical exertion, e.g., the older adult gets a fright and runs away.

Aggressive behaviours

There is an increased risk of aggression to others for people who experience substance use problems (Arseneault et al., 2000). Many

crimes are committed by people who are intoxicated with alcohol or other drugs.

Suicidal thoughts and behaviours

There is also increased risk of suicide. Of people who have a substance use disorder in the past 12 months, approximately 3% attempt suicide, compared to 0.4% of the population as a whole. Of all persons who die by suicide, 26% have a substance use disorder (Arsenault-Lapierre et al., 2004).

MHFA Actions for Substance Use

MHFA Actions – ALIFES

A Assess safety: risk of suicide, serious physical deterioration, and/or harm to others

L Listen and communicate nonjudgmentally

I Information and reassurance

F Facilitate the older adult getting appropriate professional help

E Encourage support for the older adult and caregiver

S Self-care for the first aider

Action: Assess safety: risk of suicide, serious physical deterioration, and/or harm to others

Assess safety: risk of suicide

An older adult dealing with a substance use problem can be at risk for harm in numerous ways. If an older adult is thinking of suicide, alcohol will increase the chance they will harm themselves or die by suicide.

Mental health disorders, particularly depression, are common in older adults with alcohol use disorders.38 As compared to non-depressed individuals who misuse alcohol, older adults with depression together with an alcohol use disorder tend to have more social problems and an increased risk of suicide.39 If an older adult is feeling suicidal, he or she is more likely to attempt suicide if under the influence of alcohol. Periods following a psychosocial loss, such as a separation, divorce, death or even loss of employment pose an increased risk for suicide when coupled with alcohol or substance misuse.40 Threats of suicide while intoxicated require emergency medical intervention. Thoughts of suicide without intoxication require ensuring safety with removal of access to alcohol and substances. Access to medications should be under supervision and social isolation should be

addressed. If needed, call for emergency medical intervention.

Assess safety: risk of serious physical deterioration

Alcohol withdrawal also poses a risk for serious health consequences. The late complication (day 3-7) of inadequately treated alcohol withdrawal is called delirium tremens (DTs); the most severe form of alcohol withdrawal resulting in obvious confusion, body tremulousness and racing heart rate which is a life threatening condition requiring emergency medical attention.

Assess safety: harm to others

Alcohol and other drug or substance misuse can make older adults more prone to aggression and other disorderly behaviour. Mental health first aiders should ensure their own safety by avoiding disagreements or arguments with intoxicated older adults.41

How to assess and assist in a crisis

As you talk with the older adult, be on the lookout for any indications that the older adult may be in crisis.

If you have concerns that the older adult is experiencing severe effects from **alcohol use** (intoxication, alcohol poisoning or severe withdrawal), find out how to **assess and assist** this older adult in Section 3.6 *MHFA for Severe Effects from Alcohol Use.*

If you have concerns that the older adult is experiencing severe effects from **drug use** (drug intoxication, overdose, overheating or dehydration), find out how to **assess and assist** this older adult in Section 3.7 *MHFA for Severe Effects from Drug Use.*

If you have concerns that the older adult is exhibiting **aggressive behaviours,** find out how to **assess and assist** this older adult in Section 3.8 *MHFA for Aggressive Behaviours.*

If you have concerns that the older adult may be having **suicidal thoughts and behaviours,** find out how to **assess and assist** this older adult in Section 3.1 *MHFA for Suicidal Thoughts and Behaviours.*

Action: Listen and communicate nonjudgmentally

See Section 2.1 *Depression* for more tips on nonjudgmental listening and communication. Below are some specific points that apply to talking with an older adult with a substance use problem.

- Treat the older adult with respect and dignity
- Interact with the older adult in a supportive way, rather than threatening, confronting or lecturing them
- Listen to the older adult without judging them as bad or immoral
- Avoid expressing moral judgments about their substance use
- Do not criticize the older adult's substance use. You are more likely to be able to help them in the long term if you maintain a noncritical but concerned approach
- Do not label the older adult, e.g., by calling them a "druggie" or "alcoholic"
- Try not to express your frustration at the older adult for having a substance use problem.

Action: Information and reassurance

Ask the older adult if they would like information about substance use problems or any associated risks. If they agree, provide them with relevant information. Try to find out whether the older adult wants help to change their substance use problem. If they do, offer your help and discuss what you are willing and able to do. Share the phone number for an alcohol and other drug helpline

and perhaps the address of a reputable ¡website (see Helpful resources at the end of this chapter).

Have realistic expectations for the older adult

Do not expect a change in the older adult's thinking or behaviour right away. Bear in mind that:

- Changing substance use habits is not easy.
- An older adult's willpower and self-resolve is not always enough to help them stop substance use problems.
- Giving advice alone may not help the older adult change their substance use.
- An older adult may try to change or stop their substance use more than once before they are successful.
- If abstinence from drinking is not the older adult's goal, reducing the quantity of alcohol consumed is still a worthwhile objective.

The stages of change
(Prochaska et al., 1994)

An older adult who has a substance use problem may not be ready to change. Major changes in behaviour take time and often involve the older adult going through a number of stages. There are five "stages of change," and the older adult may move back and forth between them at different times. The information and support you offer to the older adult can be tailored to their level of readiness, as shown below:

Stage 1: Pre-contemplation – the older adult does not think they have a problem

Give the older adult information about the substance and how it might be affecting them, discuss less harmful ways of using the substance and how to recognize overdose.

Stage 2: Contemplation – the older adult thinks their substance use might be a problem

Encourage the person to keep thinking about quitting, talk about the pros and cons of changing, give information and refer them to a professional.

Stage 3: Preparation – the person has decided to make a change

Encourage the person and support their decision to change and help them plan how they will stop using substances, e.g., talk to a substance use counsellor or GP.

Stage 4: Action – making the change

Provide support by helping the person develop strategies for saying "no" and avoiding people who use substances. Assist them to do other things when they feel like using substances and to find other ways to cope with distress. Encourage the person to get periodic health checks.

Stage 5: Maintenance – keeping up the new habits

Support the person to maintain new behaviours. Focus on the positive effects of not using substances and praise their achievements.

An older adult may relapse once or several times before making long-term changes to their substance use.

Support the older adult who does want to change

Tell the older adult what you are willing and able to do to help. This may range from simply being a good listener to organizing professional help. The sections below offer specific ways to help an older adult who wants to change their alcohol use problem. Some of these suggestions may also be helpful for an older adult with a drug use problem.

Encouraging low-risk drinking

The following strategies may assist the person to adopt low-risk drinking:

- Help the person to realize that only they can take responsibility for reducing their alcohol intake and that although changing drinking patterns is difficult, they should not give up trying.
- Encourage and assist the person to find information on how to reduce the harms associated with their problem drinking.
- If appropriate, inform the person that alcohol may interact with other drugs (illicit, prescribed or over the counter) in an unpredictable way which may lead to a medical emergency.
- Ask the person if they would like some tips on low-risk drinking.

If the person wants to change their drinking behaviour, suggest some of the tips for low-risk drinking in the accompanying box.

Tips for low-risk drinking

- Know what a standard drink is and be aware of the number of standard drinks they consume.
- Know the alcohol content of their drink.
- See if the number of standard drinks is listed on the beverage's packaging.
- Eat while drinking.
- Drink plenty of water while consuming alcohol to prevent dehydration.
- Drink beverages with lower alcohol content, e.g., drinking light beer instead of full-strength beer.
- Switch to non-alcoholic drinks when they start to feel the effects of alcohol.
- Do not let people top up their drink before it is finished, so as not to lose track of how much alcohol they have consumed.
- Avoid trying to keep up with friends drink for drink.
- Avoid drinking competitions and drinking games.
- Drink slowly, for example, by taking sips instead of gulps; put your drink down between sips.
- Have one drink at a time.
- Spend time in activities that don't involve drinking.
- Make drinking alcohol a complementary activity instead of the sole activity.
- Identify situations where drinking is likely and avoid them if practical.

There is often social pressure to get drunk when drinking. Encourage the person to be assertive when they feel pressured to drink more than they want or intend to. Tell the person that they have the right to refuse alcohol. Tell them that they can say "No thanks" without explanation, or suggest different ways they can say "no," such as "I don't feel like it," "I don't feel well" or "I am taking medication." Encourage the person to practice different ways of saying "no." Suggest that saying "no" to alcohol gets easier the more you do it and that the people who care about them will accept their decision not to drink or to reduce the amount they drink.

Supporting the older adult who does not want to change

If an older adult does not want to reduce or stop their substance use, you cannot make them change. It is important that you maintain a good relationship with the person,

as you may be able to influence their use in a positive way. Let the older adult know you are available to talk in the future. You can speak with a health professional who specializes in substance use disorders to determine how best to approach the older adult about your concerns, or you can consult with others who have dealt with such problems about effective ways to help the older adult. You might also discuss with the person the link between their substance use and the negative consequences they are experiencing.

What isn't supportive

If the older adult is unwilling to change their substance use:

- Do not feel guilty or responsible.
- Do not join in using substances with the person.
- Do not use negative approaches (e.g., lecturing or making them feel guilty) as these are unlikely to promote change.
- Do not try to control the person by bribing, nagging, threatening or crying.
- Do not make excuses for the person or cover up their substance use or related behaviour.
- Do not take on the person's responsibilities except if not doing so would cause harm, e.g., to their own or others' lives.
- Do not deny their basic needs, e.g., food or shelter.

If the older adult continues to have a substance use problem, you should encourage them to seek out information (e.g., reputable websites or pamphlets) about ways to reduce risks associated with alcohol or other drugs.

Action: Facilitate the older adult getting appropriate professional help

Many people with alcohol and drug problems do not receive health care or other services for these problems. A failure to seek help can cause problems with family and employment, damage physical health and increase the risk of developing other mental illnesses such as depression and anxiety disorders.

Discuss options for seeking professional help

Tell the older adult that you will support them in getting professional help. If they are willing to seek professional help, give them information about local options and encourage them to make an appointment (see *Helpful resources* at the end of this chapter).

Be prepared to facilitate transportation to attend professional services or arrange for community services that come to the older adult's home to help him or her safely reduce or stop drinking.[46]

What if the older adult doesn't want professional help?

Be prepared for a negative response when suggesting professional help. The older adult may not want such help when it is first suggested to them and may find it difficult to accept. Stigma and discrimination can be barriers to seeking help. If this is the case, explain to the older adult that there are several approaches available for treating substance use problems. If they won't seek help because they don't want to completely stop using, explain that the treatment goal may be to reduce consumption rather than to quit altogether. Reassure the older adult that professional help is confidential.

If the older adult is still unwilling to seek professional help, you should set boundaries around what behaviours you are willing and unwilling to accept from them. It is important to continue to suggest professional help to the older adult. However, pressuring the person or using negative approaches may be counterproductive.

Be prepared to talk to the older adult again in the future about seeking professional help. Be compassionate and patient while waiting for them to accept that they need professional help—ultimately, it is the person's decision. Changing a substance use problem is a process that can take time. Remember that the older adult cannot be forced to get professional help except under certain circumstances, for example, if a violent incident results in the police being called or following a medical emergency.

Action: Encourage support for the older adult and caregiver

Other people who can help

Family and friends can play an important role in the recovery of an older adult with a substance use problem (see box). Encourage the older adult to reach out to friends and family who support their efforts to change their substance use behaviours and to spend time with supportive non-using friends and family. Family and friends can help the person to seek treatment and support to change their substance use behaviour. They can also help reduce the chances of a relapse after an older adult has stopped substance use. Older adults are more likely to start using again if there is an emotional upset in their life– family and friends can offer support and encouragement during these times so the older adult¡ does not return to substance use. It is useful to warn the person that not all family and friends will be supportive of their efforts to change their use.

Role of family and friends in recovery

Research has shown that people are more likely to recover if:

- They have stable family relationships.
- They are not treated with criticism and hostility by their family.
- They have supportive friends.
- Their friends do not use alcohol or drugs themselves and they encourage the person not to use.

(Mental Health First Aid Australia, 2020b)

There are numerous groups that support individuals recovering from substance use by providing mutual support and information, including self-help groups in which people work to follow steps to recovery, e.g., Alcoholics Anonymous and Narcotics Anonymous. Research shows that these groups can be beneficial (Kelly, 2003).

There are also support groups for families of people affected by substance use disorders, such as Al-Anon and ACOA.

Self-help strategies

There are websites that allow an older adult to screen themselves for alcohol problems and which encourage the person to change (see Helpful resources at end of this chapter). There is evidence that such websites can be effective (White et al., 2010).

Addressing Social Isolation

Older adults note that the advice offered to them to reduce their social isolation, particularly from family or healthy peers, is often simplistic (e.g., "You just need to get out more often."). Older adults need help taking things one step at a time, for example, by noting when other people share a common interest and by introducing them. Older adults can be engaged with other older adults

through personal contact (such as moving to a retirement home setting, joining a community centre) or by telephone calls, letters, cards or e-mail. Friendly visiting or telephone support programs can help reduce social isolation.[47]

Action: Self-Care for the first aider

Remember to take care of yourself in your role as a mental health first aider. You may find yourself in the position of being both the caregiver and the mental health first aider, but keep in mind that each fulfils a different need for the older adult.

Refer back to MHFA Actions in Section 1 of this Reference Guide for a reminder about the importance of taking care of yourself as the older adult's first aider, and for a list of how-to suggestions for good self care practices.

Resources

ADDICTIONS FOUNDATION OF MANITOBA
www.afm.mb.ca

The Addictions Foundation of Manitoba provides intervention, rehabilitation, prevention, education and research for substance use and gambling.

ALCOHOL AND SENIORS IN CANADA
http://www.agingincanada.ca/index.htm

This Canadian website is dedicated to alcohol issues affecting seniors developed by Charmaine Spencer, Gerontology Research Centre, Simon Fraser University, Vancouver, B.C. last updated: January 26, 2006.

CENTRE FOR ADDICTION AND MENTAL HEALTH
www.camh.ca

The Centre for Addiction and Mental Health (CAMH) is a mental health teaching hospital in Toronto. Under "Health Info/Mental Illness and Addiction Index" there are resources on mental health and substance use problems, and concurrent disorders.

COMMUNITY ADDICTIONS PEER SUPPORT ASSOCIATION (CAPSA)
www.capsa.ca

CAPSA is a non-profit organization of people affected by addiction. Based in Ottawa, Ontario, CAPSA strives to empower individuals impacted by addiction by providing opportunities to integrate into the broader community through peer-support initiatives and community engagement projects. We support all pathways to recovery and endeavour to collaborate with other organizations that provide services for those in need of help.

ADDICTION GUIDE
www.addictionguide.com

Addiction Guide provides information on addiction and addiction treatment. They provide resources for people living with substance-related disorders and their families and friends.

ALCOHOLICS ANONYMOUS & NARCOTICS ANONYMOUS
www.aa.org
www.na.org

These organizations provide mutual support groups for people recovering from substance use disorders. The websites give contacts for groups in any part of Canada.

AL-ANON AND ALATEEN
www.al-anon.alateen.org

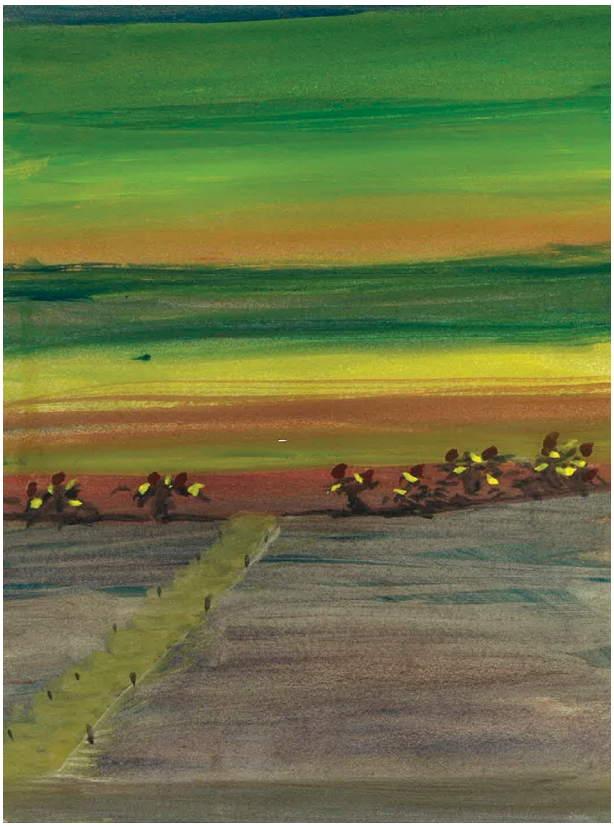
This organization provides information and support for the family members and friends. The website gives details of meetings in all provinces and cities.

BOOKS

Fletcher, A. M. (2002). *Sober for good: New solutions for drinking problems - Advice from those who have succeeded.* Houghton Mifflin Harcourt.

Based on interviews with over 200 recovered problem drinkers, this book gives guidance about different paths to recovery, whether the goal is abstinence or occasional use. It also includes advice for friends and family on helping someone who is reluctant to change.

2.5 Dementia



Journey to Recover

"This painting is my journey back to who I remember myself to be. A straight and narrow road, no bends, no curves, or crossroads to my memory of me. I cherish these moments of remembering."

Aging and Cognition

An older adult's ability to think, to learn new information and the process of acquiring that new knowledge, changes with aging. These cognitive changes can be thought of as moving along a spectrum – ranging from expected decline that does not affect intellectual functioning, to somewhat more evident decline in thinking but without interfering remarkably with an older adult's ability to be independent in everyday activities, to a deterioration in thinking that interferes with independence in everyday activities.

Cognition: The activities of thinking, understanding, learning, and remembering

The first stage along the spectrum of cognitive decline and aging is known as age-associated memory impairment (AAMI) and is considered a part of the normal aging process.[1] In AAMI a decline in short term memory is recognized by the older adult and can be measured by a standardized memory test but the decline in thinking is minimal and does not significantly impact intellectual function.[2]

The next stage along the spectrum of cognitive decline is referred to as mild cognitive impairment3 (MCI). This decline may be related to a disease process rather than simply aging. Older adults with MCI may remain stable or improve to normal over time, but more than half progressively worsen within five (5) years. MCI is considered a risk factor[4] for the next stage along the spectrum of cognitive decline described as dementia.

What is Dementia?

Dementia does not refer to a specific disease.5 It is a medical term used to describe a number of brain disorders that are characterized by a progressive loss of intellectual functions with a decline in thinking including not only memory loss, but changes in other mental processes such as reasoning, concentration and language.6 Brain function is affected enough to interfere with the older adult's ability to function at work, in relationships and in everyday activities and represents a decline from previous function such that the older adult can no longer live independently.[7,8]

Signs and Symptoms of Dementia

The signs and symptoms of dementia include:

1. Complex attention – difficulty recalling recent information, (such as recalling phone numbers or addresses just given), or reporting back what was just said.
2. Executive function – decline in planning, problem solving and decision-making.
3. Learning and memory – difficulty in learning and recalling new information (such as how to use new equipment like a cellphone or how to get to a new store).
4. Perceptual-motor – difficulties using tools, equipment and/or driving.
5. Social cognition – loss of ability to recognize what is socially acceptable behaviour (involving poor decision-making without regard to safety or appreciation of consequences).
6. Language – impaired expression with word finding difficulties, lack of clarity (clearness in what somebody is thinking) and/or repetition in conversation; often with excessive use of meaningless terms such as "that thing" and "you know what I mean."

Types of Dementia

There are a number of different types of dementia. The most common types are Alzheimer's disease and vascular dementia. Other forms include: dementia with Lewy bodies, Parkinson's disease dementia, and frontotemporal dementia.

Alzheimer's Disease

Alzheimer's disease is not a normal part of aging. Alzheimer's disease is a fatal disease that eventually affects all aspects of an older adult's life: how they think, feel and act. It is difficult to predict symptoms, the order in which they will appear, or the speed of their progression. The pathologic changes in the brain that underlie Alzheimer's disease appear to start 10 to 20 years before symptoms develop.[9] There are no abnormal movements, sensory, or coordination deficits early in the disease. The diagnosis cannot be determined by laboratory tests. Each older adult is affected differently.

Criteria for the diagnosis of Alzheimer's disease include a gradual, unremarkable, deceptive onset and progressive impairment of memory and other cognitive functions.

10 Warning Signs of Alzheimer's disease[10]

1. Memory loss that affects day-to-day function
2. Difficulty performing familiar tasks
3. Problems with language
4. Disorientation of time and place
5. Poor or decreased judgment
6. Problems with abstract thinking
7. Misplacing things
8. Changes in mood and behaviour
9. Changes in personality
10. Loss of initiative

Vascular Dementia

Vascular dementia is the second leading cause of dementia in older adults.[11] It is characterized by onset of cognitive deficits that are related to one or more strokes, a sudden blockage or rupture of a blood vessel in the brain. Large vessel strokes result in the immediate onset of major physical disability and can be easily recognized.

An older adult with vascular dementia will typically display a decrease in decision-making processes described as executive dysfunction (i.e. decline in planning, problem solving and decision-making, reasoning and

short term memory) as well as changes in mood, behaviour and ability to communicate.

Alzheimer's disease and vascular dementia often occur alongside one another and there is often overlap in their symptoms. The two conditions occurring together are referred to as mixed dementia.[12]

Stroke is a **medical emergency** and accounts for 7% of all deaths in Canada.[13] Public information on the identification of stroke was made relevant by the U.S. National Stroke Association 2009 Act F.A.S.T. campaign that emphasized a simplified approach to stroke recognition and action:[14,15]

- Facial weakness – can the person smile? Has their mouth or eye drooped?
- Arm weakness – can the person raise both arms?
- Speech problems – can the person speak clearly and understand you?
- Time to call for an ambulance if you spot any one of these signs.

Other Types

Dementia with Lewy Bodies

Dementia with Lewy bodies is also a dementia that is characterized by a gradual, unremarkable, deceptive onset with subsequent development of cognitive decline. Diagnostic features may include:[16]

- Fluctuating cognition with pronounced variations in attention and alertness
- Recurrent visual hallucinations; well-formed and detailed
- Spontaneous features of Parkinsonism – a movement disorder consisting of:
  - Tremor at rest (unintentional, rhythmic, shaking particularly of the hands or thumb while not moving)
  - Slow initiation of voluntary movement
  - Increased muscle tone causing rigidity
  - Postural instability; loss of balance causing an older adult to feel unsteady

Parkinson's Disease Dementia

Parkinsonism without a known cause in the brain (i.e., that cannot be attributed to strokes) is referred to as Parkinson's disease, a neurodegenerative illness that initially affects movement only.[17] The movement disorder features of Parkinson's disease include tremor at rest, slow initiation of voluntary movement, increased muscle tone causing rigidity and postural instability.

The most important risk factor for development of dementia in Parkinson's disease is older age,[18] with additional risk factors including later age of Parkinson's disease onset, longer duration of symptoms, hallucinations and impairments in memory or language function.[19]

Frontotemporal Dementia

Frontotemporal dementia (FTD)[20] is also a dementia characterized by a gradual, unremarkable, deceptive onset and gradual progressive decline. The frontal and temporal lobes are affected resulting in deterioration in personality, speech, behaviour and ability to function. Onset of FTD often occurs in adults under the age of 65.

In early stages during the first years of illness there are two possible presentations: one with mainly behavioural changes in social behaviour and personality and the other with mainly changes in language expression.

Behavioural and Psychological Changes

In addition to changes in cognition and function, most older adults with dementia will experience behavioural and psychological

symptoms of dementia (BPSD).[21,22] The most common BPSD include:

- Apathy (lack of interest, enthusiasm, or energy) and/or depressed mood
- Agitation and/or aggression (both verbal and physical)
- Delusions (fixed beliefs held despite strong evidence against it)
- Additional behavioural changes include:[23]
- Anxiety and/or irritability
- Elation and/or euphoria
- Resistance to care (particularly bathing)
- Disinhibition (impulsivity/lack of self-control)
- Pacing and/or wandering
- Sleep disorders
- Inappropriate sexual behavior
- Hallucinations (a false sensory perception that appears to be real in which an older adult can see, hear, smell, taste, or feel something that is not there)

Responsive Behaviours

Responsive behaviours refer to verbally or physically reactive behaviour that is directed toward another person. Physically responsive behaviours can include hitting, slapping, scratching, punching, pushing, biting, grabbing and kicking. Verbally responsive behaviours can include shouting, swearing, crying and screaming.

Responsive behaviours are rarely spontaneous or unprovoked and should be interpreted as a defensive response most often occurring when an older adult with dementia feels that his or her personal space has been intruded upon, or as an expression of some unmet physical or emotional need.[24] For example, physically responsive behaviours have been found to be associated with being too close to another person, being too cold, or the environment being too noisy whereas verbally responsive behaviours have been found to be associated with pain, poor health, being alone, and depression.[25]

Responsive behaviours are typically directed towards a caregiver and interfere with caregiving required for dressing, toileting and bathing.[26,27] Responsive behaviours are common, affecting up to 90% of older adults over the course of their illness[28,29,30] with physically responsive behaviours exhibited in 8% to 50% of older adults with dementia.[31,32,33] Responsive behaviours in dementia are challenging for the older adult as well as caregivers and are a leading risk factor for institutionalization.34

Risks Factors

There are a number of risk factors for developing dementia:

- Genetics factors
  - Known genetic risk factors for developing late-onset Alzheimer's disease (after age 65) include several genes with the strongest evidence being for the e4 version (allele) of the apolipoprotein E (APOE) gene.[35]
- Non-genetic factors
  - Known non-genetic risk factors determined by the Canadian Study of Health and Aging for developing late-onset Alzheimer's disease are fewer years of education and most significantly increasing age.[36] By age sixty, 7% are affected, at age eighty, 20% are affected, and at age eighty five; 33% of men and 46% of women are affected. Those over 90 years of age have a 50% risk of having dementia.[37]

- Potentially modifiable factors
  - Additional potentially modifiable risk factors include elevated lipids in the blood, high blood pressure, diabetes and smoking; all associated with increased risk but for which there is insufficient evidence to draw conclusions if modification of these factors can reduce the risk of Alzheimer's disease.[38] There is some evidence that physical exercise may have positive benefit, and given its countless other medical benefits, it should be encouraged with all older adults

No pharmacologic agents have been found to have significant benefits associated with their use to prevent onset of dementia.[39]

Mental Health First Aid for Dementia

MHFA Actions – ALIFES

A Assess safety: risk of suicide, serious physical deterioration, and/or harm to others

L Listen and communicate nonjudgmentally

I Information and reassurance

F Facilitate the older adult getting appropriate professional help

E Encourage support for the older adult and caregiver

S Self-care for the first aider

Action: Assess safety: risk of suicide, serious physical deterioration and/or harm to others

Assess safety: risk of suicide

Assess risk of suicide applies to those with MCI or a mild stage of dementia who suffer significant depressive and/or anxiety symptoms.

- Ask about suicidal thoughts
- Ask about risk factors
- Ask about suicidal plans

Assess safety: risk of serious physical deterioration

Most illnesses causing dementia have a gradual onset and are chronic (long-lasting) such that the risk of serious physical deterioration is an expression of the older adult's inability to care for themselves as the condition progresses. However there is one particular condition of the brain associated with dementia that is acute (brief, severe, and quickly comes to a crisis) and that can result in serious physical deterioration where crisis

intervention can make a significant difference in outcome – that condition is stroke.

Assess safety: risk of harm to others

Responsive behaviours tend to arise from unmet physical needs, environmental factors particularly excessive noise and stimulation, and interactions with caregivers whose approach may be misinterpreted and lead to psychological or physical harm to either the older adult with dementia and/or to the caregiver.[40]

How to assess and assist in a crisis

As you talk with the older adult, be on the lookout for any indications that the older adult may be in crisis.

If you have concerns that the older adult may be having **suicidal thoughts and behaviours,** find out how to **assess and assist** this older adult in Section 3.1 *MHFA for Suicidal Thoughts and Behaviours.*

If you have concerns that the older adult is exhibiting **aggressive behaviours,** find out how to a**ssess and assist** this older adult in Section 3.8 *MHFA for Aggressive Behaviours.*

Action: Listen non-judgmentally

Communicating with an older adult with dementia who is agitated can be challenging and frustrating. Emotional meltdowns in older adults with dementia are referred to as catastrophic reactions[41] rather than temper tantrums. Communication that is adapted to the needs and abilities of the older adult with dementia is at the core of all effective interventions.

When speaking with an older adult with dementia who is distressed, consider the following strategies:

- Ask others to leave the area to increase calm and reduce risk
- Approach the older adult from the front and make eye contact
- Speak slowly and calmly in a slow simple manner, one idea at a time
- Speak in short simple sentences and repeat as needed
- Ask the older adult what would help them
- "Tell me about it" is a useful response to demonstrate interest and concerned listening
- Ask questions requiring a yes or no reply only
- Ask a single question at a time and leave lots of time for answers
- Listen carefully to what the older adult is saying and observe both verbal and non-verbal communications
- Involve someone who knows the older adult well and may be able to identify the needs
- Expect repetition – listen calmly without being annoyed
- When communication is impaired listen and respond to the emotion underlying the impaired communication
- Gently suggest a word if the older adult is struggling with word finding problems
- Raise topics that the older adult enjoys talking about – e.g. past events, sports, family
- Never stand too close or stand over someone to communicate. Instead, respect the older adult's personal space and drop to their eye level
- Avoid confrontation
- Avoid correcting or providing reality checks
- Use pictures and other visual prompts if the older adult cannot communicate or understand the requested task

Action: Information and reassurance

Inform the older adult with mild cognitive impairment, or who is in the early stages of dementia and still may have partial insight (an awareness of limitations), that they may have a medical condition causing forgetfulness or other cognitive changes that requires professional assessment.

Older adults with moderate to advanced stages of dementia lack insight into the fact that they are no longer capable of living independently and do not recognize their limitations. Caregivers need to provide reassurance to the older adult with dementia that they will be kept safe and that their needs will be met.

Giving reassurance and information may not be enough. Distraction is an additional technique to help divert the attention of the older adult with dementia in order to reduce the risk of harm for either the older adult or the caregiver.

Using distraction strategies in exit seeking and wandering behaviours are helpful to reduce or prevent these behaviours. For example if an older adult with dementia wants to leave, re-directing the older adult to the kitchen to get some coffee may distract them and they may "forget" that they were trying to leave. Alternatively simply re-directing the older adult to another room can help in distracting them; if the door is no longer visible they may forget that they wanted to go out. Non-strenuous exercise, such as walking, can also be an effective distraction strategy.[42] Distraction can be helpful while providing personal care and the older adult is resistant to help.

Strategies for distraction include offering food, playing cards, picture magazines, simple puzzles, crayons for drawing, and/or music.

Action: Facilitate the older adult to get appropriate professional help

Facilitate the older adult with dementia accessing appropriate professional help since they may not have the insight to realize the extent of their problems or may lack the planning ability necessary to obtain the right kind of support. Common barriers to accessing professional help may include lack of proficiency in English, impaired mobility, hearing or visual loss or lack of access to transportation.

Roles of Professional Healthcare Providers:

- Family Physician/Nurse Practitioner
  - Screen for cognitive decline
  - Identify and treat reversible medical causes for decline if present
  - Treatment with medications if indicate
  - Refer to additional resources
- Geriatric Team and/or Memory Clinic (more complex cognitive and physical care situations)
  - Access to a geriatrician and/or neurologist and other healthcare professionals i.e., pharmacist, social worker, occupational therapist, physiotherapist
  - Screen for cognitive decline
  - Rule out or identify & treat reversible medical causes for decline
  - Assess level of independence in ADLs and instrumental activities of daily living (IADLs)[43] which include: telephone use, shopping, food preparation, housekeeping, laundry, transportation use, responsibility for own medications and ability to handle finances
  - Start treatment with medications if indicated

- Assess for and treat causes for physical frailty (vulnerability to decline)

- Geriatric Psychiatry Team (more complex mood and behavioural situations)
  - Access to a geriatric psychiatrist and other healthcare professionals i.e., nurse, social worker, occupational therapist
  - Specialized assessments of cognitive and functional decline
  - Specialized assessments of mood, thought and behaviour
  - Treatment of mental health conditions
  - Assessment and treatment of difficult responsive behaviours
  - Complex medication regimes for treatment of responsive behaviours with aggression
  - Professional intervention for any older adult with dementia is strongly recommended[44] for the following reasons:

1. Maintenance of function, including cognitive functions
2. Managing of challenging behaviours
3. Managing of aggression

Action: Encourage supports for the older adult and caregiver

Older adult

Beginning in the early stages of dementia; caregivers, family members and friends should provide the older adult with dementia opportunities to maintain an active life and to promote independence as much as possible.

Caregiver

The Alzheimer Society and other websites listed in the resource section, offer resources including individual and group counselling, educational workshops and online courses for family caregivers to learn about effective caregiving approaches.

The challenges for caring for an older adult with dementia are considerable; depression, anxiety, insomnia, frustration, guilt, anger, feelings of burden and being trapped, poorer physical health with physical symptoms (e.g., headaches, stomach distress, and insomnia), conflicts in relationships and social isolation are known to be common outcomes among caregivers.[45]

Factors likely to contribute to caregiver stress include the reality that things may truly be getting worse as disease processes progress; the push and pull of multiple roles faced by caregivers, and the lack of control and predictability over neurocognitive illnesses such as Alzheimer's disease.[46]

Support for the caregiver can be useful to alleviate caregiver stress. Listed below are a number of suggested strategies designed to enhance caregiver resilience:

1. **Psycho-educational skill building** that focuses on increasing caregiver knowledge of a specific disorder and/or teaching caregivers specific skills. These skills may include problem solving strategies such as using re-directing techniques when the older adult with dementia wants to leave, environmental modification such as installing an alarm system to alert the caregiver if the older adult with dementia is trying to wander outside, approaches to deal with responsive behaviours or skills to manage their own stress (for example, mindfulness based stress reduction techniques). The goal of providing psy-cho-educational support for caregivers is to increase the caregiver's sense of competence in his/her role since this is associated with less caregiver burden. Typically, most local Alzheimer's Society chapters have psycho-educational and

skill building workshops and/or online courses.

2. **Exercise-based interventions.** Physical exercise alleviates symptoms of Alzheimer's disease.[47,48] Physical exercise may also help prevent the onset of dementia.[49] One of the biggest challenges is finding ways to successfully implement an exercise program for older adults with dementia and caregivers.
3. **Psychotherapy** (individual and group counselling) are available from the Alzheimer Society[50] and other community agencies and may be helpful to reduce anxiety, depression and sense of burden among caregivers.[51] The available support caregivers receive themselves may directly impact the frequency and severity of behavioural problems since the well-being of the caregiver is associated with better outcomes (less behavioural problems) for people with dementia. Caregiver support is associated with delayed placement in a long term care facility.[52]
4. **Self-help education** about dementia care is another option for caregivers and there are many resources available including websites and books. The 36-Hour Day: A family guide to caring for people who have Alzheimer disease, related dementias, and memory loss53 was the first (1981) book of its kind to educate caregivers. It remains a recommended favourite for people caring for an older adult with dementia. Most Alzheimer's Societies have a lending library and counsellors can recommend appropriate books and websites.
5. **Respite care –** Whether it is for a few hours having a companion in the home, having the older adult with dementia attend a day program or admitting them to a long term care facility for a few weeks; respite care offers the opportunity to reduce stress, restore energy and keep the caregiver's life in balance. Taking time for oneself is associated with better caregiver outcomes.
6. **Long term care –** There is no single reason that determines need for institution-alization. Rather it is the compatibility between the older adult with dementia and the caregiver(s) and their resources and supports that determine need for placement. Thus, support of both older adults with dementia and their caregivers carry equal importance in delaying insti-tutionalization. Admission to a long term care facility is very common in the later stages of dementia and it should not be seen as a sign of caregiver's weakness. In many circumstances placing a relative in a facility is emotionally very difficult and caregivers should be supported in making these difficult decisions. It is important to emphasize that admission to a long term care facility is sometimes the safest, most realistic and appropriate option for people with dementia and their caregivers.

Action: Self-Care for the first aider

Remember to take care of yourself in your role as a mental health first aider. You may find yourself in the position of being both the caregiver and the mental health first aider, but keep in mind that each fulfils a different need for the older adult.

Refer back to MHFA Actions in Section 1 of this Reference Guide for a reminder about the importance of taking care of yourself as the older adult's first aider, and for a list of how-to suggestions for good self care practices.

Resources

ALZHEIMER KNOWLEDGE EXCHANGE RESOURCE CENTRE (AKE)
www.akeresourcecentre.org

Information related to the care of persons with Alzheimer Disease and related dementias.

ALZHEIMER SOCIETY OF CANADA
www.alzheimer.ca

Information on Alzheimer's disease, related dementias and caregiving resources; including discussion forums and links to local chapters.

THE CANADIAN ASSOCIATION OF OCCUPATIONAL THERAPISTS (CAOT)
www.caot.ca

CAOT launched the National Blueprint for Injury Prevention in Older Drivers in February 2009. The Blueprint strives to enhance the capacity of older adults to maintain their fitness to drive and ability to drive safely for as long as possible.

CANADIAN INITIATIVE ON FRAILTY AND AGING
www.frail-fragile.ca

Goal is to improve the quality of health care and life for older Canadians

DEMENTIA FRIENDS CANADA
www.dementiafriends.ca

A national awareness and public engagement initiative whose aim is to create a more aware and informed Canadian about dementia. A Dementia Friend is someone who learns a little bit more about what it's like to live with dementia and then turns that understanding into simple actions that can help people with dementia live well.

HEART AND STROKE FOUNDATION
www.heartandstroke.com

A Canadian volunteer-based health charity that pursues eliminating heart disease and stroke and reducing their impact through the advancement of research, the promotion of healthy living, and advocacy.

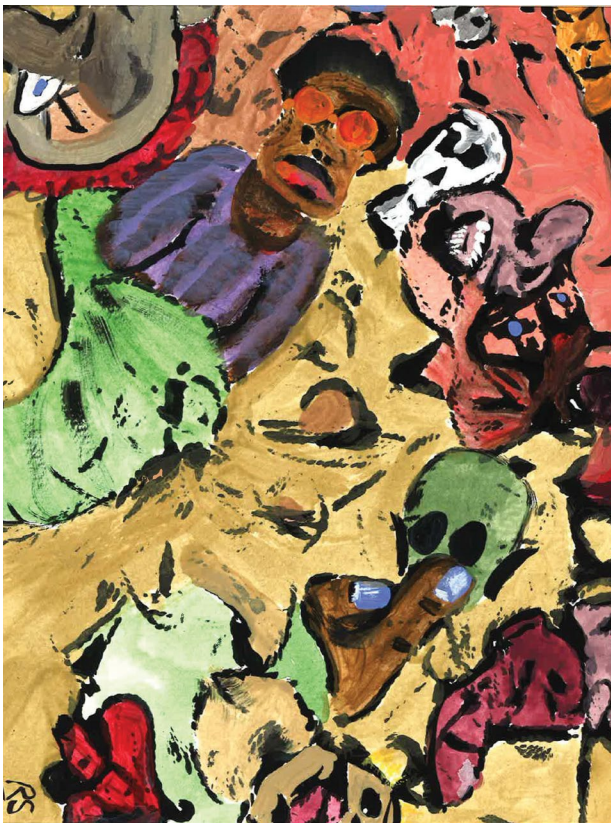
MURRAY ALZHEIMER RESEARCH AND EDUCATION PROGRAM (MAREP)
https://uwaterloo.ca/murray-alzheimer-research-and-education-program/research/projects/responsive-behaviours

MAREP integrates research and educational activities in an effort to improve dementia care practices in Canada.

PARKINSON SOCIETY CANADA
www.parkinson.ca

Provides educational workshops, conferences, seminars and online resources in both English and French.

2.6 Delirium



Untitled
"Colors, shapes, sound, many faces – what are they trying to do to me?
In black sockets – will I lose myself here? Who can help me?"

What is Delirium?

Delirium is a medical emergency that commonly occurs in older adults. Delirium is often not recognized or is misdiagnosed as another condition, such as dementia or depression. Family members or caregivers who know the older adult are in the best position to notice changes in the behaviour and the mental state of the older adult

Delirium in older adults should be considered a warning sign of a potentially life threatening disease requiring emergency medical attention and evaluation;[1] however, it is also potentially preventable.[2]

Differentiating Delirium, Dementia & Depression in Organic vs Psychiatric Illness

(Published August 2016 by Anton Helman https://emergencymedicinecases.com/organic-vs-psychiatric-illness/)

Delirium is the acute and fluctuating onset of in-attention, with disorganized thinking, and/or altered level of awareness. Unlike dementia (which progresses slowly) delirium happens acutely. In the elderly, 70% of delirium is initially “hypoactive,” which can delay its detection in the ED.

Delirium is a very serious presentation, which always has an underlying medical cause. Length of stay in hospital, and in-hospital mortality increases twofold in patients diagnosed with delirium, and delirium is not always reversible. Always assess the baseline functional status of elderly patients, and be suspicious of any acute decline.

Features	Delirium	Dementia	Depression
Onset	Acute (hours to days)	Insideous (months to years)	Acute or insidious (weeks to months)
Course	Fluctuating	Progressive	May be chronic
Duration	Hours to weeks	Months to years	Months to years
Counciousness	Altered	Ususally clear	Clear
Attention	Impared	Normal except in severe dementia	May be decreased
Psychomotor changes	Increased or decreased	Often normal	May be slowed in severe cases
Reversibility	Usually	Irreversible	Usually

Signs and Symptoms of Delirium

It is characterized by an abrupt and fluctuating change in thinking signaled by the following:

- A decline in attention
- Disturbances in:
  - awareness
  - orientation to place and time
  - new learning
  - ability to think coherently
  - perception of reality
  - behaviour with activity being either markedly reduced or agitated

The main emotions of an older adult experiencing delirium may be fear, distress, anxiety, confusion and feeling threatened. Feelings of hopelessness, helplessness and sadness are also possible during an episode of delirium. These feelings may trigger responsive behaviour (as a result of a need to escape from a state of fearfulness) and/or may lead the older adult to attempt suicide. On the other hand, older adults may also experience delirium with a disinterested perplexity, in which they observe events as through a mist.

If delirium goes undiagnosed and untreated it can lead to:

- Persistent decline in ability to think and function
- Loss of physical function
- Long term care institutionalization
- Even death[3]

Ultimately, delirium in older adults should be considered as a warning sign of a potentially life threatening disease requiring emergency medical evaluation.[4]

Types of Delirium

The change in behaviour caused by delirium can be classified as being hyperactive, hypoactive or mixed. The type of delirium depends on the rate of thinking and level of activity of the older adult

- **Hyperactive:** Characterized by disorganized and accelerated thinking and speech. The individual's behaviour may be agitated, restless, frightened and even aggressive to self or others (due to fearfulness). Older adults may suffer from hallucinations – typically visual (visions of animals, insects, people) – and may develop suspiciousness and paranoid delusional thinking.
- **Hypoactive:** Characterized by reduced rate of thinking and speech. The individual's

level of alertness and activity is reduced with lethargy, drowsiness, indifference and apathy. The hypoactive form is more common in older adults.[5]

- **Mixed Cases:** Characterized by symptoms of both hyperactive and hypoactive forms being present.

Risk Factors for Delirium

Risk factors for delirium can be divided into precipitating factors; things that "trigger" delirium and predisposing factors; conditions that increase the probability of delirium occurring.

Factors that Increase the Risk of Delirium

Predisposing factors that increase the probability of delirium occurring in older adults include:

- Pre-existing dementia or cognitive impairment
- Depression
- Pre-existing neurological disease
- Chronic medical conditions
- Older age, hearing or visual deficits
- Regular alcohol consumption
- Regular use of multiple medications; particularly tranquilizers, narcotic analgesics and anticholinergics used for overactive bladder.[6]

Triggering Factors of Delirium

There are numerous precipitating factors that trigger delirium in older adults and can include just about any new medical condition that disrupts the state of balance between the brain and the body. These include:

- Dehydration
- Oxygen deficiency
- Severe pain
- Head trauma
- Surgery
- Heart failure
- Infection with sepsis (the body's response to life-threatening infection that enters into the bloodstream)
- Urinary tract infection

Delirium may be precipitated unintentionally in hospitalized older adults by medical treatments or procedures such as anesthesia, urinary catheterization and the use of physical restraints to prevent falls.

Several prescribed medications can precipitate delirium in older adults due to toxicity at usual therapeutic doses such as narcotic analgesics (pain-killers) or even Gravol® for nausea.

Delirium and Hospitalization

Delirium can also occur during hospitalization as a result of such things as unfamiliar surroundings, unfamiliar people and excessive noise (such as what occurs upon arrival in the Emergency Room of a hospital).[7] Delirium may also occur due to postoperative immobility (hip fracture repair having the highest rates).[8] Older adults in intensive care and palliative care have significantly higher rates of delirium. Older adults who develop delirium within a hospital tend to have an extended length of stay after the diagnosis of delirium is made (on average an additional 8 days).[9] Lack of detection of delirium has been shown to lead to worse hospital outcomes and even increased mortality.[10]

Mental Health First Aid for Delirium

MHFA Actions – ALIFES

A Assess safety: risk of suicide, serious physical deterioration, and/or harm to others

L Listen and communicate nonjudgmentally

I Information and reassurance

F Facilitate the older adult getting appropriate professional help

E Encourage support for the older adult and caregiver

S Self-care for the first aider

Action: Assess safety: risk of suicide, serious physical deterioration and/or harm to others

It is difficult to assess with confidence what is on the mind of someone during an episode of delirium. Communication will be disrupted due to inattentiveness and the older adult will not be fully rational. The dominant emotions during delirium may be fear, anxiety and feeling threatened. These feelings may trigger risky or responsive behaviours. Risk of harm to self or others can develop out of a need to escape from a state of fearfulness, such as running away, striking out, or attempting suicide.

An episode of delirium should always be treated as a crisis.

How to assess and assist in a crisis

As you talk with the older adult, be on the lookout for any indications that the older adult may be in crisis.

If you have concerns that the older adult may be having **suicidal thoughts and behaviours,** find out how to **assess and assist** this older adult in Section 3.1 *MHFA for Suicidal Thoughts and Behaviours.*

If you have concerns that the older adult may be having a **psychotic episode,** find out how to **assess and assist** this older adult in Section 3.5 *MHFA for Severe Psychotic States.*

If you have concerns that the older adult is exhibiting **aggressive behaviours,** find out how to **assess and assis**t this older adult in Section 3.8 *MHFA for Aggressive Behaviours.*

Psychosis (loss of contact with reality) may develop during delirium including suspiciousness (paranoia) and frightening visual hallucinations. To guard against this, the older adult should not be left alone until emergency medical attention has been obtained or has arrived. Even at the hospital, the risk to self or others may persist. To reduce the risk, it can be beneficial for the

older adult in a delirium to have a caregiver stay with them.

Action: Listen non-judgmentally

The distress and humiliation seniors feel during delirium is compounded by the difficulty they have communicating with others.[11] The older adult's impaired ability to learn new information aggravates the experience. The older adult will likely recall very little of what was said or what occurred during an episode of delirium.

Any retained memories may be particularly frightening and vivid. A small proportion of older adults are troubled by their experiences, but for most the psychological outcome is good; they seem to pass off the experience as an unusual dream.[12] Allowing the older adult to discuss concerns regarding any recalled memories of the delirium is important to lessen any lingering worries or fears related to the experiences (real or perceived) during the delirium.

It is important for the first aider to:

- Listen to what the older adult is saying without judging
- Make direct eye contact
- Convey an attitude of warmth and kindness
- Use simple words and short sentences while listening and speaking to an older adult experiencing delirium
- Keep identifying yourself
- Keep calling the older adult's name and using gestures during any attempts at conversation because of the inattentiveness and impaired recall that the older adult will be experiencing.[13]

Action: Information and reassurance

An older adult experiencing delirium is very confused and likely unable to accept information about their condition. Reassure the older adult of their safety.

It may not be possible to make sense of the confused stories that older adults with delirium tell. It is best to respond with reassurance without attempting to debate the unreality of any perceived experiences and to distract them to a more neutral or non-threatening topic of conversation.

Reassure the hospitalized older adult with delirium who is disoriented to time and place that they are in hospital because they have a medical condition that is being treated.

Action: Facilitate the older adult to get appropriate professional help

An older adult experiencing delirium requires emergency medical attention. Typically, hospitalization will be required to investigate and treat the underlying cause. Abrupt change in mental status due to delirium may be the only clue that an older adult is suffering an acute medical illness. A list of all current medications and their dosages, or better yet the actual pill bottles or blister packs should be provided to emergency medical personnel.

Action: Encourage supports for the older adult and caregiver

Older adult

Although older adults are particularly vulnerable to episodes of delirium while hospitalized, delirium is not necessarily inevitable for older adults who are medically ill.[14] There are strategies and supports that may be of benefit for preventing delirium, particularly in predisposed older adults entering a hospital. Be sure to check with the attending physician before carrying out these activities. Possible strategies include:[15,16]

- Staying mentally active
  - Arranging for familiar people to visit regularly
  - Having a bedside clock, calendar and pictures from home
  - Talking about topics of interest
  - Reading books, magazines, etc.
- Staying physically active
- Eating and drinking well
- Maintaining adequate hearing
- Maintaining healthy vision
- Maintaining health rest and sleep

Caregiver

While an older adult with delirium requires support, so to do caregivers. Delirium in a loved one can be frightening to witness. The caregiver can become overwhelmed with the needs of the older adult and neglect their own personal health needs. Due to delirium resulting in sleep-wake reversal (sleeping during the day and awake during the night), the caregiver can become sleep deprived, putting them at risk for exhaustion and depression. It is very important for the caregiver to be supported during this time as well.

Possible support systems include:

- Family, friends and community
- Support groups
  - There are groups available (online, in-person) that provide support and a variety of resources including information addressing issues that may be of interest to family members caring for older adults experiencing mental health problems.
  - There are also workshops offered by different agencies that may provide additional support to caregivers.
- Practice self-care

Action: Self-Care for the first aider

Remember to take care of yourself in your role as a mental health first aider. You may find yourself in the position of being both the caregiver and the mental health first aider, but keep in mind that each fulfils a different need for the older adult.

Refer back to MHFA Actions in Section 1 of this Reference Guide for a reminder about the importance of taking care of yourself as the older adult's first aider, and for a list of how-to suggestions for good self care practices.

Resources

CANADIAN COALITION OF SENIORS MENTAL HEALTH
http://www.ccsmh.ca/en/booklet/index.cfm

"Delirium in Older Adults: a guide for seniors and their families"

VANCOUVER ISLAND HEALTH AUTHORITY (VIHA)
http://www.viha.ca/mhas/resources/delirium/tools.htm

This webpage provides an abundance of resources for prevention, recognition, assessment and intervention for delirium in seniors.

HOSPITAL ELDER LIFE PROGRAM
www.hospitalelderlifeprogram.org

Developed by Dr. Sharon K. Inouye and colleagues The Hospital Elder Life Program (HELP) is a copyrighted program for hospitals, designed to prevent delirium by keeping hospitalized older people oriented to their surroundings, meeting their needs for nutrition, fluids, and sleep and keeping them mobile within the limitations of their physical condition. HELP has been disseminated widely in the U.S. and in numerous hospitals in Canada as well. The website contains useful educational information for caregivers.

Section 3: MHFA for Crisis Situations

Hanging On
By Michelle Hosking

"I am trying to hang on desperately to something real or solid, feeling as if the universe has split open; unrealities flood my inner world but hoping I will somehow pull through it."

Introduction

This section contains recommendations for members of the public on how to assess and assist in a number of mental health and substance use crisis situations. Some of these crises can occur in older adults with various mental illnesses or those who are in emotional distress. Other crises may precipitate the onset of a mental illness or may be related to substance use. The role of the first aider is to assist the older adult until appropriate professional help is received or the crisis resolves.

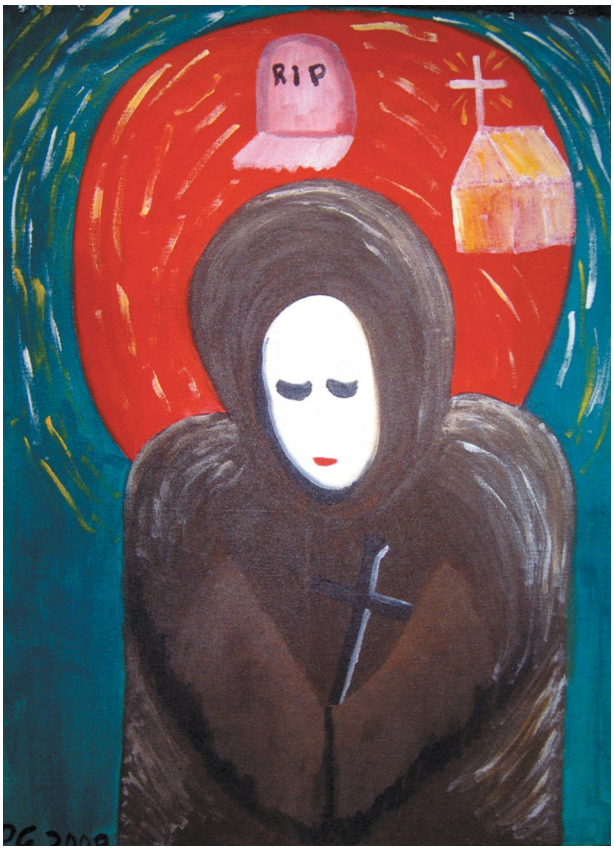
The first aid advice in this section is based on international guidelines that have been developed using the expert consensus of panels of mental health and substance use consumers, carers and clinicians. These experts came from a range of developed English-speaking countries, including Australia, Canada, Ireland, New Zealand, the UK and the USA.

Each individual is unique, and it is important to tailor your support to that person's needs. These recommendations therefore may not be appropriate for every older adult who may be in crisis. Crises vary in severity and the first aid given also varies. If the crisis is severe enough to require emergency professional help, then your role as a first aider finishes when the professional takes over. If the crisis is less severe, the first aid can continue with other MHFA actions after the crisis resolves.

First aid recommendations are provided for the following crisis situations:

- Suicidal thoughts and behaviours
- Non-suicidal self-injury
- Panic attacks
- Following a traumatic event
- Severe psychotic states
- Severe effects from alcohol use
- Severe effects from drug use

3.1 MHFA for Suicidal Thoughts and Behaviours



Depressed and Suicidal
By Patricia Girvasi
"This painting depicts depression and how if you don't get help you can end up committing suicide. The church is one means of getting help as for some people God can be a release of depression. Having someone to talk to and praying for help also makes an older adult think positively."

This section was adapted from the following sources:

- Mental Health First Aid Australia. (2016). *Suicidal Thoughts and Behaviours: Mental Health First Aid Guidelines.* https://www.mhfa.com.au/sites/default/files/MHFA_suicide_guidelinesA4%202014%20Revised.pdf
- Ross, A., Kelly, C., & Jorm, A. (2014). Re-development of mental health first aid guidelines for non-suicidal self-injury: a Delphi study. *BMC Psychiatry, 14(241).* https://doi.org/10.1186/s12888-014-0241-8

An important note

Self-injury can indicate a number of different things. Someone who is hurting themselves may be at risk of suicide. Others engage in a pattern of self-injury over weeks, months or years and are not necessarily suicidal. This advice can be of use to you only if the person you are helping is suicidal. If the person you are assisting is injuring themselves, but is not suicidal, please refer to Section 3.2 *MHFA for Non-Suicidal Self-Injury.*

How to assess

Important signs that an older adult may be having thoughts of suicide (Rudd et al., 2006):

- Threatening to hurt or kill themselves
- Looking for ways to kill themselves: seeking access to pills, weapons or other means
- Talking or writing about death, dying or suicide
- Hopelessness
- Rage, anger, seeking revenge
- Acting recklessly or engaging in risky activities, seemingly without thinking
- Feeling trapped, like there's no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family or society
- Anxiety, agitation, inability to sleep or sleeping all the time

- Dramatic changes in mood (including sudden improvement in mood following an episode of depression)
- No reason for living, no sense of purpose in life.

People may show one or many of these signs, and some may show signs not on this list. If you are concerned the person may be at risk of suicide, you need to approach them and have a conversation about your concerns.

Preparing yourself to approach the person

Be aware of your own attitudes about suicide and the impact they have on your ability to provide assistance, e.g., beliefs that suicide is morally wrong or that it is a rational option. If the person is from a different cultural or religious background to your own, keep in mind that they might have beliefs and attitudes about suicide that differ from your own. Be aware that it is more important to genuinely want to help than to be of the same age, gender or cultural background as the person. If you feel unable to ask the person about suicidal thoughts, find someone else who can.

Making the approach

Act promptly if you think someone is considering suicide. Even if you only have a mild suspicion that the person is having suicidal thoughts, you should still approach them. Tell the person about your concerns. Describe behaviours that have caused you to be concerned about suicide. However, understand that the person may not want to talk with you. In this instance, you should offer to help them find someone else to talk to.

Asking about thoughts of suicide

Anyone could have thoughts of suicide. If you think someone might be having suicidal thoughts, you should ask that person directly. Unless someone tells you, the only way to know if they are thinking about suicide is to ask. For example, you could ask:

- "Are you having thoughts of suicide?" or
- "Are you thinking about killing yourself?"

While it is more important to ask the question directly than to be concerned about the exact wording, you should not ask about suicide in leading or judgmental ways, e.g., "You're not thinking of doing anything stupid, are you?"

Sometimes people are reluctant to ask directly about suicide because they think they will put the idea in the person's head. This is not true. Asking them about suicidal thoughts will not increase the risk that they will act on them. Instead, asking the person about suicidal thoughts will allow them the chance to talk about their problems and show them that somebody cares.

Although it is common to feel panic or shock when someone discloses thoughts of suicide, it is important to avoid expressing negative reactions. Do your best to appear calm, confident and empathic in the face of the suicide crisis, as this may have a reassuring effect for the person.

How can I tell how urgent the situation is?

Take all thoughts of suicide seriously and take action. Do not dismiss the person's thoughts as "attention seeking" or a "cry for help." Determine the urgency of taking action based on recognition of suicide warning signs.

Enquire about issues that affect their immediate safety by asking the person:

- Whether they have a plan for suicide
- How they intend to suicide, i.e., ask them direct questions about how and where they intend to suicide

- Whether they have decided when they will carry out their plan
- Whether they have already taken steps to secure the means to end their life
- Whether they have been using drugs or alcohol. Intoxication can increase the risk of an older adult acting on suicidal thoughts
- Whether they have ever attempted or planned suicide in the past.

If the person says they are hearing voices, ask what the voices are telling them. This is important in case the voices are relevant to their current suicidal thoughts.

It is also useful to find out what supports are available to the person. Ask the person:

- Whether they have told anyone about how they are feeling
- Whether there have been changes in their employment, social life or family
- Whether they have received treatment for mental health and substance use problems or are taking any medication.

Be aware that those at the highest risk for acting on thoughts of suicide in the near future are those who have a specific suicide plan, the means to carry out the plan, a time set for doing it and an intention to do it. However, the lack of a plan for suicide is not sufficient to ensure safety.

How to assist

How should I talk with someone who is having thoughts of suicide?

It is more important to be genuinely caring than to say "'all the right things." Be supportive and understanding of the person and listen to them with undivided attention. Suicidal thoughts are often a plea for help and a desperate attempt to escape from problems and distressing feelings.

Do not avoid using the word "suicide." It is important to discuss the issue directly without dread or expressing negative judgment. Demonstrate appropriate language when referring to suicide by using the terms "suicide" or "die by suicide," and avoiding use of terms to describe suicide that promote stigmatizing attitudes, e.g., "commit suicide" (implying it is a crime or sin) or referring to past suicide attempts as having "failed" or been "unsuccessful" (implying death would have been a favourable outcome).

Ask the person about what they are thinking and feeling. Reassure them that you want to hear whatever they have to say. Allow them to talk about these thoughts and feelings and their reasons for wanting to die and acknowledge what they say. Let the person know it is okay to talk about things that might be painful, even if it is hard. Allow them to express their feelings, e.g., allow them to cry, express anger or scream. The person may feel relief at being able to do so.

Remember to thank the person for sharing their feelings with you and acknowledge the courage this takes (see boxes on "Listening tips" and "What not to do").

Listening Tips

- Be patient and calm while the person is talking about their feelings.
- Listen to the person without expressing judgment, accepting what they are saying without agreeing or disagreeing with their behaviour or point of view.
- Ask open-ended questions (i.e., questions that cannot be simply answered with "yes" or "no") to find out more about the suicidal thoughts and feelings and the problems behind them.
- Show you are listening by summarizing what the person is saying. Clarify important points with the person to make sure they are fully understood.
- Express empathy for the person.

What not to do

- Do not argue or debate with the person about their thoughts of suicide.
- Do not discuss with the person whether suicide is right or wrong.
- Do not use guilt or threats to prevent suicide, e.g., do not tell the person they will go to hell or ruin other people's lives if they die by suicide.
- Do not minimize the person's problems.
- Do not offer glib "reassurance" such as "Don't worry," "Cheer up," "You have everything going for you" or "Everything will be alright."
- Do not interrupt with stories of your own.
- Do not communicate a lack of interest or negative attitude through your body language.
- Do not "call their bluff" (dare or tell the person to "Just do it").
- Do not attempt to give the person a diagnosis of a mental illness.

How can I keep the person safe?

Once you have established that a suicide risk is present, you need to take action to keep the person safe. An older adult who is suicidal should not be left on their own. If you suspect there is an immediate risk of the person acting on suicidal thoughts, act quickly, even if you are unsure. Work collaboratively with the person to ensure their safety, rather than acting alone to prevent suicide.

Remind the person that suicidal thoughts need not be acted on. Reassure the person that there are solutions to problems or ways of coping other than suicide.

When talking to the person, focus on the things that will keep them safe for now, rather than the things that put them at risk. To help keep the person safe, develop a safety plan with them (see box). Engage the person to the fullest extent possible in decisions about a safety plan. However, do not assume that a safety plan by itself is adequate to keep the person safe.

Safety plan

A safety plan is an agreement between the person and the first aider that involves actions to keep the person safe. The safety plan should:

- Focus on what the person should do rather than what they shouldn't.
- Be clear, outlining what will be done, who will be doing it and when it will be carried out.
- Be for a length of time that will be easy for the person to cope with, so that they can feel able to fulfil the agreement and have a sense of achievement.
- Include contact numbers that the person agrees to call if they are having thoughts of suicide, e.g., the person's doctor or mental health care professional, a suicide helpline or 24-hour crisis line, friends and family members who will help in an emergency.

Find out who or what has supported the person in the past and whether these supports are still available. Ask them how they would like to be supported and if there is anything you can do to help, **but do not try to take on their responsibilities.**

Although you can offer support, you are not responsible for the actions or behaviours of someone else and cannot control what they might decide to do.

Seeking professional help

Encourage the person to reach out to appropriate professional help as soon as possible. Seek out information about the resources and services available for an older adult who is having thoughts of suicide, including local services that can assist in response to people at risk of suicide such as hospitals, mental health and substance use clinics, mobile outreach crisis teams, suicide prevention helplines and local emergency services. Provide this information to the person and discuss help-seeking options with them. If they don't want to talk to someone face-to-face, encourage them to contact a suicide helpline.

If the person is reluctant to seek help, keep encouraging them to see a mental health and substance use professional and contact a suicide prevention hotline for guidance on how to help them. If the person refuses professional help, call a mental health centre or crisis telephone line and ask for advice on the situation.

If you believe the person will not stay safe, seek their permission to contact their regular doctor or mental health professional about your concerns. If possible, the health professional contacted should be someone the person already knows and trusts.

If the person has a specific plan for suicide, or if they have the means to carry out their suicide plan, call a mental health centre or crisis telephone line and ask for advice on the situation.

If the person has a weapon, contact the police. Inform the police that the person is having thoughts of suicide to help them respond appropriately. Make sure you do not put yourself in any danger while offering support to the person.

Be prepared for the person to possibly express anger and feel betrayed by your attempt to prevent their suicide or help them get professional help. Try not to take any hurtful actions or words of the person personally.

What if the person wants me to promise not to tell anyone else? You must never agree to keep a plan for suicide or risk of suicide a

secret. If the person doesn't want you to tell anyone about their suicidal thoughts, you should not agree. Instead, offer an explanation for why you cannot, e.g., "I care about you too much to keep a secret like this. You need help and I am here to help you get it." Treat the person with respect and involve them in decisions about who else knows about the suicidal crisis.

If the person refuses to give permission to disclose information about their suicidal thoughts, then you may need to breach their confidentiality in order to ensure their safety.

In doing so, you need to be honest and tell the person who you will be notifying.

Keep in mind that it is much better to have the person angry at you for sharing their suicidal thoughts without their permission in order to obtain help, than to lose the person to suicide.

What should I do if the person has acted on suicidal thoughts?

If the person has already harmed themselves, administer first aid and call emergency services to request an ambulance. Keep in mind that despite our best efforts, we may not be successful in preventing suicide.

The person I am trying to help has injured themselves, but insists they are not suicidal. What should I do?

Some people injure themselves for reasons other than suicide. This may be to relieve overwhelming feelings, to punish themselves or to express a need for help. This can be distressing to witness. See Section 3.2 MHFA for Non-Suicidal Self-Injury to help you understand and assist if this is occurring.

Taking care of yourself

After helping someone who is having thoughts of suicide, make sure you take appropriate self-care. Providing support and assistance can be exhausting, and it is therefore important to take care of yourself.

3 key actions for helping an older adult with suicidal thoughts or behaviours:

1. If you think someone is having thoughts of suicide, ask them directly.
2. Work together to keep them safe for now.
3. Connect them to professional help.

3.2 MHFA for Non-Suicidal Self-Injury (NSSI)

Self Portrait
By Delia Crabbe
"This is made with aluminium, muslin, tulle, fly screen, netting, thread. The figures in this piece are me, in various positions that express how I was feeling. There are also many hands, representing the support of family and friends. The dove represents a symbol of hope and God's presence, even in such a dark place."

This section was adapted from the following sources:

- Mental Health First Aid Australia. (2014). *Non-suicidal Self-injury: First Aid Guidelines.* http://www.mhfa.com.au/sites/default/files/MHFA_selfinjury_guidelinesA4 2014 Revised_1.pdf
- Ross, A., Kelly, C., & Jorm, A. (2014). Re-development of mental health first aid guidelines for non-suicidal self-injury: a Delphi study. *BMC Psychiatry, 14(241).* https://doi.org/10.1186/s12888-014-0241-8

An important note

This first aid advice applies only if the person is injuring themselves for reasons other than suicide. Some people engage in non-suicidal self-injury even when suicidal. This means that even though they are having thoughts of suicide, their self-inflicted injuries are not intended to result in death. Some people say that engaging in non-suicidal self-injury helps them to avoid acting on suicidal thoughts. If the person you are assisting is injuring themselves and is suicidal, you will also need to refer to Section 3.1 *MHFA for Suicidal Thoughts and Behaviours.*

Facts on non-suicidal self-injury

Many terms are used to describe self-injury, including self-harm, self-mutilation, cutting and parasuicide.

There is a great deal of debate about what self-injury is and how it is different from suicidal behaviour. Here the term non-suicidal self-injury is used to refer to situations where the self-injury is not intended to result in death. It is not always easy to tell the difference between non-suicidal self-injury and a suicide attempt. The only way to know is to ask the person directly if they are suicidal.

Why do people engage in non-suicidal self-injury?

People self-injure for many reasons. The main ones are (Martin et al., 2010):

- To manage feelings of distress
- To punish themselves
- To communicate personal distress to others.

What are the physical and mental health risks of self-injury?

Injuries to the skin often go untreated (e.g., people may be unwilling to seek sutures for wounds or may not undertake good wound care to keep injuries from becoming infected). As a result, the injuries can take a long time to heal, and there may be complications from infection. Hitting body parts against hard surfaces may result in small fractures that may become complicated if untreated.

Over time, self-injury can become the central strategy for coping with problems, making it very hard to use more adaptive ways of coping. For some people, self-injury can be a very difficult habit to break.

How to assess

If you suspect that someone you care about is deliberately injuring themselves, you need to discuss it with them. Do not ignore suspicious injuries you have noticed on the person's body. Take all self-injuring behaviour seriously, regardless of the severity of the injuries or the intent.

The most common methods of self-injury are:

- Cutting
- Scratching
- Deliberately hitting body on hard surface
- Punching, hitting or slapping self
- Biting
- Burning

(Martin, G. et al., 2010)

How to assist

What should I do if I suspect someone is injuring themselves?

If you suspect that someone you care about is deliberately injuring themselves, you need to discuss it with them. Before talking to the person, acknowledge and deal with your own feelings about self-injuring behaviours. If you feel you are unable to talk to the person who is self-injuring, try to find someone else who can talk to them.

Choose a private place for the conversation. Directly express your concerns that the person may be injuring themselves. Ask about self-injury in a way that makes it clear to the person that you have some understanding of self-injury, e.g., "Sometimes, when people are in a lot of emotional pain, they injure themselves on purpose. Is that how your injury happened?".

Self-injury is a very private thing and is hard to talk about. Do not demand to talk about things the person is not ready to discuss. You should avoid expressing a strong emotional response of anger, fear, revulsion or frustration.

If the person is receiving psychiatric care, ask if their caregiver knows about the injuries.

What should I do if I find someone deliberately injuring themselves?

If you have interrupted someone who is in the act of self-injury, intervene in a supportive and nonjudgmental way. Although it is natural to feel upset, helpless and even angry upon discovering that someone you know self-injures, try to remain calm and avoid expressions of shock or anger. Tell the person that you are concerned about them and ask whether you can do anything to alleviate the distress. Ask if medical attention is needed.

When is emergency medical attention necessary?

Avoid overreacting; medical attention is only required if the injury is severe. Contact emergency services if a wound or injury is serious. Any cut that is gaping requires medical attention, as it may need stitches. Any burn which is two centimetres or larger in diameter, and any burn on the hands, feet or face requires medical attention.

If the person has harmed themselves by taking an overdose of medication or consuming poison, call an ambulance, as the risk of death or permanent harm is high. Deliberate overdose is more frequently intended to result in death but is sometimes a form of self-injury. Regardless of an older adult's intentions, emergency help must be sought.

How should I talk with someone who is deliberately injuring themselves?

Keep in mind that "stopping self-injury" should not be the focus of the conversation. Instead, look at what can be done to make the person's life more manageable or their environment less distressing. Understand that self-injury cannot be stopped overnight, and people will need time to recover and learn healthy coping mechanisms.

Behave in a supportive and nonjudgmental way. Understand that self-injury makes the person's life easier and accept their reasons for doing it. Be supportive without being permissive of the behaviour. Be aware of what your body language is communicating about your attitudes.

Use a calm voice when talking to the person. Avoid expressing anger or a desire to punish the person for self-injuring. Be comfortable with silence; allow the person time to process what has been talked about. Be prepared for the expression of intense emotions.

Express concern and actively listen

When talking with the person, use "I" statements instead of "you" statements, e.g., "I feel worried/angry/frustrated when you…," instead of "You make me feel worried/angry/frustrated…" Ask the person questions about their self-injury, but avoid pressuring them to talk about it. Reflect what the person is saying by acknowledging their experience as they are describing it.

Give reassurance and information

Express empathy for how the person is feeling. Validate the person's emotions by explaining that these emotions are appropriate and valid.

Let them know they are not alone and that you are there to support them. Work

collaboratively with the person in finding solutions, i.e., by finding out what they want to happen and discussing any possible actions with them.

Reassure the person that there are sources of help and support available. Tell the person that you want to help and let them know the ways in which you are willing to help them.

Don't promise the person that you will keep their self-injury a secret. If you need to tell somebody about the person's self-injury to keep them safe, speak to the person about this first. Avoid gossipping or talking to others without the person's permission.

Things to avoid when talking with someone about non-suicidal self-injury

- Do not minimize the person's feelings or problems.
- Do not use statements that don't take the person's pain seriously, e.g., "But you've got a great life" or "Things aren't that bad."
- Do not try to solve the person's problems for them.
- Do not touch (e.g., hug or hold hands with) the person without their permission.
- Do not use terms such as "self-mutilator," "self-injurer" or "cutter" to refer to the person.
- Do not accuse the person of attention seeking
- Do not make the person feel guilty about the effect their self-injuring is having on others.
- Do not set goals or pacts, such as "If you promise not to hurt yourself between now and next week, you're doing really well," unless the person asks you to do this.
- Do not try to make the person stop self-injuring (e.g., by removing self-injury tools) or giving them ultimatums, e.g., "If you don't stop self-injuring, you have to move out."
- Do not offer drugs, prescription pills or alcohol to the person.

What do I do if the person is not ready to talk?

Respect the person's right not to talk about their self-injuring behaviour. If the person doesn't want to talk right away, let them know that you want to listen to them when they are ready. Ask the person what would make them feel safe enough to be able to discuss their feelings. Do not force the issue unless the injury is severe. If the person still doesn't want to talk, ask a health professional for advice on what to do.

Seeking professional help

Self-injury is often a symptom of a mental health problem that can be treated. Encourage the person to seek professional help. Let them remain in control over how to seek help as much as possible. Suggest and discuss options for getting help rather than directing the person on what to do. Help the person map out a plan of action for seeking help. Talk about how you can help them to seek treatment and who they can talk to, e.g., a mental health service or a mental health professional.

Provide praise for any steps the person takes towards getting professional help. Follow up with the person to check whether they have found professional help that is suitable for them.

You should seek mental health assistance on the person's behalf if:

- The person asks you to
- The injury is severe or getting more severe, such as cuts getting deeper or bones being broken
- The self-injurious behaviour is interfering with daily life
- The person has injured their eyes
- The person has injured their genitals
- The person has expressed a desire to die.

Keep in mind that not all people who self-injure want to change their behaviour. Even though you can offer support, you are not responsible for the actions or behaviour of someone else and cannot control what they do.

If the person is an adolescent, a more directive approach may be needed. Help the adolescent map out a plan of action for seeking help and offer to go along with them to an appointment.

Encouraging alternatives to self-injury

Encourage the person to seek other ways to relieve their distress. Help the person to use coping strategies that do not involve self-injuring and help them to make a plan about what to do when they feel like self-injuring. Suggest some coping strategies and discuss with the person what might be helpful for them. These may include:

- Encouraging the person to share their feelings with other people, such as a close friend or family member, when they are feeling distressed or have the urge to self-injure.
- Helping the person think of ways to reduce their distress, e.g., having a hot bath, listening to loud music or doing something kind for themselves.
- Offering the person information materials (e.g., a website or fact sheet) about alternatives to self-injury.

3.3 MHFA for Panic Attacks

Panic
By Claire Kelly
"Panic is terrifying—the fear can be likened to terrifying threats from somewhere you can't quite see. But the image is cartoony, because although the fear is real, the threats are not."

This section was adapted from the following sources:

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5 ed.).* American Psychiatric Association.
- Mental Health First Aid Australia. (2012). *Panic Attacks: Mental Health First Aid Guidelines.* http://www.mhfa.com.au/sites/default/files/MHFA_panic_guidelines_A4_2012.pdf

Facts on panic attacks

More than one-in-four people have a panic attack at some time in their lives. Few go on to have repeated attacks, and fewer still go on to develop panic disorder or agoraphobia. Although anyone can have a panic attack, people with anxiety disorders are more prone to them.

Some panic attacks do not appear to be triggered by anything specific. These are called "uncued" panic attacks. Other panic attacks may be associated with a feared situation. For example, an older adult with social anxiety disorder may experience a panic attack in a social setting.

How to assess

Signs and symptoms of a panic attack

A panic attack is a distinct episode of high anxiety, with fear or discomfort, which develops abruptly and has its peak within 10 minutes. During the attack, several of the following symptoms are present.

- Palpitations, pounding heart or rapid heart rate
- Sweating, chills or hot flashes
- Trembling and shaking
- Numbness or tingling
- Sensations of shortness of breath, sensations of choking or smothering
- Dizziness, light-headedness, feeling faint or unsteady
- Chest pain or discomfort
- Abdominal distress or nausea
- Feelings of unreality or being detached from oneself
- Fears of losing control or going crazy

- Fear of dying.

If someone is experiencing the above symptoms and you suspect that they are having a panic attack, you should first ask them if they know what is happening and whether they have ever had a panic attack before.

How to assist

What should I do if I think someone is having a panic attack?

If you are helping someone you do not know, introduce yourself. If the person says that they have had panic attacks before, and believe that they are having one now, ask them if they need any kind of help, and give it to them, where possible.

What if I am uncertain whether the person is really having a panic attack and not something more serious like a heart attack?

The symptoms of a panic attack sometimes resemble the symptoms of a heart attack or other medical problem. It is not possible to be totally sure that an older adult is having a panic attack. Only a medical professional can tell if it is something more serious. If the person has not had a panic attack before, and doesn't think they are having one now, you should follow physical first aid guidelines. The first step is to help the person into a supported sitting position (for example, against a wall).

Ask the person, or check to see, if they are wearing a medical alert bracelet or necklace. If they are, follow the instructions on the alert or seek medical assistance.

If the person loses consciousness, apply physical first aid principles. Check for breathing and pulse and call an ambulance.

What should I say and do if I know the person is having a panic attack?

Reassure the person that they are experiencing a panic attack. It is important that you remain calm and that you do not start to panic yourself. Speak to the person in a reassuring but firm manner and be patient. Speak clearly and slowly and use short sentences. Invite the person to sit down somewhere comfortably.

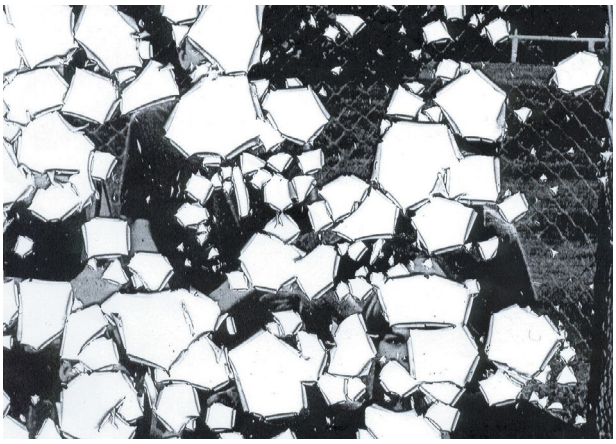
Rather than making assumptions about what the person needs, ask them directly what they think might help.

Do not belittle the person's experience. Acknowledge that the terror feels very real, but reassure them that a panic attack, while very frightening, is not life threatening or dangerous. Reassure them that they are safe and that the symptoms will pass.

What should I say and do when the panic attack has ended?

After the panic attack has subsided, ask the person if they know where they can get information about panic attacks. If they don't know, offer some suggestions. Tell the person that if the panic attacks recur and are causing them distress, they should speak to an appropriate health professional. You should be aware of the range of professional help available for panic attacks in your community. Reassure the person that there are effective treatments available for panic attacks and panic disorder.

3.4 MHFA Following a Traumatic Event



Traumatic Events
By Catriona Taralrud-Bay
"This is a black and white photo with deterioration and manipulation, then photocopied. The white shapes are all the traumas crowding out the world for the traumatized, who are in the black and grey world behind. The fence represents war, the face in the middle of the right-hand side (my son) represents those with trauma that needs healing."

This section was adapted from the following sources:

- Kelly, C. M., Jorm, A. F., & Kitchener, B. A. (2010). Development of mental health first aid guidelines on how a member of the public can support an older adult affected by a traumatic event: *A Delphi study. BMC Psychiatry, 10(1),* 1-15. https://doi.org/10.1186/1471-244X-10-49
- Mental Health First Aid Australia (2012). *Traumatic Events: Mental Health First Aid Guidelines.* http://www.mhfa.com.au/sites/default/files/MHFA_adult_guidelines_A4_2012.pdf

Facts on Traumatic Events

A traumatic event is one that causes an individual or group to experience intense feelings of terror, horror, helplessness, or hopelessness. Examples of traumas include involvement in war, accidents, assault (including physical or sexual assault, mugging or robbery, or family violence), and witnessing something terrible happen. Mass traumatic events include terrorist attacks, mass shootings, warfare and severe weather events.

The traumatic event is not necessarily directly experienced by the person. The person might witness it happening to someone else, learn about a traumatic event that has occurred to someone close to them, or they are exposed to repeated or extreme details of the event.

MHFA might not always occur immediately after the traumatic event. For instance, there are other sorts of traumas that are not single discrete incidents: common examples of recurring trauma include sexual, physical or emotional abuse, or torture. In these cases, the first aid recommendations here will be used when the first aider becomes aware of what has been happening.

Sometimes the memories of a traumatic event suddenly or unexpectedly return, weeks, months or even years afterwards. Again, the first aid recommendations here will be used when the first aider becomes aware of this.

It is important to know that people can differ a lot in how they react to traumatic events.

Particular types of traumas may affect some individuals more than others.

A history of trauma may make some people more susceptible to later traumatic events, while others become more resilient as a result.

How to assess

An older adult who has experienced a traumatic event may react strongly right away, showing you that they need immediate assistance. Others may have a delayed reaction. This means that if you are helping someone you know and see on a regular basis, you may be continually assessing them for signs of distress over the next few weeks.

How to assist

What are the first priorities for helping someone after a traumatic event?

If relevant, you need to ensure your own safety before offering help to anyone. Check for potential dangers, such as fire, weapons, debris or other people who may become aggressive, before deciding to approach an older adult to offer help. If you are helping someone who you do not know, introduce yourself and explain what your role is. Ask for the person's name and use it when talking to them. Remain calm and do what you can to create a safe environment by taking the person to a safer location or removing any immediate dangers.

If the person is injured, it is important that their injuries are attended to. If you are able, offer the person first aid for their injuries, and seek medical assistance. If the person seems physically unhurt, you need to watch for signs that their physical or mental state is declining and be prepared to seek emergency medical assistance for them. Be aware that an older adult may suddenly become disoriented, or an apparently uninjured person may have internal injuries that reveal themselves more slowly.

Try to determine what the person's immediate needs are for food, water, shelter or clothing. However, if there are professional helpers nearby (police, ambulance or others) who are better able to meet those needs, don't take over their role.

If the person has been a victim of assault, you need to consider the possibility that forensic evidence may need to be collected (e.g., cheek swabs, evidence on clothing or skin). Work with the person to preserve such evidence where possible. For example, they may want to change their clothes and shower, which may destroy forensic evidence. It may be helpful to put clothing in a bag for police to take as evidence and suggest to the person that they wait to shower until after a forensic exam. Although collecting evidence is important, you should not force the person to do anything they don't want to do.

Do not make any promises you may not be able to keep. For example, don't tell someone that you will get them home soon if this may not be the case.

What are the priorities if I am helping after a mass traumatic event?

Mass traumatic events are those that affect large numbers of people. They include severe environmental events (such as fires and floods), acts of war and terrorism, and mass shootings. In addition to the general principles outlined above, there are a number of things you need to do.

Find out what emergency help is available. If there are professional helpers at the scene, you should follow their directions.

Be aware of and responsive to the comfort and dignity of the person you are helping, for example by offering the person something to cover themselves with (such as a blanket) and asking bystanders or media to go away. Try not to appear rushed or impatient.

Give the person truthful information and admit that you lack information when this is the case. Tell the person about any available

sources of information which are offered to survivors (for example, information sessions, fact sheets and phone numbers for information lines) as they become available. Do not try to give the person any information they do not want to hear, as this can be traumatic in itself.

How do I talk to someone who has just experienced a traumatic event?

When talking to an older adult who has experienced a traumatic event, it is more important to be genuinely caring than to say all the "right things." Show the person that you understand and care and ask them how they would like to be helped. Speak clearly and avoid clinical and technical language, and communicate with the person as an equal, rather than as a superior or expert. If the person seems unable to understand what is said, you may need to repeat yourself several times. Be aware that providing support doesn't have to be complicated; it can involve small things like spending time with the person, having a cup of tea or coffee, chatting about day-to-day life or giving them a hug.

Behaviour such as withdrawal, irritability and bad temper may be a response to the trauma, so try not to take such behaviour personally. Try to be friendly, even if the person is being difficult. The person may not be as distressed about what has happened as you might expect them to be, and this is fine. Don't tell the person how they should be feeling. Tell them that everyone deals with trauma at their own pace and in their own way. Be aware that cultural differences may influence the way some people respond to a traumatic event; for example, in some cultures, expressing vulnerability or grief around strangers is not considered appropriate.

Should we talk about what happened? How can I support someone in doing so?

It is very important that you do not force the person to tell their story. Remember that you are not the person's therapist. Only encourage the person to talk about their reactions if they feel ready and want to do so. If the person does want to talk, don't interrupt to share your own feelings, experiences or opinions. Be aware that the person may need to talk repetitively about the trauma, so you may need to be willing to listen on more than one occasion. Avoid saying anything that might trivialize the person's feelings, such as "Don't cry" or "Calm down," or anything that might trivialize their experience, such as "You should just be glad you're alive."

Be aware that the person may experience survivor's guilt, the feeling that it is unfair that others died, or were injured, while the survivor was not.

How can I help the person to cope over the next few weeks or months?

If you are helping someone you know after a traumatic event, you can help them to cope with their reactions over the next few weeks or months. You may be helping a family member, perhaps a spouse, sibling or parent you are living with. If you are helping someone you don't know, unless you are responsible for them in some professional capacity, it is not expected that you will have further contact with them.

Encourage the person to tell others when they need or want something, rather than assume others will know what they want. Also encourage them to identify sources of support, including loved ones and friends, but remember that it is important to respect the person's need to be alone at times.

Encourage the person to take care of themselves, to get plenty of rest if they feel tired, to do things that feel good to them (e.g., take baths, read, exercise, watch television), and to recall any coping strategies they have successfully used in the past and use them again. Encourage them to spend time somewhere they feel safe and comfortable.

Be aware that the person may suddenly or unexpectedly remember details of the event and may or may not wish to discuss them. If this happens, the general principles outlined above can help you to assist the person.

Discourage the person from using negative coping strategies such as working too hard, using alcohol or other drugs, or engaging in self-destructive behaviour.

When should the person seek professional help?

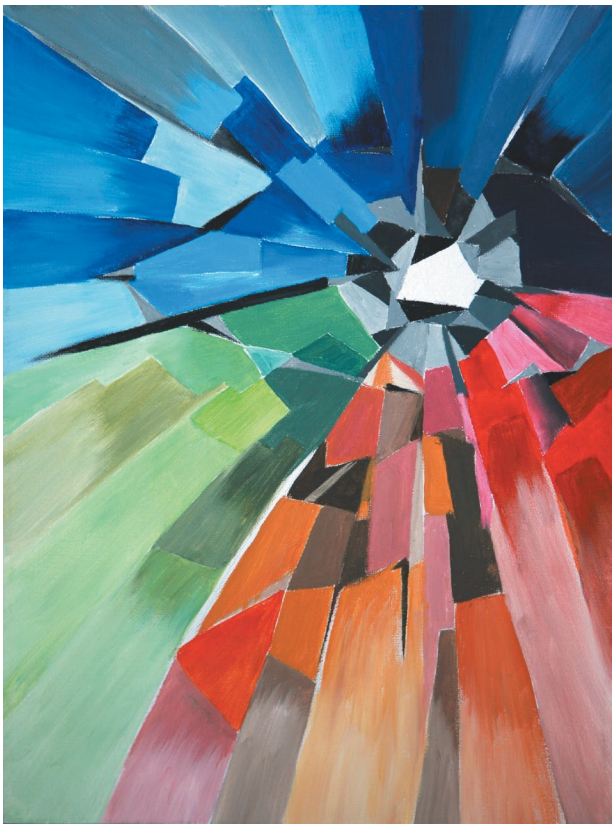
Not everyone will need professional help to recover from a traumatic event. Research has shown that, in an attempt to prevent post-traumatic stress disorder, providing psychological help to everyone within three months following a traumatic event is not helpful and may even have an adverse effect on some individuals. However, if the person wants to seek help, you should support them to do so. Be aware of the sorts of professional help that are available locally, and if the person does not like the first professional they speak to, you should tell them that it is okay to try a different one. If the person hasn't indicated that they want professional help, the following guidelines can help you to determine whether help is needed.

If at any time the person becomes suicidal, you should seek professional help. Section 3.1 *MHFA for Suicidal Thoughts and Behaviours* may be useful in helping you to do this. Also, if at any time the person misuses alcohol or other drugs to deal with the trauma, you should encourage them to seek professional help.

After four weeks, some return to normal functioning is expected. You should encourage the person to seek professional help if after four weeks or more following the trauma:

- They still feel very upset or fearful
- They are unable to escape intense, ongoing distressing feelings
- Their important relationships are suffering as a result of the trauma, e.g., if they withdraw from their family or friends
- They feel jumpy or have nightmares because of or about the trauma.

3.5 MHFA for Severe Psychotic States



Psychosis
By Hien Bui
"My painting looks like the broken glass pieces of psychosis. There is an image of an eye which reflects both views from the unwell person to the world and vice versa. This eye has five main colours that reflect the five main senses of human beings which have been broken."

This section was adapted from the following sources:

- Mental Health First Aid Australia. (2012). *Psychosis: First Aid Guidelines.* http://www.mhfa.com.au/sites/default/files/MHFA_psychosis_guidelines_A4_2012.pdf
- Langlands, R. L., Jorm, A. F., Kelly, C. M., & Kitchener, B. A. (2007). First Aid Recommendations for Psychosis: Using the Delphi Method to Gain Consensus Between Mental Health Consumers, Carers, and Clinicians. *Schizophrenia Bulletin, 34(3),* 435-443. https://doi.org/10.1093/schbul/sbm099
- Pharoah, F., Mari, J. J., Rathbone, J., & Wong, W. (2010). Family intervention for schizophrenia. *Cochrane Database of Systematic Reviews (12).* https://doi.org/10.1002/14651858.CD000088.pub3

Facts on severe psychotic states

If someone has a psychotic illness, they may at times experience severe psychotic states. Some people experience a severe psychotic state only rarely, perhaps every few years; others do so more frequently, and some may experience these states several times a year.

A severe psychotic state can occur without an apparent cause or may be triggered by something specific. Possible triggers include extra stresses or life events (even positive life events such as a new job or a holiday). Forgetting to take medication, or choosing not to, can also trigger a psychotic episode, and this is one of the reasons that it is best for people to continue using their medication as prescribed.

A severe psychotic state may develop gradually over a few days or it may seem to come on very suddenly. For this reason, early signs of a psychotic state should be addressed as quickly as possible.

How to assess

An older adult in a severe psychotic state can have:

- Overwhelming delusions and hallucinations
- Very disorganized thinking

- Bizarre and disruptive behaviours.

The person will appear very distressed or their behaviours may be disturbing to others. When an older adult is in this state, they can come to harm unintentionally because of their delusions or hallucinations, e.g., the person believes they have special powers to protect them from danger such as driving through red lights, or the person may run through traffic to try to escape from their terrifying hallucinations.

How to assist

When helping someone in a severe psychotic state, you should try to remain as calm as possible. It is important to communicate to the person in a clear and concise manner and use short, simple sentences. Speak quietly in a nonthreatening tone of voice and at a moderate pace. If the person asks you questions, answer them calmly. You should comply with requests unless they are unsafe or unreasonable. This gives the person the opportunity to feel somewhat in control.

If the person has an Advance Care Directive or relapse prevention plan, you should follow those instructions. Try to find out if the person has anyone they trust (e.g., close friends, family) and try to enlist their help. You should also assess whether it is safe for the person to be alone and, if not, should ensure that someone stays with them.

It is possible that the person might act on a delusion or hallucination. Remember that your primary task is to de-escalate the situation and therefore you should not do anything to further agitate the person. Try to maintain safety and protect the person, yourself and others around you from harm. It may help to invite the person to sit down. Make sure that you have access to an exit.

Sometimes it is not possible to de-escalate the situation, and if this is the case you should be prepared to call for help from emergency services and convey specific, concise observations about the severity of the person's behaviour and symptoms. When any unfamiliar helpers arrive, explain to the person who they are and how they are going to help. However, if your concerns about the person are dismissed by the services you contact, you should persevere in trying to seek support for the individual.

3.6 MHFA for Severe Effects of Alcohol Use

The Visibly Invisible
By Brenda Hume
"This is what I felt when I drew this picture: isolation, loneliness, depression, sadness, emptiness, self-loathing, all of which are often the symptoms of drinking and even the bigger issue of mental illness. No one should have to live life in such pain and desperation. I believe these are treatable and with help can be avoided."

This section was adapted from the following sources:

- Kingston, A. H., Jorm, A. F., Kitchener, B. A., Hides, L., Kelly, C. M., Morgan, A. J., Hart, L. M., & Lubman, D. I. (2009). Helping someone with problem drinking: Mental health first aid guidelines - a Delphi expert consensus study. *BMC Psychiatry, 9(1), 79.* https://doi.org/10.1186/1471-244X-9-79
- Mental Health First Aid Australia. *Helping Someone with Alcohol Use Problems: Mental Health First Aid Guidelines.* https://www.mhfa.com.au/sites/default/files/mhfa_alcohol_use_guidelines_2020.pdf

Facts on alcohol intoxication, poisoning and withdrawal

Alcohol intoxication refers to significantly elevated levels of alcohol in an older adult's bloodstream, which substantially impairs the person's thinking and behaviour.

Alcohol poisoning means the person has a toxic level of alcohol in the bloodstream. This can lead to the person's death. The amount of alcohol that causes alcohol poisoning is different for every person.

Alcohol withdrawal refers to the unpleasant symptoms an older adult experiences when they stop drinking or drink substantially less than usual. Unmedicated alcohol withdrawal may lead to seizures.

How to assess

Common signs and symptoms of **alcohol intoxication** include:

- Loss of coordination
- Slurred speech
- Staggering or falling over
- Loud, argumentative or aggressive behaviour
- Vomiting
- Blackouts (no memory of what happened during the drinking episode)
- Drowsiness or sleepiness.

Signs and symptoms of alcohol intoxication and poisoning which may lead to a medical emergency are:

- Continuous vomiting
- Cannot be woken
- Unconsciousness
- Signs of a possible head injury, e.g., they are vomiting and talking incoherently
- Irregular, shallow or slow breathing
- Irregular, weak or slow pulse rate
- Cold, clammy, pale or bluish-coloured skin.

Signs and symptoms of severe **alcohol withdrawal,** which may lead to a medical emergency are:

- Delirium tremens (a state of confusion and visual hallucinations)
- Agitation
- Fever
- Seizures

How to assist

If the person is intoxicated:

- Stay calm
- Communicate appropriately. Talk with the person in a respectful manner and use simple, clear language. Do not laugh at, make fun of, or provoke the person.
- Monitor for danger. While intoxicated, the person may engage in a wide range of risky activities (such as having unprotected sex, vandalizing property or driving a car). Assess the situation for potential dangers and ensure that the person, yourself and others are safe. Monitor the person and their environment to prevent tripping or falling. Ask the person if they have taken any medications or other drugs, in case their condition deteriorates into a medical emergency.
- Ensure the person's safety. Stay with the person or ensure they are not left alone. Be aware that the person may be more intoxicated than they realize. Keep them away from machines and dangerous objects. If the person attempts to drive a vehicle (or ride a bike), you should try to discourage them, e.g., by telling them about the risks to both themselves and others. Only prevent the person from driving if it is safe to do so. If it is unsafe, call the police. Arrange for the person to go to a hospital if you think the person is a risk to themselves; otherwise organize a safe mode of transport to get the person home. Alcohol intoxication, poisoning and withdrawal may lead to medical emergencies. Be aware that alcohol consumption can mask pain from injuries.

When to call an ambulance

Call an ambulance or seek medical help in any of the following circumstances:

- The person is unconscious, i.e., cannot be woken
- The person has irregular, shallow or slow breathing
- The person has an irregular, weak or slow pulse rate
- The person has cold, clammy, pale or bluish coloured skin
- The person is continuously vomiting
- The person shows signs of a possible head injury, e.g., they are vomiting and talking incoherently.
- The person has a seizure
- The person has delirium tremens – a state of confusion and visual hallucinations
- Drink spiking is suspected.

Tips about calling an ambulance

- Do not be afraid to seek medical help for the person, even if there may be legal implications for them.
- Be aware that ambulance and hospital staff are there to help the person and not to enforce the law.
- When you call for an ambulance, it is important that you follow the instructions of the telephone operator.
- When asked, describe the person's symptoms and explain that the person has been drinking alcohol.
- Have the address of your location ready to give to the telephone operator and stay with the person until the ambulance arrives.
- It is beneficial for a friend or family member to accompany the person to hospital, as they may be able to provide relevant information.

What to do while waiting for the ambulance

While waiting for the ambulance ensure that:

- The person is not left alone.
- No food is given to the person, as they may choke on it if they are not fully conscious.
- The person's airway, breathing and circulation are monitored.
- If the person is hard to wake, put them in the recovery position (see box "Helping an unconscious person").
- If the person is vomiting and conscious, keep the person sitting. Alternatively, put them in the recovery position. If necessary, clear the person's airway after they have vomited.

Can I help the person sober up?

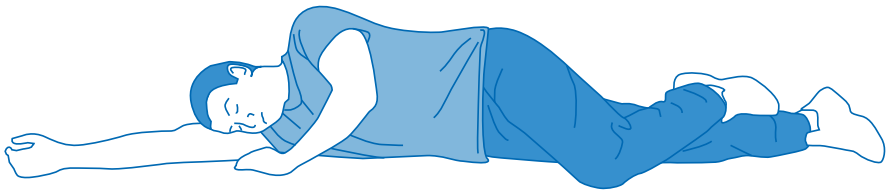
Only time will reverse the effects of intoxication. The body metabolizes approximately one standard drink of alcohol an hour. Drinking black coffee, sleeping, walking and cold showers will not speed up this process.

Helping an unconscious person

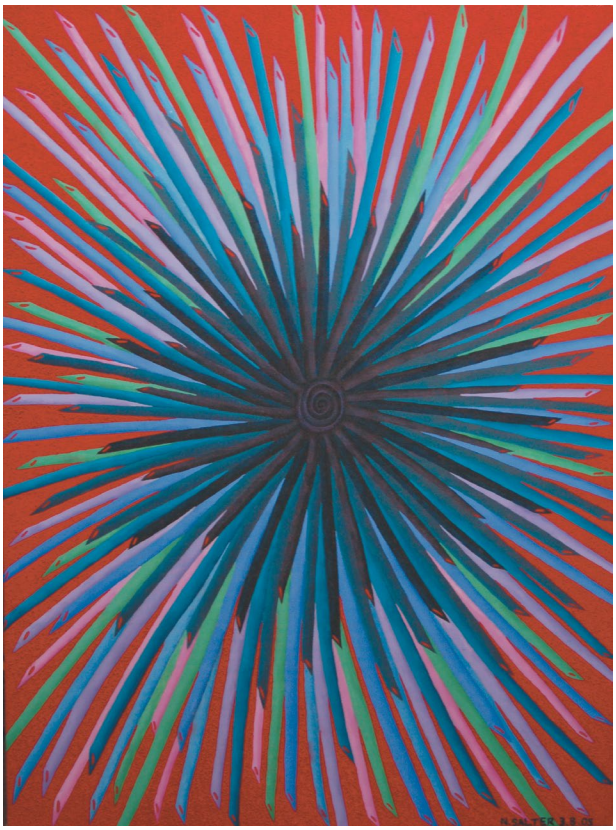
Do not leave the person lying on their back, as they could suffocate on their vomit or their tongue could block their airway. Putting the person in the recovery position will help to keep the airway open. Before rolling the person into the recovery position, check for sharp objects, e.g., broken glass or syringes on the ground. If necessary, clear the person's airway after they have vomited. Keep the person warm without allowing them to overheat.

The person should be placed on a firm surface—the ground or on a bed, not on a couch, and with no pillows or cushions close to their face. On a couch, the person may roll forward or back and suffocate.

If the person is alcohol or drug affected they may not be quite unconscious and may react to being physically touched by lashing out, or they may be afraid. Therefore, it is better not to touch them on the shoulder; instead, nudge their foot gently with your own to check their level of consciousness. Speak to them before placing them in the recovery position and explain to them throughout the whole process what you are doing.



3.7 MHFA for the Effects of Severe Drug Use



Escaping the Spiral of Needles
By Nicole Salter
Nicole painted this in 2005 when she was 20 years old. At the time she was overcoming a substance use problem. The middle part of the painting uses dark colours and represents addiction. As she escapes the addiction the colours brighten. At the time she was making a decision between her relationship with her boyfriend or substance use. She decided that if she chose drugs she would still be thinking about her boyfriend, so she chose him instead.

This section was adapted from the following sources:

- Kingston, A. H., Morgan, A. J., Jorm, A. F., Hall, K., Hart, L. M., Kelly, C. M., & Lubman, D. I. (2011). Helping someone with problem drug use: a delphi consensus study of consumers, carers, and clinicians. *BMC Psychiatry, 11(1)*, 3. https://doi.org/10.1186/1471-244X-11-3
- Mental Health First Aid Australia. *Helping Someone with Drug Use Problems: Mental Health First Aid Guidelines.* https://www.mhfa.com.au/sites/default/files/problem_drug_use_mhfa_guidelines_-_may_2020.pdf

Facts on drug-affected states

Drug-affected states are short-term changes in an older adult's state of mind or behaviour as a result of drug use. These states distress the person or impair their ability to function. The effects of drugs on behaviour can vary from person to person depending on the sort of drug being used and the amount taken.

Illicit drugs can have varying effects, as they are not manufactured in a controlled way. It is often difficult to make a distinction between the effects of different drugs. Overdose refers to the use of an amount of a drug that could cause death, most typically opioid drugs. Overdose leads quickly to loss of consciousness.

How to assess

Some drugs have stimulating effects ("uppers" such as cocaine and amphetamines), including making the person feel energetic and confident. Signs of more acute intoxication include becoming frustrated or angry, having a racing heart, and overheating or dehydration.

Some drugs have hallucinogenic effects ("trips" such as magic mushrooms and LSD), including hallucinations and delusions and feelings of affection for others. Signs of more acute intoxication include having more

negative hallucinations and delusions and becoming fearful or paranoid.

Some drugs have depressant effects ("downers" such as cannabis and tranquilizers), including fatigue, slurred speech and slowed reflexes. Signs of more acute intoxication include feelings of having trouble moving, vomiting and loss of consciousness.

Some drugs (such as ecstasy and cannabis) may have multiple effects. This is why it can be hard to tell what sort of drug has been used.

Overheating or dehydration from drug use can also lead to a medical emergency. Prolonged dancing in a hot environment (such as a dance party) while on some drugs (e.g., ecstasy) without adequate water intake can cause the person's body temperature to rise to dangerous levels. This can lead to symptoms of overheating or dehydration, such as:

- Feeling hot, exhausted and weak
- Persistent headache
- Pale, cool, clammy skin
- Rapid breathing and shortness of breath
- Fatigue, thirst and nausea
- Giddiness and feeling faint.

How to assist

If the person is in a drug-affected state:

- Stay calm.
- Communicate appropriately. Talk with the person in a respectful manner and use simple, clear language. Be prepared to repeat simple requests and instructions, as the person may find it difficult to comprehend what has been said. Do not speak in an angry manner. Do not laugh at, make fun of or provoke the person.
- Monitor for danger. While in a drug-affected state, the person may engage in a wide range of risky activities (such as having unprotected sex, vandalizing property or driving a car). Assess the situation for potential dangers and ensure that the person, yourself and others are safe. Monitor the person and their environment to prevent tripping or falling.
- Ensure the person's safety. Stay with the person or ensure they are not left alone. Be aware that the person may be more affected than they realize. Keep them away from machines and dangerous objects. If the person attempts to drive a vehicle (or ride a bike), you should try to discourage them, e.g., by telling them about the risks to both themselves and others. Only prevent the person from driving if it is safe to do so. If it is unsafe, call the police. Arrange for the person to go to a hospital if you think the person is a risk to themselves; otherwise organize a safe mode of transport to get the person home. Encourage the person to tell someone if they start to feel unwell or uneasy, and to call emergency services if they have an adverse reaction. Drug use can lead to a range of medical emergencies.

When to call an ambulance

Call an ambulance or seek medical help in any of the following circumstances:

- The person cannot be woken.
- Deteriorating or loss of consciousness.
- The person has irregular, shallow or slow breathing.
- The person has an irregular, weak or slow pulse rate.
- The person has cold, clammy, pale or bluish-coloured skin.
- The person is continuously vomiting.

- The person shows signs of a possible head injury (for example, they are vomiting and talking incoherently).
- The person has a seizure.
- The person has delirium—a state of confusion and visual hallucinations.
- Overheating, dehydration or overhydration.

Tips about calling an ambulance

- Do not be afraid to seek medical help for the person, even if there may be legal implications for the person. Be aware that ambulance and hospital staff are there to help the person and not to enforce the law.
- When you call for an ambulance, it is important that you follow the instructions of the telephone operator.
- When asked, describe the person's symptoms and explain that the person has been using drugs. Try to get detailed information about what drugs the person has taken by either asking the person, their friends or visually scanning the environment for clues.
- Have the address of your location ready to give to the telephone operator and stay with the person until the ambulance arrives.
- It is beneficial for a friend or family member to accompany the person to hospital, as they may be able to provide relevant information.

What to do while waiting for the ambulance

Ensure that:

- The person is not left alone.
- No food is given to the person, as they may choke on it if they are not fully conscious.
- The person's airway, breathing and circulation are monitored.
- If the person is hard to wake, put them in the recovery position (see Helping an unconscious person next page).
- Give first aid for any overheating or dehydration.

Helping an older adult who is overheating or dehydrated

If the person is showing symptoms of overheating or dehydration, you must keep the person calm and seek medical help immediately. Encourage the person to stop dancing and to rest somewhere quiet and cool. While waiting for help to arrive, reduce the person's body temperature gradually. Do this by loosening any restrictive clothing or removing any additional layers, and encourage the person to sip non-alcoholic fluids, e.g., water and soft drinks. Prevent the person from drinking too much water too quickly as this may lead to overhydration and even coma or death. Discourage the person from drinking alcohol as it may further dehydrate them.

What do I do if the intoxicated person becomes aggressive?

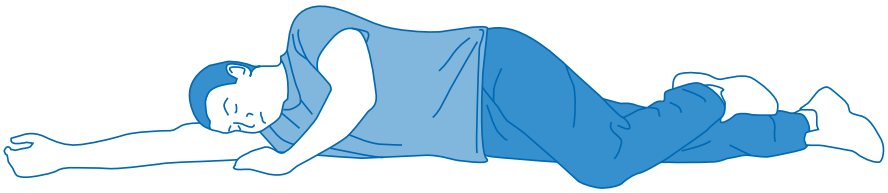
If this occurs, follow the advice in Section 3.8 *MHFA for Aggressive Behaviours.*

Helping an unconscious person

Do not leave the person lying on their back, as they could suffocate on their vomit or their tongue could block their airway. Putting the person in the recovery position will help to keep the airway open. Before rolling the person into the recovery position, check for sharp objects, e.g., broken glass or syringes on the ground. If necessary, clear the person's airway after they have vomited. Keep the person warm without allowing them to overheat.

The person should be placed on a firm surface—the ground or on a bed, not on a couch, and with no pillows or cushions close to their face. On a couch, the person may roll forward or back and suffocate.

If the person is alcohol or drug affected they may not be quite unconscious and may react to being physically touched by lashing out, or they may be afraid. Therefore, it is better not to touch them on the shoulder; instead, nudge their foot gently with your own to check their level of consciousness. Speak to them before placing them in the recovery position and explain to them throughout the whole process what you are doing.



3.8 MHFA for Aggressive Behaviours

The Fight Between Fire and Water
By Peter

"The two opposites fighting. Fire represents our rage, our desires. Water is our salve, our restraint, our calm and is used to keep fire under control."

This section was adapted from the following sources:

- Mental Health First Aid Australia (2012). *Psychosis: Mental Health First Aid Guidelines.* http://www.mhfa.com.au/sites/default/files/MHFA_psychosis_guidelines_A4_2012.pdf
- Mental Health First Aid Australia. (2020) *Helping Someone with Alcohol Use Problems: Mental Health First Aid Guidelines.* https://www.mhfa.com.au/sites/default/files/mhfa_alcohol_use_guidelines_2020.pdf

Facts on aggressive behaviours

The vast majority of people with mental illnesses are not dangerous to others. Only a small proportion (up to 10%) of violence in society is due to mental illness (Arseneault et al., 2000; Noffsinger & Resnick, 1999; Walsh et al., 2002).

Depression and anxiety disorders have little or no association with violent behaviour towards others. However, there is an increased risk of violence for people who experience substance use disorders, personality disorders or psychosis (Arseneault et al., 2000; Fazel et al., 2010).

The use of alcohol or other drugs has a stronger association with violence than do mental illnesses. Many crimes are committed by people who are intoxicated with alcohol or other drugs.

When a violent act is committed by an older adult having an episode of psychosis, it is generally done out of fear, with the person believing they are acting out of self-defence.

How to assess

Aggression has different components to it—verbal (e.g., insults or threats), behavioural (e.g., pounding, throwing things, violating personal space) and emotional (e.g., raised voice, looks angry). What is perceived as aggression can vary between individuals and across cultures. It is best to prevent aggression and therefore take action to de-escalate the situation as soon as you perceive any aggressive behaviour. If you are concerned that the person is becoming aggressive, you need to take steps to protect yourself and others.

How to assist

If the person becomes aggressive, ensure your own safety at all times. Remain as calm as possible and try to de-escalate the situation.

How to de-escalate the situation

- Speak to the person slowly and confidently with a gentle, caring tone of voice.
- Do not respond in a hostile, disciplinary or challenging manner.
- Do not argue with the person.
- Do not threaten them, as this may increase fear or prompt aggressive behaviour.
- Avoid raising your voice or talking too fast.
- Be aware that the person may overreact to negative words. Therefore, use positive words (such as “Stay calm”) instead of negative words (such as “Don’t fight“).
- Stay calm and avoid nervous behaviour, e.g., shuffling your feet or making abrupt movements.
- Do not restrict the person’s movement, e.g., if they want to pace up and down the room.
- Remain aware that the person’s symptoms or fear causing their aggression might be exacerbated if you take certain steps, e.g., involve the police.
- Consider taking a break from the conversation to allow the person a chance to calm down.
- Consider inviting the person to sit down if they are standing.

Take any threats or warnings seriously, particularly if the person believes they are being persecuted. If you are frightened,

seek outside help immediately. You should never put yourself at risk and always ensure you have access to an exit. Similarly, if the person's aggression escalates out of control at any time, you should remove yourself from the situation and call for emergency assistance, e.g., the mental health crisis team or the police.

If you believe that the aggression is related to a mental health problem, you may need to call a mental health crisis team. If you do so, it is best to describe the person's symptoms and behaviours rather than trying to make a diagnosis of your own. Be aware that the crisis team may not attend without a police presence.

If the situation becomes unsafe, it may be necessary to involve the police. If you suspect that the person's aggression is related to a mental health problem, to assist the police in their response, you should tell them that this is the case and that you need their help to obtain medical treatment and to control the person's aggressive behaviour. Aggressive behaviour is frequently associated with intoxication with alcohol or another drug. If this is the case, and you decide to call the police, tell the police that you believe the person is intoxicated, and what substances you believe have been used. In either case, you should tell the police whether or not the person is armed.

Appendices

Appendix 1: MHFA Key Terms and Concepts

Mental health

The World Health Organization has defined "mental health" as

"… a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (World Health Organization, 2018).

Mental health is fundamental to our collective and individual ability as humans to think, emote, interact with each other, earn a living and enjoy life. It influences how we think and feel about ourselves and others and how we interpret events. It affects our capacity to learn, communicate, and form, sustain or end relationships. Good mental health buffers us from stresses and hardships that are part of life for us all and can help reduce the risk of developing mental problems or disorders. Even when someone develops a mental health problem or disorder, they can nonetheless experience good mental health, and this can contribute to their journey of recovery (Provencher & Keyes, 2011).

Mental well-being or mental wellness

These two terms are often used interchangeably with mental health when referring to positive mental health. Our mental health/wellness/well-being allows us to realize our potential, cope with stress effectively, bounce back from life challenges and be active, productive members of our communities.

How each of us defines our mental health/wellness/well-being can be very different and quite individualized, it is about living well and feeling capable despite life's challenges (Bridge the gApp, n.d.; Public Health Agency of Canada, n.d.).

Note: In this MHFA course, we'll use the term "mental well-being."

What's the connection between mental health and mental well-being?

Excerpt from: Toward Recovery and Well-being: A Framework for a Mental Health Strategy for Canada (Mental Health Commission of Canada, 2009, p. 10)

"We will all experience varying levels of need related to our mental health at different times during our lives. Sometimes, people's mental health will be challenged by short-term reactions to difficult situations such as school pressures, work-related stress, relationship conflict, or grieving the loss of a loved one. These challenges are usually eased with time and informal support. At other times, the degree of need will be sufficiently great that people will require more specialized assistance. Estimates suggest that, in any given year, about one in every five people living in Canada will experience diagnosable mental health problems or illnesses. These can occur at any time of life, affecting infants, children and youth, adults, and older adults No one is immune – no matter where they live, what their age, or what they do in life. This means that just about every family in the country will be directly affected, to some degree, by mental illness. People can have varying degrees of mental health, regardless of whether or not they have a mental illness. For example, some people, whether they have a mental illness or not, have tremendous resilience, strength, healthy relationships, and a positive outlook. Having good mental health helps to protect people from the onset of mental health problems

and illnesses and to buffer the impact of the stresses and hardships that are part of life for everyone. Being mentally healthy involves having both a sense of coherence that helps people to function well despite the challenges they confront, and the resiliency to bounce back from setbacks. The evidence suggests that people who experience the best mental health – independently of whether or not they are living with symptoms of a mental illness – function better that those who are either moderately mentally healthy or in poor mental health. Not only is mental health essential for well-being and functioning in every setting, but mental, physical, and spiritual health influence one another. Others, whether they have a mental illness or not, may feel that day-to-day life is a struggle, that they have limited prospects, few friends, and are more easily set back by life's challenges."

Mental health disorder or mental illness

A mental health disorder or a mental illness is a diagnosable illness that affects an older adult's thinking, emotional state and behaviour, and disrupts the person's ability to work or carry out other daily activities and engage in satisfying personal relationships (American Psychiatric Association, 2013).

In Canada most health professionals will use the Diagnostic Statistical Manual 5 (DSM 5) or International Classification of Diseases (ICD 10) to assess whether or not an older adult meets the criteria for diagnosis of a mental health, substance use, or addiction disorder.

Note: In this MHFA course, we'll use the term "mental health disorder."

Substance Use Disorder

For an older adult to have a substance use disorder, their substance use problems must have an adverse effect on their life during the past year in two or more of the following areas:

- Using a substance in larger amounts or for longer periods than intended
- Wanting to cut down use or quit entirely but finding this difficult
- Spending a lot of time obtaining the substance, using it or recovering from its effects
- Craving (i.e., a strong urge) to use the substance
- Neglecting roles and responsibilities at work, school and home
- Continuing to use despite this causing on-going relationship problems with other people, e.g., arguments, fights
- Giving up other important activities you once enjoyed because of the substance use
- Using in ways that are hazardous to oneself or others (e.g., driving a car or using machinery while affected by a substance)
- Continuing to use despite mental or physical health problems caused by the substance
- Needing to use more of the substance to get the desired effect (tolerance)
- Experiencing withdrawal symptoms when use stops, which can be relieved by taking more of the substance

Concurrent Disorders

Mental health problems can often occur in combination with substance use or addiction disorder. Research shows that more than 50% of those seeking help for a substance use disorder or addiction also have a mental

illness, and 15-20% of those seeking help from mental health services are also living with an addiction or substance use disorder (Canadian Centre on Substance Abuse, 2009).

Concurrent disorders is a term used to refer to co-occurring addiction and mental health problems. This term covers a wide array of combinations of problems, such as: anxiety disorder and an alcohol problem, schizophrenia and cannabis dependence, borderline personality disorder and heroin dependence, and bipolar disorder and problem gambling. These problems can co-occur in a variety of ways. They may be active at the same time or at different times, in the present or in the past, and their symptoms may vary in intensity and form over time. People often ask, "Which came first: the mental health problem or the substance use problem?" This is a hard question to answer. It's more useful to think of them as independent problems that interact with each other (Centre for Addiction and Mental Health, n.d.-a).

Co-Morbidity

Mental health and substance use problems also occur in combination with physical health problems, including neuro degenerative disorders. This is most often referred to as co-morbidity. For example, it is not uncommon for an older adult with diabetes or heart disease to also experience depression. Studies have demonstrated that people score lower on subjective well-being scales when physical-mental comorbidity is present (Wang & Kim, 2020).

The incidence of depression may be 30% in vascular dementia and in Alzheimer's disease (Enache et al., 2011) and over 40% in the dementia associated with Parkinson's and Huntington's diseases (Reijnders et al., 2008).

A mental health or substance use "problem"

A mental health or substance use problem is a broader term including both illnesses and symptoms of illnesses that may not be severe enough to warrant the diagnosis of a mental illness. The word "problem" covers a wider range of mental health or substance use concerns—from the worries we all experience and cope with as part of everyday life, to those mental health or substance use disorders that more severely impact one's ability to carry out daily life activities or maintain relationships or increase risk for suicide.

This course provides information on how to assist older adults with a wide range of mental health and substance use problems and not only those with diagnosable disorders.

Recovery

The concept of "recovery" as discussed in this course refers to living a satisfying, hopeful and contributing life, even when experiencing ongoing symptoms of a mental health or substance use problem or illness. Recovery journeys build on individual, family, cultural and community strengths and can be supported by many types of services, supports and treatments.

Recovery principles are anchored around in hope, dignity, self-determination and responsibility and can be adapted to the realities of different life stages, and to the full range of mental health problems and illnesses. Recovery is not only possible; it should be expected. Factors that help individuals on their recovery journey include:

- support from family and friends
- meaningful participation on society, and

- professional help and evidence-based treatment and supports

The following excerpt offers further clarity on the concept of recovery as discussed in this course:

"There is no single, comprehensive definition of recovery and well-being that is shared by everyone. In part, this flows from the fact that each person's journey of recovery is necessarily different, as they draw on their own unique set of resources, strengths, and relationships to confront the specific challenges they face. Experience has shown that the journey of recovery will likely not be a linear one, and that individuals may experience setbacks along the way. But whose life is otherwise, and why should there be a different standard for people seeking to pursue a journey of recovery than for those who are not experiencing mental health problems or illnesses? The journey of recovery and well-being has no fixed end point; it is a path along which people can discover or rediscover their strengths and work to attain the best possible quality of life. This journey will build on individual, family, cultural, and community strengths and will reflect people's unique histories and traditions" (Mental Health Commission of Canada, 2009, p. 13).

Stigma

Stigma refers to the negative and prejudicial ways in which older adults living with a mental health or substance use problem are labelled. It is an overarching term that encompasses the processes of labelling, separation, prejudice, and discrimination. Lack of knowledge of mental illness spreads fear and misinformation, labels individuals and perpetuates stereotypes. Stigma affects how people think, feel and act towards others who are deemed to be different.

Note – Use of terms in this course

When we speak of mental health and substance use problems and disorder in this course, we are referring to clinically significant patterns of behaviour or emotions that are associated with some level of distress, suffering, or impairment in one or more areas such as school, work, social and family interactions, or the ability to live independently.

There are many different kinds of mental health and substance use problems and illnesses. They range from anxiety and depressive disorders through to schizophrenia and bipolar disorder, and these problems and illnesses are often associated with a formal medical diagnosis. There is no single cause for most mental health problems and illnesses. They are thought to be the result of a complex interaction among social, economic, psychological and biological or genetic factors. The factors that play a role in the development of mental health problems and illnesses are very similar to those that influence our overall mental health and well-being, and vice versa.

Appendix 2: Summary of Communication Strategies

Build rapport and trust to help the older adult speak openly

Why is this important?

"Recovery is made possible by having a safe space to be ourselves, and to find friends, family and peers who know and understand our experiences; it's nurtured when our voices are heard, and we get to speak our stories of courage and resilience. Recovery is about hope" (Mental Health Commission of Canada, 2015, p. 6).

Build rapport and trust with words

Use "I" statements and describe behaviours rather than making judgments.
Sam, I noticed that you are sleeping in past noon and have missed two appointments. I'm worried about you. I'd like to help.

Ask open questions to invite the older adult to share thoughts or feelings.
It sounds like you are having a difficult time right now. I'm wondering if you would like to talk with me about it?

Clarify and confirm: Clarify your understanding of what the older adult said in your own words and ask for confirmation that your understanding is accurate.
What I'm hearing is... Is this correct?

Demonstrate empathy.
I can understand that having to remain isolated from your friends during this pandemic can be difficult.

Talk about things that refer back to what the other person has said. Find links between common experiences.
You mentioned that you've been having problems sleeping. The same thing happens to me when I'm stressed at work. What do you find has helped?

Ask questions to assess risk of harm to self or to others.
I realize it may be hard to talk about this. Thank you for being honest. Can I ask, how long have you been feeling this way?

Ask questions to assess risk of suicide.

- *Can I ask, have you had thoughts of suicide?*
- *Thank you for being honest. Can I ask, do you have a plan?*
- *I'm worried about your safety. Do you have the means?*
- *And to clarify, do you have a time in mind?*

Build rapport and trust with nonverbal language

It is better to approach the older adult alone, because having a number of people confront them at the same time could be overwhelming.

Small smiles can be used to show that the listener is paying attention to what is being said or as a way of agreeing or being happy about the messages being received. Combined with nods of the head, smiles can be powerful in affirming that messages are being listened to and understood.

If it is safe, sit down, even if the older adult is standing. This may seem less threatening. It is best to sit alongside the older adult and angled towards them, rather than directly opposite them.

It is normal and usually encouraging for the listener to look at the speaker. Eye contact can however be intimidating, especially for more shy speakers – gauge how much eye contact is appropriate for any given situation.

Mirror and match mannerisms and speech appropriately to create and maintain rapport subconsciously.

Continue using these strategies to create and maintain rapport and trust throughout the conversation.

Understand the situation fully

Why is this important?

Listening and communicating nonjudgmentally are actions that occur throughout the giving of first aid. It can help the older adult to feel heard and understood, while not being judged in any way. This can make it easy for the older adult to feel comfortable to talk freely about their problems and to ask for help. It will also help to prepare for a discussion of practical and appropriate supports.

Understand the situation fully with words

Ask questions which show that you genuinely care and are interested in what the person is saying.

- *You mentioned… Can you tell me more about that?*
- *Feelings of hopelessness can be difficult to cope with. You mentioned… can you talk more about that?*

Check your understanding by restating what they have said and summarizing facts and feelings.

Encourage the older adult to speak by using "low-level messages."

- *I see…*
- *Uh-huh…*
- *Mm-hmm*

Understand the situation fully with nonverbal language

Listen not only to what the older adult says, but how they say it; their tone of voice and nonverbal cues will give extra clues about how they are feeling.

Posture can tell a lot about the sender and receiver in interpersonal interactions. The attentive listener tends to lean slightly forward or sideways whilst sitting. Other signs of active listening may include a slight slant of the head or resting the head on one hand.

Maintain an open body position. Don't cross your arms over your body, as this may appear defensive. **Nod to encourage the older adult to keep speaking.**

Be patient, even when the person isn't communicating well, is repetitive or is speaking slower and less clearly than usual. Resist any urge to finish the older adult's sentences.

Remember that pauses and silences are okay. The older adult may need time to think on what has been said or may be struggling to find the words they need.

Maintain comfortable eye contact, i.e., the level of eye contact that the older adult seems most comfortable with. Avoid staring.

Avoid distracting gestures, such as fidgeting with a pen, glancing at other things or tapping your feet or fingers, as these could be interpreted as a lack of interest.

Motivate the older adult to reach out to supports by offering messages of hope that recovery to improved mental well-being is possible.

Why is this important?

People who experience mental health or substance use problems are often led to believe that they should not expect to improve, that they will never be able to function well in society, or that they will always be incapable of caring for themselves. This lack of hope can become self-fulfilling. Key components of recovery are finding, maintaining and repairing hope, believing in oneself, having a sense of being able to accomplish things, and being optimistic about the future.

Offer messages of hope

Remind the older adult that they are not alone and that you are interested in helping them.
I want you to know that you are not alone. Others have experienced this too. Your problems not a reflection of personal weakness or a character defect.

Remind the older adult of their strength.
I realize that this can be difficult to talk about. It is brave of you to reach out for help by talking with me.

Express empathy for how the older adult is feeling. Validate the person's emotions by explaining that these emotions are appropriate and valid.
Given what you've been going through, it is understandable that you feel this way.

Highlight and repeat the hopeful messages you heard them say:
It sounds like even though you are having a difficult time now, there have better ones in the past.

Do not give glib reassurances, e.g., "Don't worry," "Cheer up," "You have everything going for you" or "Everything will be alright."

Motivate the older adult to reach out to supports by encouraging personal choice and responsibility for mental well-being.

Why is this important?

"Recovery is nurtured by working with people to help activate their internal resources, so they are able to retain and deepen a belief in their abilities, strengthen their sense of personal agency and acquire control over their journey of recovery and well-being. When people are encouraged to focus on their strengths and what they can do—rather than on their limitations and the barriers they face—they are more likely to access available resources, take risks and explore new opportunities. Recovery-oriented practice enables people to choose from amongst a full range of treatments, supports and services that would benefit them." (Mental Health Commission of Canada, 2015, p. 20)

Encouraging personal choice and responsibility for mental well-being by using a collaborative approach.

Remind them that others have experienced recovery to improved mental well-being by reaching out to supports.

Older adults can and do recover from mental health or substance use problems or learn to manage their symptoms, especially with early diagnosis.

Work collaboratively with the older adult in finding solutions, i.e., by finding out what they want to happen, or what has helped in the past.
What has helped you through difficult times in the past?

Build on the older adult's ideas.
You mentioned that in the past your sister was helpful. What if we reached out to her?

If they are reluctant to talk or to reach out to supports, keep the door open to future discussions.
I want you to know that if ever you do start feeling worse, you can always talk to me about it.

Appendix 3: Cultural Considerations and Communication Techniques

Untitled
By Johanna Parker
"Overcoming the past injustices has made strong spirits rise and stand tall, like tree trunks bold and solid."

This section was adapted from the following source:

Mental Health First Aid Australia. (2012a). *Cultural Considerations & Communication Techniques: Guidelines for providing Mental Health First Aid to an Aboriginal or Torres Strait Islander Person.* https://www.mhfa.com.au/sites/default/files/AMHFA_Cultural_guidelines_email_2012.pdf

Learn about the person's culture and their concept of mental health and well-being

An older adult's culture plays a very important role in the way they understand and talk about health and ill health, and how they go about seeking help from friends, family or professionals.

Know what is normal, and what is not, in the person's culture

When assisting someone outside your own culture or community, it is very important that you take into consideration the spiritual or cultural context of the person's behaviours. Fear of misdiagnosis can be a strong barrier to help-seeking. For these reasons, you should take great care not to simply assume that the person is developing a mental illness or experiencing a mental health crisis.

Please be aware that these guidelines are not exhaustive, and although they may assist you in providing first aid, they alone will not make you a culturally competent first aider.

Intercultural Communication

- Be aware that an older adult's culture will shape how they understand health and ill health
- Learn about the specific cultural beliefs that surround mental illness in the person's community
- Learn how mental illness is described in the person's community (knowing what words and ideas are used to talk about the symptoms or behaviours)
- Be aware of which concepts, behaviours or language are taboo (knowing what might cause shame)
- Don't make assumptions about beliefs, practices or preferences.

Know which ways of communicating are culturally appropriate

When approaching someone outside your own culture or community to discuss their mental

well-being, be aware that what is considered respectful communication (including body language, seating position and use of certain words) may differ from community to community and region to region, especially between rural and remote areas. In some communities, for example, eye contact is considered to be staring and may make the person feel as though they are being judged.

Begin by having a chat with the person. Spend time with them and let them know that you are worried about them. Ask for the person's permission before asking about sensitive topics but suggest that they may feel better once they have spoken about their problems. Be careful not to falsely imply that by talking about mental illness the person's problems will go away. Instead, just reassure the person that you care and want to help.

When discussing your concerns, use simple and clear language.

Avoid asking lots of questions and speaking to the person in a patronizing manner. Allow for periods of silence while the person considers what you have said and allow them to have plenty of time to tell their story.

If family members are present, expect that they might answer some questions on behalf of the person. Avoid asking questions that might embarrass the person in front of their family and friends and remember never to criticize members of the extended family in front of the person. If you think that it might make the person more comfortable, ask them if they would like to find another safe area, away from family and friends, in which to talk.

Remember that it is more important to make the person feel comfortable, respected and cared for than to do all the "right things" and follow all the "rules" when communicating. Importantly, if the person finds it too hard to talk about their problems, you should respect this.

Do not shame the person, their family or community

The concept of shame is very important within many cultural communities and can be a barrier to seeking help. Shame may also be caused through not practicing cultural safety.

Be aware of what language and behaviours cause shame within the person's community. Understand how the person you are helping might feel shame if you behave a certain way or use certain words. In some communities, for instance, talking about mental illness can cause individuals to feel shame, and therefore it might be helpful to stick to discussing behaviours and feelings, rather than talking about labels such as "depression" or "psychosis." Also understand how this community might feel shame. In some more traditional communities, for example, insisting that the person see a health worker from outside their own culture might cause shame to the community, as it implies that their own ways of healing are inferior to others.

Use community and family supports

If you are worried about the person's safety, or if the person is experiencing a crisis, be persistent in trying to get the person help and support from others. Make sure you have a discussion with them about how they would like to be helped.

Try to get the person's family involved in supporting them until they get better, but in doing so, you must uphold the person's right to confidentiality. Unless you are worried that there is a risk of harm to the person or harm to others, you should have the person's permission before seeking help from family or other community members.

Another way to be supportive is to encourage the person to build personal relationships with people who they can trust, respect and turn to for support or assistance when feeling unwell. Also, find out what the person's interests and activities are and encourage participation in any group activities that will help them to develop feelings of purpose, belonging and achievement.

Appendix 4: Considerations for MHFA with members of the 2SLGBTQ+ Community

Untitled
By Maggie Ann Crowe
"This is a sketch of how it feels to me, to be visibly trangender. Helpless to staring accusing faces seen in every shadow."

This section was adapted from the following source:

Mental Health First Aid Australia. (2020a). *Considerations When Providing Mental Health First Aid to an LGBTIQ Person.* https://www.mhfa.com.au/sites/default/files/considerations_when_providing_mhfa_to_an_lgbtiq_person_guidelines_-_may_2020_0.pdf

Purpose of these guidelines

These guidelines outline ways of demonstrating respect when offering MHFA to 2SLGBTQ+ persons.

How to use these guidelines

These guidelines are a general set of recommendations. Each individual is unique, and it is important to tailor your support to that person's needs. Therefore, these recommendations may not be appropriate for every person.

Understanding 2SLGBTQ+ experiences

So that you can better support a 2SLGBTQ+ person with mental health and substance use problems, learn as much as you can about the 2SLGBTQ+ community, including the way culture and religion impact on 2SLGBTQ+ people, e.g., shame due to cultural or religious norms.

Sexuality and gender lie on a spectrum, rather than falling within rigid categories, e.g., not everybody identifies as male or female. Sexuality and gender may also change over time. There is great diversity among people using any particular 2SLGBTQ+ label, and a 2SLGBTQ+ person may hold a range of identities, e.g., queer and transgender.

Do not make assumptions about:

- The person's sexuality or gender identity based on the way they look, act, talk, dress, or who their friends are, or whether they have children
- The way the person is likely to behave or think based on your knowledge of the person's 2SLGBTQ+ experience

- The person's sexuality based on their gender identity, and vice versa.

If you are interacting with a same-sex attracted person who is of the same gender as you, do not assume that the person is sexually attracted to you, just as you would not assume that all heterosexual members of the opposite sex are attracted to you.

If you are a 2SLGBTQ+ person, you should not make assumptions based on your own experience or understanding of being 2SLGBTQ+.

Mental health and substance use problems in 2SLGBTQ+ people

2SLGBTQ+ experiences and identities are not mental illnesses. However, 2SLGBTQ+ people are at an increased risk of depression, anxiety, substance use problems, suicidal thoughts and behaviours, and non-suicidal self-injury. You should also know that:

- Bisexual people are at an increased risk of mental health and substance use problems as compared to gay men and lesbians.
- Transgender people are at an increased risk of eating and body image disorders.
- Same-sex attracted men are at an increased risk of eating and body image disorders.

2SLGBTQ+ experiences do not, in themselves, cause mental health and substance use problems. Instead, they may be associated with specific stressors. There are a number of risk factors for mental health and substance use problems that are specific to or more common for 2SLGBTQ+ people. These include:

- Being in a minority group
- Discrimination, prejudice and abuse
- Actual or anticipated insensitive treatment or violence
- Intersex people receiving "corrective" surgery they did not consent to, often in infancy (see box for more information about surgical interventions relating to sex and gender).

However, not all people 2SLGBTQ+ experience distress related to their identity. Therefore, do not assume that 2SLGBTQ+ experiences are related to any mental health and substance use problems an older adult may have or distress they are experiencing.

Talking with a 2SLGBTQ+ person

Language and terminology

It can be difficult for an older adult to disclose that they are 2SLGBTQ+ because of the language people use to ask questions, especially when one assumes heterosexuality and cisgender experiences are universal, e.g., asking a woman if she has a boyfriend or husband, or asking someone if they are male or female. By using appropriate and inclusive language you can help the person to feel safe and comfortable about disclosing information that may be relevant to their distress. Any attempts to use correct language and terminology are likely to be appreciated by the 2SLGBTQ+ person.

Use the same terms that the person does to describe themselves, their sexual or romantic partners, relationships and identity. If you are uncertain about what terms to use, you should ask the person. Make your questions as open as possible to give the person room to describe and express themselves in a way they are comfortable with, e.g., instead of asking "Are you straight, gay or bisexual?", ask "How do you describe your sexuality?".

There are some things you should not do:

- Do not use the term "homosexual" unless the person refers to themselves in this

way, as this term can carry negative connotations for some people.

- Do not use the term "hermaphrodite" or "disorders of sex development" (DSD) to refer to intersex people, because these terms are misleading and stigmatizing.
- Do not use terms such as "tranny," "transsexual," "transvestite" or "cross-dresser" when referring to a transgender person, as this may be offensive.

Be aware that the person may use terms to describe themselves or others that have historically been derogatory (this is called "reclaimed language"), e.g., "fag" or "dyke." However, do not assume that it is acceptable for you to use these terms.

Pronouns

Using the wrong gender pronouns when interacting with a 2SLGBTQ+ person can be very embarrassing or humiliating for them. Some people choose not to use gendered pronouns to refer to themselves, as they may identify themselves as having a gender other than male or female, having more than one gender identity, or having no gender at all.

If the person you are assisting is not familiar to you and you are unsure of the person's gender identity, you should:

- Communicate in terms that are gender and relationship neutral, e.g., using "partner" rather than "boyfriend" or "girlfriend."
- Use non-gendered pronouns (i.e., "they," "them," and "their," even when referring to an individual) or use the person's name in place of a gendered pronoun (i.e., instead of saying, "That belongs to her," say "That belongs to Sam").
- Ask about this in a respectful and inclusive way, e.g., "I use feminine pronouns to refer to myself. Can I ask what pronouns you use?".

Talking and asking questions about 2SLGBTQ+ experience

Unless it is relevant to assisting the person, do not ask the person if they are 2SLGBTQ+. However, if it is relevant and you are in doubt about how to talk with the person about their 2SLGBTQ+ experience, ask them. If you have questions for the person about their 2SLGBTQ+ experience, seek permission from the person to ask these questions. Watch for subtle cues that indicate that the person may be uncomfortable with the questions you are asking. Do not focus only on their 2SLGBTQ+ experience, e.g., if a transgender person is undergoing gender affirmation, try not to focus only on this.

Do not ask any questions of the person that you would not ask a non-2SLGBTQ+ person. For example, no one would think to ask a cisgender person, "Do you think this is just a phase?". Similarly, do not ask a transgender person what their "real" name is (i.e., the name they were born with), as this may be offensive. Do not make jokes about sexuality, gender identity or intersex variation or say things that involve stereotyping, e.g., "Gay people are so…."

Do not ask questions about sex, sexuality, sexual partners, genitals or similar issues unless it is relevant to assisting the person. However, you should make it clear that you are open to discussing any issue without asking for personal disclosure from the person, e.g., "I am not going to ask you to give me details of your 2SLGBTQ+ experience, but I am open to discussing anything you need to."

Difficulties you may encounter when talking to the person

If the person doesn't feel comfortable talking to you or vice versa, you should help them find someone more suitable to talk to, unless it is a crisis and you are the only person available. Try not to take it personally if the

person does not feel comfortable talking to you.

Ask the person to tell you if you do or say anything that makes them uncomfortable and apologize if you do. After you apologize, move on, rather than focusing on the mistake or on what you have learned. Do not let the fear of saying the wrong thing prevent you from offering to help the person. It is more important to be genuinely caring than to say, "all the right things."

Be aware that 2SLGBTQ+ people who have been marginalized may express anger and hostility. Try not to take this personally.

Supporting the 2SLGBTQ+ Person

Treat the 2SLGBTQ+ person as an older adult first and foremost, rather than defining them by their 2SLGBTQ+ experience.

Although no one is obligated to share their 2SLGBTQ+ experience, helping the person to feel comfortable in your presence may go a long way toward open exchange of feelings and thoughts. You can do this by:

- Appropriately and correctly acknowledging the person's 2SLGBTQ+ experience, which can also improve the person's sense of well-being
- Asking the person what they think would help them, irrespective of the possible causes of their distress
- Asking what help the person needs, rather than making assumptions about what they need based on their 2SLGBTQ+ experience
- Showing your support in a concrete way by respecting the choices the person makes about clothing, name and pronouns, even if you don't understand or feel comfortable with it
- Listening to the person and not feeling that you need to have answers or provide advice.

Sexuality and gender identity are not a choice, and any attempts to convince the person that they can change them can be harmful. It is also important that you do not do the following:

- Do not offer your opinion on the person's 2SLGBTQ+ experience unless it is invited.
- Do not express judgment about the person's 2SLGBTQ+ experience when interacting with them.
- Do not refer to your own religious or moral beliefs about 2SLGBTQ+ people.
- Do not give the person the impression that being 2SLGBTQ+ is a "deviation from the norm."
- Do not say things that are intended to reassure but are mostly not helpful or patronizing, e.g., "Some of my best friends are gay."

Some of the supports that non-2SLGBTQ+ people use may not be appropriate for a 2SLGBTQ+ person. For example, if the person's family of origin has rejected them because of their 2SLGBTQ+ experience, encourage the person to seek support from other sources.

However, do not assume that the 2SLGBTQ+ community will be supportive of the person you are helping. Transgender or intersex people who identify as heterosexual may not feel part of either the 2SLGBTQ+ or straight communities, leading to reduced support. Similarly, a bisexual person may not feel part of either the 2SLGBTQ+ or straight communities, because they can face prejudice from both, leading to reduced support.

When the person experiences discrimination and stigma

All 2SLGBTQ+ people, even those who have grown up with supportive family and friends, will most likely have experienced some degree of discrimination or prejudice. They may also experience discrimination and prejudice from others with 2SLGBTQ+ experience. 2SLGBTQ+ people can even begin to believe these negative attitudes about themselves, absorbed from the world around them (internalized stigma), which can cause them distress.

If the person is experiencing mental health and substance use problems due to bullying, harassment or discrimination related to their 2SLGBTQ+ experience, you should let the person know that they can:

- Report it to authorities, if it is safe to do so
- Pursue their rights
- Contact a support service for 2SLGBTQ+ people

Seek help from a 2SLGBTQ+ advocacy organization.

You should also:

- Let them know they have a right to be safe at all times.
- Ask them what support they would like from you.
- Let them know of any services where they can report bullying, harassment or discrimination anonymously.
- Direct them to services that can help them pursue their rights.
- Encourage them to seek professional help.

However, you should not push the person to take action, but rather support them if they choose to.

When the person comes out or discloses

In these guidelines, the term coming out refers to the situation where a 2SLGBTQ+ person tells others with whom they have an ongoing relationship about their sexuality, gender identity or intersex variation for the first time. Coming out may refer to the first time an older adult shares their sexuality, gender identity or intersex variation with anyone, or it could be the process by which they begin to share this with others in their life. Be aware that not all transgender and intersex people will go through a "coming out" process.

The term disclosure refers to the situation where a 2SLGBTQ+ person who is generally open about their sexuality, gender identity or intersex variation tells a new person for the first time. This might include telling the first aider or a mental health and substance use professional.

In these guidelines, this distinction is made because the emotional cost of coming out may be greater than for disclosure.

Coming out

Be aware of the factors that may affect the risk of mental health and substance use problems during the coming out process, e.g., possibility of rejection, discrimination or abuse by family, friends, employer, co-workers, etc. However, you should know that coming out may have a positive effect on the person's mental health and substance use and well-being.

If the person comes out to you, be aware that it may be the first time the person has ever told anyone about their 2SLGBTQ+ experience. You should not express surprise or concern. Acknowledge that coming out may have been difficult and taken a lot of courage. If you ask the person follow-up questions, these should

be to indicate support and care, rather than to satisfy your curiosity.

If the person wants to come out, but is distressed about how others may react, discuss strategies that will help to reduce the chance of negative reactions from others. This may include:

- Identifying the best person or people to come out to first, so that the likelihood of a positive first experience is optimized
- Identifying two or more trusted people who can support the person during the coming-out process.

If there is no one available to support the person during the coming-out process, you should help them to connect with a relevant organization.

If the person has experienced negative reactions in response to their coming out which are contributing to their mental health and substance use problems, you should:

- Listen to the person nonjudgmentally rather than offer advice.
- Validate the person's feelings, e.g., "It's understandable that you are upset by your parent's reaction."
- Reassure the person that you accept and support them.
- Tell the person that it may take time for others to accept their 2SLGBTQ+ experience.
- Know about and inform the person of online resources that share others' experiences of coming out.
- Encourage the person to contact a support service for 2SLGBTQ+ people.

Disclosure

Some people may not want to disclose their 2SLGBTQ+ experience to you or may not want to disclose until a good connection has developed. This may be due to actual or anticipated negative experiences that have led to a fear of discrimination or being treated insensitively.

If the person does disclose to you that they are or may be 2SLGBTQ+, you should ask them:

- If they feel that their 2SLGBTQ+ experience is contributing to their distress
- If they are experiencing bullying or discrimination related to this
- Whether they want other people to know who else knows about their 2SLGBTQ+ experience, so that you do not unintentionally "out" them.

There are things you should not do:

- Do not express a negative reaction, because this may exacerbate the person's distress.
- Do not tell the person that this was obvious or that you already knew, as this can be impolite or offensive.

Unless there is a risk of harm to the person or others, you should keep confidential anything they have told you. They may not wish to tell others, or they may wish to tell others in their own way.

Seeking treatment for mental health and substance use problems

You should know about sources of information and resources relevant to the mental health and substance use of 2SLGBTQ+ people, including local services and professionals that specialize in the mental health and substance use of 2SLGBTQ+ people or are 2SLGBTQ+ friendly. However, do not assume that all "2SLGBTQ+-friendly" services are really appropriate for the person's specific 2SLGBTQ+ experience. Help the person find resources and services specific to their

2SLGBTQ+ experience, where available, e.g., transgender-friendly or intersex-friendly services. Even if there is a 2SLGBTQ+-specific service, the person may be reluctant to attend. If this is the case, help the person find a mainstream service that is sensitive to the needs of 2SLGBTQ+ people.

You should be aware of the potential barriers limiting access to professional help for 2SLGBTQ+ people, e.g., actual or anticipated discrimination. If the person lives in a rural area, they may face additional challenges, such as geographical isolation, rural culture, limited access to culturally competent mental health and substance use services, and greater exposure to discrimination. You should ask the person about any barriers they need assistance with.

If appropriate services are not available, or the person is not comfortable accessing face-to-face services because of their 2SLGBTQ+ experience, consider recommending online resources, e.g., online counselling.

If the person is in a mental health or substance use crisis situation (e.g., if they are suicidal), you can enlist the help of others without sharing the person's 2SLGBTQ+ experience. You should also be aware of the possibility of family (family of origin or family of choice) or intimate partner violence and offer contacts for appropriate services, if needed.

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By Marianne McGlashan

"The picture is created using a monochromatic theme to illustrate the darkness of depression."

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