INFORMATION FOR FIRST RESPONDERS IN MENTAL HEALTH or ADDICTION CRISES

Prepared by the partners of Forward House Community Society
serving adults with mental health and addictions issues
and their community partners

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This document is intended for use by first responders to a mental health crisis, who may include the following:

I Emergency Services

- **RCMP**
- **Ambulance**
- **Fire**

II School Faculty

III Religious Leaders

IV Workplace Administration

V Private Individuals

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1. OVERVIEW OF COMMONLY OCCURING PSYCHIATRIC CONDITIONS

DEPRESSION

>Depression can be **situational**, in response to any loss or anticipated loss including the death of a loved one or pet, relocation, declining health, aging, loss of employment, or change in marital or partnership status.

>Depression can be **clinical,** a biochemical condition not associated with any specific or known trigger.

>Depression often accompanies other physical or mental illnesses. It is the single most commonly occurring mental condition in our society, affecting as many as 1 in 2 of us.

Signs of Depression

- Pessimism and feelings of hopelessness
- Early morning waking
- Major changes in sleeping habits, resulting in sleeplessness or over-sleeping
- Major changes in eating habits and weight
- Inability of have fun; loss of interest in activities normally enjoyed
- Difficulty concentrating
- Self-blame; low self-esteem which can reflect in poor attention to cleanliness, dress and housekeeping
- Curtains and blinds may be kept drawn
- Chronic pain that has no medical cause
- Suicide *thoughts* and, sometimes, suicide *gestures* (guarded overdosing, cutting and wrist slashing are common gestures)
- Suicide *attempts* are generally planned ahead and suicide intent may not be apparent.
- Dysthymia is a relatively constant low mood, which can deepen further into depression
- Seasonal Affective Disorder (SAD) occurs during the winter months in response to reduced periods of sunlight, and abates as periods of daylight are lengthened

TREATMENT

- Anti-depressant medications are very effective in addressing the effects of this condition
- Creative activity helps to offset depression
- Alcohol, sugar and caffeine are short-term stimulants and long-term depressants, and should be avoided
- Exercise helps to ease depression through the release of endorphins
- SAD lights mimic sunlight and often help those with depression
- Support from trusted family members and friends is invaluable. Some find group supports helpful as well.
- Any activity or exercise that helps to improve self-esteem is extremely important
- Alternatives:
    - positive affirmations help to promote feelings of belonging and hope
    - fresh, 'living' fruits and vegetables, whole grains, vitamins B and C
    - colours: yellow and orange help to cheer and boost mood; red is stimulating; green promotes balance; blue relaxes.
    - aromas: jasmine, orange and lemon scents help lift mood
    - energy work such as Reiki and Healing Touch can restore balance to a stressed system

BI-POLAR AFFECTIVE DISORDER

> This disorder affects mood (affect), causing people to swing between highs and lows beyond the range of normal experience. Between the poles is a period of varying duration when moods are relatively like everyone else's.

> This condition often shows up in one's twenties, more or less equally in men and women, and may run in families. As many as 3 in 100 of us share this experience.

>Relationships of all kinds are profoundly affected by this condition

> **Dysthymia** is a relatively constant low mood, which can deepen further into depression
> **Cyclothymia** is a related condition in which the manic and depressive episodes are less intense
> **Rapid cycling** refers to a shortened period between depression and mania, such that there may be four distinct mood changes in a year. This does not refer to frequent daily mood swings. Rapid cycling occurs more often in women than in men

Signs of Mania (High)

- Feeling of euphoria, high energy and excitement
- Flight of ideas, racing thoughts, rapid or pressured speech
- Busy, Busy, Busy activity
- Spending sprees
- Poor sleep
- Irritability
- Hyper-sexuality
- Increased risk-taking, including substance abuse
- Poor insight into changes in behaviour
- People usually like mania; they feel invincible. Others around them often find the behaviours difficult
- Some people experience only one episode of mania

Signs of Depression (Low)

- Pessimism and feelings of hopelessness
- Early morning waking
- Major changes in sleeping habits, resulting in sleeplessness or over-sleeping
- Major changes in eating habits and weight
- Inability of have fun; loss of interest in activities normally enjoyed
- Difficulty concentrating
- Self-blame; low self-esteem which can reflect in poor attention to cleanliness, dress and housekeeping
- Curtains and blinds may be kept drawn
- Chronic pain that has no medical cause
- Suicide *thoughts* and, sometimes, suicide *gestures* (guarded overdosing, cutting and wrist slashing are common gestures)
- Suicide *attempts* are generally planned ahead and suicide intent may not be apparent.
- Depression usually happens before any manic episode(s)

TREATMENT:

- Bi-Polar Affective Disorder is commonly treated with medications that stabilize mood. They are non-addictive and free of charge with some disability programs.
- People with this disorder may find support in self-help groups.
- Some people find that keeping a sleep journal and noting changes in size of handwriting, weight or speech to be helpful indicators of onset of illness
- People with this condition are well advised to appoint a trusted friend or family member to assist them in recognizing changes inn behaviour
- Exercise helps to spend excess energy during mania and invigorate a slump during depression
- Caffeine, sugar and alcohol are short-term stimulants and long-term depressants, and should be avoided
- Creative endeavours help to offset depression
- Alternatives:
    - exercise and conscious breathing help to relax, spend the negative energy and restore balance
    - maintaining a strong support system is essential

PANIC AND ANXIETY

> Panic and anxiety pervade our society, affecting 1 in 75 of us

> Panic and anxiety may be distinguished as follows:

PANIC…a sudden 'out of the blue' fight-or-flight feeling of intense fear, including…

- Sense of impending doom and an urgent need to escape
- Fear of 'going crazy' or fear of dying
- Choking, smothering and shortness of breath
- Sweating, hot flashes pr chills
- Heart palpitations and chest pains
- Dizziness and nausea
- Trembling

Panic can lead to these things:

- Avoidance of situation leading to first panic attack for fear of having another one
- Avoidance of any situation from which escape seems problematic (agoraphobia)
- Financial dependence as a result of avoidance of stressors
- Risk of self-medication and self-injury

ANXIETY: Anxiety disorders fall into categories, including these:

a) Generalized Anxiety Disorder (GAD)

- may be diagnosed after 6 months of **excessive worry** about health, finances and work, for example, that results in these signs:
  - irritability
  - muscle aches
  - fatigue
  - insomnia
  - difficulty concentrating
  - difficulties in work and social relationships
  -

b) Obsessive-Compulsive Disorder (OCD)

- characterized by persistent and recurring anxious thoughts leading to **repetitive actions intended to ease the anxiety. Examples:**
  - obsessive worry about contamination may lead to extreme need for cleanliness, compulsive cleaning, and refusal to touch commonly handled objects like doorknobs
  - obsessive worry about home safety may lead to compulsive checking and re-checking of locks and windows without satisfaction
  - rigid observance of a daily ritual

c) Post-Traumatic Stress Disorder (PTSD)

- Characterized by recurring and distressing memory or drams about/reliving of an horrific past event involving extreme danger, such as abuse, war experience,

or natural disaster. Every effort is made to avoid situations associated with the event. This may present as…

- sleep disturbances and nightmares
- angry outbursts
- hyper-vigilance

d) **Phobias:** extreme fear of specific experiences such as flying or heights or of potentially embarrassing social situations

Panic and Anxiety can impact profoundly on social and professional relationships

TREATMENT

- Counselling can help identify triggers to panic and anxiety and find practical solutions, which may include desensitizing the fear reaction through *safe*, repeated exposure to the experience
- Medications: a broad range of anti-anxiety and anti-depressant medications can effectively control the symptoms
- Activity: exercise helps to spend the considerable energy of panic or anxiety. Engaging in activities with which one is familiar and capable are grounding and help the anxious person to take charge.
- Conscious breathing automatically relaxes
- B vitamins help calm the nervous system; vitamin B3 (Niacin) is effective in helping recover mental stability; vitamin C heals and de-toxifies; proteins help regain overall health, especially important when anxiety is substance-induced. Whole grains and fresh, 'living' fruits and vegetables help to restore general health
- Alternatives:
  - colour: yellow and orange cheer and boost mood; pink, in moderation, calms; green promotes balance; blue relaxes and suppresses appetite; purple comforts; red stimulates appetite and energy
  - positive affirmations: thoughts are habitual and what we believe tends to become true; therefore training our thoughts to affirm our worth and safety is helpful

SCHIZOPHRENIA

> As one of the least understood and most disabling mental illnesses, schizophrenia is probably the most feared.

> Schizophrenia is a **thought disorder** believed to arise from imbalances in the brain chemicals dopamine and glutamate that allow brain cells to communicate. Environmental and genetic factors may play also important roles.

> Schizophrenia affects 1 in 100 people, tending to manifest in the prime of young adulthood, between the ages of 15 and 30, a little earlier in men than in women. Its onset may be gradual or apparently sudden.

> Persons with this illness are often at a high risk of suicide.

Positive Symptoms of Schizophrenia: effects that are 'added'; recognizable behaviours that indicate altered understanding of what is real

- **Hallucinations: seeing, hearing, feeling and smelling things others do not.** Auditory hallucinations ('the voices') are common and may comment on behaviour or command the ill person to do (often harmful) things to others or, far more often, to himself. Hallucinations are beyond the control of the persons with schizophrenia
- **Delusions:** irrational thoughts or beliefs that persist despite logical evidence to the contrary
  - **a) paranoid** delusions entail belief in being stalked, cheated or persecuted. For example, one might believe that wearing a certain colour marks him as an alien
  - **b) religious** delusions are the belief in being evil or holy
  - **c) grandeur** delusions are the belief in one's fame
  - **d) Reference delusions** are the belief that one is being referred to, such as that the TV is talking to her, or that her thoughts are being broadcasted aloud
- **Disorganized thoughts and speech:** the inability to organize thoughts logically, resulting in **unintelligible communication**. In **thought blocking**, one feels the thoughts stopped right in the middle. **Speech can become garbled** and characterized by neologisms, or '**word salad'**.
- **Disorganized movements:** involuntary and sometimes repetitive movement and mannerisms

Negative Symptoms of Schizophrenia: aspects of the person that are 'taken away', sometimes also associated with other illnesses and not always immediately recognized as indicative of schizophrenia

- Social withdrawal
- Lack of motivation and unsustainable interest in an activity
- Flat or inappropriate affect (facial expression or voice)
- Neglect of personal hygiene

TREATMENT

- **Medication:** anti-psychotic medications control the positive symptoms of schizophrenia. Side effects can be debilitating which increase the likelihood of non-compliance. Newer ones have fewer side effects, however, and there are also medications to control these. Other medications may be prescribed to help mitigate sleep disturbances and depression. **Anti-**psychotic medications deplete iron and vitamins B3, B6, E and K; therefore, diets rich in these nutrients and/or supplements are advised. Additionally, essential fatty acids and vitamin E assist brain function

- **Whole grains and fresh fruits and vegetables** are essential
- **Balance of rest and activity** is important to avert depression, improve supply of oxygen to the brain and healing.
- **Socializing** is important for persons with this alienating illness. A strong support system to minimize isolation is advised
- **Avoiding over-stimulation** is important. Wearing sunglasses and listening to music through earphones have been effective in reducing the visual and auditory hallucinations
- **Learning as much as one can about the illness helps to reduce the fear that often accompanies positive symptoms**. Family members and friends need to be informed. The ill person and his or her support team need to develop a plan in the event of emergencies

2. Signs of Distress or Psychosis

Signs of distress in illness:

- Agitation
- Withdrawal
- Isolation
- Avoidance of stress triggers- people, places, situations
- Poor self care, unusual or unkempt appearance
- Recklessness/hyper-activity, risk-taking
- Restlessness
- Compulsive behaviours – examples: excessive need to check if doors are locked; excessive hand washing; excessive counting of change; excessive need to travel in certain directions or in certain ways; excessive smoking; pacing;
- Unusual body movements
- Lashing out verbally or behaviourally
- Irrational fear of anything
- Physical signs, such as sweating; choking; dizziness; nausea; hyperventilating; rapid, pressured or unusual speech; complaints of chest pain
- Flight of ideas
- Grandiose statements
- Inappropriate sexual posturing
- Flat (expressionless) facial expression or voice
- Inappropriate affect, such as laughing at something sad or frightening
- 'vacant' stare
- evidence of self-injury
- expression of thoughts of suicide

Signs of Psychosis:

- Evidence of delusions: irrational thoughts, such as that one's thoughts can be heard, or that the TV or radio is talking to them, or that a colour or sound or shape identifies them to dangerous people; belief that one is being stalked or persecuted; suggestion that one is holy or evil
- Evidence of hallucinations: seeing, smelling, feeling or hearing anything others do not. Hallucinations are commonly violent, punishing and frightening. Hearing voices is common, and they may command the person to hurt himself or someone else.
- Garbled speech, unintelligible 'word salad'; train of thought is unintelligible
- Involuntary and sometimes repetitive movements and mannerisms
- Disorientation to any of three spheres (person, place and time)

3. Addictions issues

ADDICTIONS

It seems that ours is an addicted society. Period. We are hooked on a host of substances, legal, illegal and prescribed. We are hooked on food, especially caffeine and sugar. A look at ourselves and our lifestyle in society tells us we are surely addicted to gambling, chaos, money, contact (internet, cell phones), games and sex. We are addicted to exercise, fame, technology and, of all things, work. Why? What is it about our genetic make-up or our social structures that makes these things increasingly apparent?

WHAT IS ADDICTION?

Addiction has been defined variously as follows:

1. **Oxford Illustrated Dictionary**:
   a) a state of physiological or psychological dependence on a potentially harmful drug
   b) devotion to, or habitual application to, a particular thing
2. **Buddhist philosophy**: 'the satisfaction of the ego's desires; prevailing attachment to joy and pleasure.'
3. **DSM IV**: "a maladaptive pattern of substance use, leading to clinically significant impairment or distress"
4. **Quantum Physics**: physical addiction is a product of our thoughts
5. **William Blake** (poet): "He who binds himself to joy
   "Does the winged life destroy…"
6. **Anon**: an addiction is a behaviour we can't stop, or don't stop, despite evidence of its harmfulness

WHO BECOMES ADDICTED?

- Generally accepted in western medicine is a genetic predisposition. The likelihood of becoming an addict is proportionate to the number of 1st degree relatives who are addicts. Statistically, for instance, if one of two parents is addicted, fifty per cent of their children will become addicts; where both parents are addicts, the number increases to eighty per cent.

- Foetal exposure to substances results in children being born addicted.

- Early experimentation with substances, peer involvement, visual cues from advertisements, and possession of an addictive personality all contribute to the likelihood of developing addiction. The *addictive personality* is characterized by, or susceptible to, addiction.

- The tendency to become addicted to substances or behaviours increases as a result of self-medicating co-occuring conditions that cause physical and/or emotional pain and distress. These may include chronic pain, terminal illness, attention deficit disorder, eating disorders, social phobias, anxiety, panic, depression, schizophrenia and bi-polar affective disorder.

Other contributing factors may include…

- society promoting separation and isolation, in which those who are perceived as different are alienated
- society in which commerce instructs our values; reverence for unattainable and unsustainable qualities such as wealth, youth and beauty
- society fuelled by instant information and sensationalism, encouraging the insistence upon instant gratification
- environmental factors such as air, noise, light and water pollution; genetically modified foods

Warning Signs of Addiction: Substance use or behaviour may be an addiction if…

- It is the #1 priority in day to day living
- It compromises physical health
- It brings about depression, black-outs, or memory gaps
- It can be linked to the breakdown of any relationship
- Others remarks about it are annoying
- The use or behaviour is secret
- More and more is needed to feel 'normal', much less a 'rush'
- It leads to feelings of guilt or shame
- The people around the user are also addicts
- There are occasional thoughts of the need to cut down
- The need to continue is rationalized
- The craving is as strong as or stronger than the need for food or water
- Self-discipline is poor or absent
- Using is done alone
- Stopping causes anxiety and panic, tremors, sweating or pain
- There are observable, significant changes in behaviour
- There are observable changes in peer group
- There are observable changes in eating and/or sleeping habits
- There are significant changes in appearance and personal hygiene

Substances: a substance must cause the release of dopamine to be considered addictive. Dopamine is a neurotransmitter (brain chemical) that affects thought and learning new motor sequences. It increases motivation, heart rate and blood pressure, and assists memory, attention and problem-solving.

Dopamine is associated with the system of the brain that provides feelings of pleasure, in turn providing reinforcement to repeat behaviours leading to pleasure.

The following charts indicate the effects of some of the more commonly used substances:

Substance	Classification	Desired Effects	Ill Effects	Notes
Alcohol	**Stimulant-Short Term** **Depressant-Long Term**	-euphoria -reduced anxiety & inhibition -reduced pain sensation	-flushing, vomiting -reduced muscle co-ordination -incontinence -slurred speech -impaired judgment -reduced respiration -reduced blood pressure -potentiates other drugs incl. anti-histamines, barbiturates, cocaine, tranquillizers -liver damage -heart disease -Foetal Alcohol Syndrome -alcohol poisoning -death	-effects vary according to weight, metabolism and general health
Nicotine	**Stimulant** an alkaloid and powerful neurotoxin	-pleasure -mild euphoria -alertness -reduced anxiety -calmness	-increased blood pressure -increased blood sugar levels -increased heart rate -increased adrenaline -decreased appetite	-75%-95% of people with schizophrenia smoke; nicotine reduces positive symptoms -chewing tobacco and snuff contain greater amounts of nicotine, absorbed through mucous membranes
Marijuana (THC)	**Stimulant**	-euphoria -decreased social inhibition -laughter, talkativeness -increased sense of personal closeness -enhanced physical and emotional sensitivity -introspection and dreaminess	-dry mouth and throat -impaired short term memory & comprehension -anxiety, panic -paranoia -hallucinations -distorted sense of time -dizziness, staggering -increased risk of some cancers -increased testosterone & risk of infertility in women; decreased testosterone in men -impairment of cardiac function -bronchitis & other abnormal lung function	-most people who experiment with 'harder' drugs used marijuana first

Substance	Classification	Desired Effects	Ill Effects	Notes
Crytsal Meth (chalk, ice, glass, speed, crank, etc.)	**Stimulant**	-euphoria -increased energy -increased alertness -increased libido -decreased appetite	-shortness of breath -rapid, irregular heart beat -nausea, dizziness -damage to teeth & gums -increased body temp -uncontrollable muscle movements -change in blood pressure -chest pain -heart attack -paranoia, suspiciousness -confusion -mood swings -hyper-vigilance -panic -compulsive behaviours -violent behaviour -seizures -hallucinations -psychosis -death	- highly addictive even after one use -fatality rate is relatively high
Cocaine	**Stimulant**	-euphoria -increased sense of pleasure	-dilated pupils -nose bleeds, runny nose, decreased sense of smell -restlessness, irritability -difficulty swallowing -nausea, abdominal pain -increased body temp -increased blood pressure -respiratory failure -increased alertness -reduced fatigue -hoarseness -heart attack -stroke -bowel gangrene -increased risk of HIV, blood and bone disease -when mixed with alcohol, markedly increased risk of sudden death	-can be snorted or injected

Ecstasy **('E',MDMA, Adam,etc.)**	**Stimulant**	-enhanced sense of touch, pleasure, and social closeness -increased energy	-nausea, vomiting -muscle aches & loss of muscle control -increased heart rate & arrhythmia -high blood pressure -liver damage -seizures -depression -paranoia -panic and anxiety -bulimia -reduced impulse control -thought impairment -psychotic features -death	-considered less addictive than cocaine
Heroin	**Opiate** (derived from morphine)	-pleasant 'rush'	-flushing -dry mouth -heaviness in extremities -nausea & vomiting -itching -reduced respiration -reduced cardiac function -emotional disturbances -clouded mental function -reduced pain awareness -bacterial infections -increased risk of HIV, AIDS, Hep B and C -arthritis -pneumonia, lung infections -abscesses -liver and kidney disease -collapsed veins -death	-most rapid acting opiate -many users smoke heroin before injecting -often cut with quinine and poisons

4. Signs of Chemical Influence and Withdrawal

Substance	Signs of Influence *	Signs of Withdrawal
Alcohol	-unusual body movements; e.g. reeling -defiant, impulsive or risk-taking behaviour -slurred speech -loud behaviour -withdrawn behaviour; crying -odour of alcohol -unconsciousness	-anxiety -sleeplessness -sweating -irritability -poor appetite -tremors -hallucinations -headache -thirst
Nicotine	-calmness -coughing, wheezing, shortness of breath	-irritability -craving -eating re: oral gratification
Marijuana (THC)	-talkativeness -giggling and laughter -enhanced hunger and eating -decreased inhibition -introspection -paranoia -hallucinations -lethargy -distinctive odour -red, bloodshot eyes -thirst	-craving through habituation -agitation -anxiety -decreased appetite -low mood -physical tension
Crystal Meth	-anxiety, confusion -paranoia -hallucinations -dilated pupils -nose bleeds -twitching, shaking -tactile delusions -moodiness, depression -bravado -sores that don’t heal -burn marks on lips & fingers -tracks -erratic attention span - -need for money -unkempt appearance	-violent outbursts -fatigue -long, interrupted sleep periods -irritability -intense hunger -anxiety -depression -mental confusion -restlessness -craving -psychosis
Cocaine	-increased blood pressure -dilated pupils, bloodshot eyes -increased energy, body temp -mental alertness -nausea -abdominal pain -runny nose, sniffing -rapid speech -decreased appetite	-agitation, anxiety -depression -angry outbursts -lethargy, fatigue -muscle pain, shaking -nausea, vomiting -disturbed sleep -shaking -irritability

Ecstasy	-increased energy -mild hallucinations -mild euphoria	-depression -anxiety, panic -sleeplessness -depersonalization -de-realization -paranoia

Heroin	-clouded mental function -nausea, vomiting -slow respiration -slow heart rate -suppressed sensation of pain -collapsed veins -abscesses -bacterial infections -arthritis symptoms -tracks -evidence of paraphernalia	-chills/sweating -involuntary leg movements -nausea, vomiting -diarrhea -restlessness -insomnia -bone pain -stomach pain -gooseflesh -dilated pupils -tremors, shaking -yawning -watery eyes

Treatments include de-tox, medication, rehabilitation, peer and familial support and professional psychosocial and psycho-educational interventions.

***** With all substances, evidence of paraphernalia indicates probable use. Pieces of broken glass or mirror, rolled money, tubing, syringes, burnt spoons or razor blades are common tools in substance use.

Dos and Don'ts (Please)
Personal message

Please DO…

- **Look for a medical alert card, charm, tag, pendant or bracelet.**

Forward House issues *to those who wish them* red Velcro- fastener bands containing medical information, including mental illness or addiction. They may be found on a belt loop, backpack, purse strap, helmet strap, or shoe. Important contact information is included.

- **Be aware that mental illness often coexists with addiction and/or physical illness, and that the symptoms may mimic one another**
- **Remember that I am probably very afraid and uniforms increase the fear. I see you as very powerful.**
- **Approach me calmly and quietly**
- **Use my first name if you can, and use your first name too.**
- **Assure me you are trying to help me to safety**
- **Assure me that my contacts are being notified**
- **Observe for any evidence of self-injury**
- **Remember that while psychotic I am not responsible for my actions. I will be held accountable for my behaviour, including any criminal behaviour, when I am assessed by a psychiatrist as capable of understanding.**
- **If I appear to be suicidal, ask me if I have a plan, the means to carry it out, and a time in mind to do so. Asking me will <u>not</u> put thoughts of suicide in my head. Take me to a hospital.**
- **If I must be restrained, please do so gently and assure me you are keeping me safe.**
- **Always tell me what you are going to do and what will happen next.**
- **Be patient**
- **Talk to me**

Please DON'T objectify me. Don't….

- **Call me names or dismiss me as 'crazy'**
- **Leave me unattended**
- **Make threats**
- **Make promises you can't keep**
- **Shout at me**
- **Pull a weapon unnecessarily (R.C.M.P.)**
- **Use lights or sirens *unnecessarily.* These may over-stimulate me and increase fear and agitation**
- **Handle me roughly**
- **Talk *about* me and forget I can still hear you**
- **Talk about what a hard shift you are having or how you need a vacation**

5. SUICIDE
PREVENTION, ASSESSMENT, INTERVENTION and POSTVENTION

I GENERAL NOTES ABOUT SUICIDE

- **Many people who commit suicide**, perhaps as many as 90%, **have a mental illness at the time of death**. In the balance are those who choose to end their own lives to end political persecution or torment, terminal illness, abuse, or other situation.
- **Some completed suicides are accidental**, **subsequent to a gesture** such as overdosing that has been miscalculated.
- **Some completed suicides are the result of reckless, excessive risk-taking behaviour** that indicates **benign intent** (like tempting fate. E.G.: 'I will not actively take steps to end my life, but if I die doing _____ that will be fine.')
- **Most people who complete suicide do not wish to die**, but wish to end their mental or physical pain
- **People who intend to commit suicide may show no signs of distress; they are at peace with the decision they have made**. True intent, therefore, can be difficult to assess. Often, the person whose intent is to complete suicide has made previous gestures or attempts. **Any warning signs or 'red' flags' whatsoever should be taken very seriously.**
- **Most people who complete suicide talk about it first.**
- **Women who complete suicide often use less non-violent means than do men**. Men are more likely to use firearms or other weapons.
- **Not talking about suicide does not make it go away**. People are not talked into suicide by asking them if they feel suicidal. Not asking when there are warning signs (see below) could be fatal.
- **Suicide planning and completion take energy**. One in severe depression is at greater risk when the depression lifts somewhat.
- **Suicide is not genetic; however, the suicide of a family member can profoundly influence those left behind.**
- **Suicide does not discriminate by race, religion, social class, intelligence.**

II CAUSES OF SUICIDE

- **Untreated or unsuccessfully treated mental illness**… in particular, depression that occurs alone or as part of other mental illness such as bi-polar affective disorder and schizophrenia
- **Negative and traumatic life experiences** giving rise to situational depression include these:
  - death of a loved one, including a pet
  - death by suicide of a family member
  - breakdown of a relationship
  - loss of custody of a child
  - loss of employment
  - serious or terminal illness
  - loss of capacity through accident, illness or aging
  - chronic physical or emotional pain, as a result of verbal, sexual or physical abuse or any act of humiliation
  - serious legal problems
  - any act of enforced isolation
  - bullying and stigma

III PREVENTION OF SUICIDE

The opposites of the causes of suicide are preventive of suicide.

- All people need to feel safe, cared for by a community such as family, capable of contributing and having inherent worth. Therefore, the development of safe, caring support systems within which one expresses one's unique abilities and to which he has a deep sense of belonging is critical to well being and ultimately prevents suicide ideation, gestures and completion.
- In one's community, one may resolve personal and legal difficulties, access emotional support and encouragement, receive treatment for physical, mental and spiritual conditions and illnesses and develop self esteem. Self-help groups and professional counsellors, heath practitioners and guides serve to promote belonging and resolution of issues contributing to suicide
- Observation for any warning signs of suicide and appropriate interventions will help prevent completion. Knowledge is critical. You cannot keep any secret that could lead to someone's death; therefore do not agree to keep a secret about suicide thoughts, a plan, or means to carry to through. Often, consciously or otherwise, the person asking you to keep the secret is in fact relying on you to intervene.
- A person truly intent on suicide is likely to complete, even in a hospital. There is unlikely to be any talk or outward sign. In this event, there is probably nothing one can do.

III WARNINGS OF SUICIDE

- **words or phrases indicating loss of the intent to live,** including these:
  - 'I can't go on any longer.'
  - 'I hate my life.'
  - 'Nothing matters any more
  - 'The world will be better off without me.'
- **writing poems or drawing pictures about death or suicide**
- **writing a will**
- **giving away possessions**
- **excessive expression of guilt or shame**
- **dramatic change in personality**
- **previous suicide attempt(s)**
- **poor coping skills**

IV SUICIDE ASSESSMENT

Having observed warning signs of possible suicide, it is important to try to assess the risk.

Ask for answers to these questions:

1. **Do you feel suicidal?**
2. **Do you have a plan? (method)**
3. **Do you have the means to carry it out?**
4. **When do you plan to do this?**

REMEMBER: ASKING THE QUESTONS DOES NOT MAKE A PERSON FEEL SUICIDAL

- **LOW RISK:**
  - Thoughts of death and suicide recur
  - There is no plan, means or time frame.
  - There is no previous history of suicide attempt(s). Supports are in place.

- **MEDIUM RISK:**
  - Thoughts of death and suicide recur
  - There may be a plan and the means, but not a time frame.
  - There may be reasons given why one won't kill himself, such as not wanting to hurt the children or leave a pet alone.
  - There is other evidence of future thought, such as intention to keep an appointment or attend an upcoming event. One may be able to imagine things getting better some day.
  - There is a history of suicide attempt(s), but there are perceived supports in place.

- **HIGH RISK:**
  - Thoughts of death and suicide prevail.
  - There is intent. There is a plan, the means to carry it out and a time in mind to do so. Often, if the time is not imminent, it will be specific and related to some event, such as after a friend's birthday, or after Christmas, or before winter. There is no apparent reason *not* to carry out the plan, and no evidence of future thought beyond that time or hope that things might improve.
  - The focus of being is on the act of suicide.
  - There is a history of previous attempt(s) and no supports in place.
  - **If the risk is assessed as high, immediate intervention is required.**

V INTERVENTION

- **Call 911**
- **Don't have access to a phone? Yell 'FIRE'. This is more likely to get a response than any other distress call**
- **While you are waiting for help…**
  - **Do NOT leave the person unattended**
  - **Reassure the person that help is coming**
  - **Use a voice that is calm and reassuring. Try not to sound shocked or frightened**
  - **Listen to what the person is saying and let him/her know that you care what happens**
  - **Do not express judgment of the person or the suicide intent**
  - **Allow for crying or yelling or swearing; all these things help to release the emotion. Try to keep the person from acting violently or harm himself**

IF YOU ARE THE EMERGENCY RESPONDER (example, police or ambulance), please refer to 'DOs AND DON'Ts

VI POSTVENTION: The provision of initial and ongoing assistance and support to all those affected by a completed suicide, including family, friends, colleagues classmates, and emergency or private first responders.

NOTES:

> Reactions to suicide include guilt; shame; shock; anger toward the one completing suicide and anyone else thought of as being responsible; grief; hopelessness; anxiety; panic; depression; feelings of betrayal; disturbances in eating, sleeping and work; substance abuse; isolation.
>Stigma: Because of the social stigma around suicide, the 'survivors' of the suicide may be similarly blamed and stigmatized.

GOALS of POSTVENTION:

- to provide those affected by suicide the tools for grieving and debriefing, and referral to professional supports
- to provide these things in ways that are sensitive to cultural influences. For example, bereavement may be complicated by religious beliefs that suicide is a sin
- to prevent or minimize contagion (modeling the suicide)

-**Critical Incident Stress Debriefing (CISD)** provides *initial* supports in a safe setting in which those affected (particularly first responders) are able to relate in confidence their experience, surmise reasons for the suicide and experience mutual support, usually within three days of the suicide. Emotional release and sense-making of the suicide as well as identifying signs of stress and distress are usually accomplished through CISD.
-*community* postvention is provided *when appropriate*, such as when the suicide was completed by a high-profile person, a popular colleague, or youth, or when completed in public.
- **Ongoing Supports** serve to help prevent further suicides

Resource Information:
Liaising with those who can assist you

EMERGENCY:

Police……………………………………………………………………………………………911
Fire………………………………………………………………………………………………911
Ambulance………………………………………………………………………………………911
Nanaimo Regional General Hospital………………………………………………248-2332
Crisis Line…………………………………………………………………………………248-3111
Urgent Response (1-9 pm daily; leave message)……………………………947-8228

OTHER:

<u>ADDICTIONS</u>:
Addictions Services……………………………………………………………………954-4737
A.A…………………………………………………………………………………………248-7273
Alanon…………………………………………………………………………752-0904/757-2098
N.A……………………………………………………………………………………1-888-265-7333
Parksville Mental Health and Addictions Services……………………………947-8228
Forward House (mental health & addictions rehab.)…………………………954-0785

<u>MENTAL HEALTH</u>:
Associated Family and Community Support Services Ltd……………………248-0076
District 69 Family Resource Centre…………………………………………………752-6766
Crisis Line…………………………………………………………………………………248-3111
Forward House (mental health & addictions rehab.)…………………………954-9785
Haven Society……………………………………………………………………………248-3500
Ministry for Children and Family Development…………………………………954-4737
Mood Disorder Society…………………………………………………………………248-5551
Parksville Mental Health and Addictions Services……………………………947-8228
Parksville Mental Health and Addictions Services-Seniors and Outreach…947-8225
Parksville/Qualicum Schizophrenia Society……………………………752-3337/248-0486
RCMP Victims' Services………………………………………………………………248-6111
S.O.S…Society of Organized Services (counseling)……………………………248-2093
Victims' Services…………………………………………………………………………954-2277
Parksville Public Health Unit…………………………………………………………248-2044

ABOUT US:

FORWARD HOUSE COMMUNITY SOCIETY provides programs and services seven days a week for adults in District 69 who have chronic or acute mental health issues, and who may have concurrent addiction issues. Ours is a non-profit society, a registered charity in good standing. We comply with Best Practices, FOIPPA, VIHA contractual obligations, Public Health regulations, Employment Standards and WCB legislation. We are proud to be affiliated with **Parksville Mental Health and Addictions offices**, our local Partnership Advisory Team, the Central Vancouver Island Regional Mental Health and Addictions Committee, BC Schizophrenia Society, Malaspina University-College Collaborative Nursing Team and Oceanside Volunteer Association.

Partnership Model: Our partnership is comprised of our clients, their families, service providers, Forward House volunteers and students, and concerned community members. Each partner is provided equal opportunity to suggest, implement and evaluate our programs. Final decisions are made by those responsible for their outcome.

We are dedicated to community inclusion and individual and community health. Our two principle reasons for being are to provide the social connect within which our clients explore skills and opportunities for personal growth and develop peer and professional supports, and to provide relevant and current education for our clients, students, volunteers, staff and members of our host community. We are pleased to mentor university and college students of human services, psychology, community support services, practical and baccalaureate nursing, social work and ministry.

Forward House provides holistic care with regard to body, mind and spirit, a model recognized by the Ministry of Health and Authors of Best Practices in Psychosocial Rehabilitation, and presented to the 2004 conference of the International Association of Psychosocial Rehabilitation Services (IAPSRS) in Vancouver. We are pleased to have garnered the first B.C. Psychological Association Award as a mentally healthy workplace. We are further pleased to have our client-produced film about schizophrenia seconded by the International Schizophrenia Foundation for their education campaigns.

All referrals to our program flow from our Parksville Mental Health and Addictions offices. All clients attend on a voluntary basis. No one lives at the house, but we are open 354 days a year, every day but statutory holidays.

Recent initiatives include the development of this guide book for first responders, provision of medical alert bracelets including mental health information and contacts *for those of our clients who wish them*, and a micro-enterprise program. A complete list of our services is included for your reference.

HOW CAN WE HELP YOU?

When named as a contact by our client, we can be reached for support in case of apprehension or admission to hospital. We may be named in addition to physician, next of kin and mental health therapist. It is our belief that a familiar face may help to defuse a crisis and alleviate anxiety for all parties. Contacting us must never preclude contact of the appropriate emergency responder, such as RCMP or ambulance.

Our Partners-in-Education panel is available at no charge to speak with your group about mental health and addiction issues from first hand experience.

We will be pleased to share any resource information you may require.

Our resource directory and book of subjective accounts are available at a nominal charge, with fifty per cent discounts applied for students and non-profit agencies.

Our film series *First Contact,* concerning depression, bi-polar affective disorder, panic and anxiety, addictions, and schizophrenia are available at a nominal charge. They may also be viewed on You Tube, Live Video and Yahoo Video Internet stations.

HOW CAN YOU HELP US?

- Ask us questions. We are here to answer them.
- Take part in our various functions made known throughout the year.
- Become knowledgeable about the facts and concerns. Knowing is empowering for all.
- If you are an emergency responder, please consider speaking with us about your roles in the lives of our people. Help us to understand your needs and expectations.
- Talk to us.

Information Sources

- Suicide.org
- Narcanon.org
- National Library of Health
- CCIS
- Island Crisis Care Society
- DSM IV

The information in this guide is accurate to the best of our knowledge. It is not intended to replace the information or advise of a physician.