Mental Health

Specialty Training

October 2008

Basic Training for Managers and Caregivers

Washington State Department of Social & Health Services

ADSA Aging & Disability Services Administration

Mental Health
Specialty Training

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Icons to Help Guide You Through the Materials

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Classroom Activity	Additional Material	Supplemental Readings	Share With Families	Caregiver Tips

Mental Health
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Mental Health
Specialty Training

MODULE 1

Introduction to Mental Disorders

Washington State
Department of Social
& Health Services

ADSA Aging & Disability
Services Administration
www.adsa.dshs.wa.gov

What Do You Know About Mental Disorders?

Check "True" or "False" for each of the questions below to see what you know about mental disorders.

True	False	
☐	☐	1. Bad parenting causes mental disorders.
☐	☐	2. Mental disorders are rare.
☐	☐	3. Only uneducated and poor people develop mental disorders.
☐	☐	4. People with mental disorders are usually dangerous.
☐	☐	5. Culture can influence whether a person with a mental disorder decides to seek treatment.
☐	☐	6. When communicating with a person who is actively hallucinating, it is important to find out what the hallucination is about.
☐	☐	7. A person with a mental disorder who is physically aggressive should not be physically restrained.
☐	☐	8. A person with a mental disorder who is decompensating will always experience a relapse.
☐	☐	9. Talking to a person with depression about suicide increases the risk that he or she will do it.
☐	☐	10. Medications can cure mental disorders.

Check to see how you did on page 16.

Understanding Mental Disorders

Module Goals:

To provide caregivers and managers:

- A general overview about mental disorders.
- More information on four of the most common mental disorders.

Overview of Mental Disorders

Mental disorders are biologically based brain disorders that can greatly interfere with a person's thinking, feelings, mood, the ability to relate to others, and the capacity to cope with the demands of life.

In any given year, an estimated 1 out of 4 adults age 18 and older have a diagnosable mental disorder. In fact, mental disorders are the leading cause of disability in America.

In any given year, an estimated 1 out of 4 adults age 18 and older have a diagnosable mental disorder.

In spite of these statistics, many people remain unaware of the significant number of adults who have a mental disorder. And, many adults who would benefit from treatment, never get it. This, in part, is because:

- Mental disorders are challenging to diagnose.
- The symptoms of a mental disorder vary along a ***continuum*** and there is no exact line that separates health from disorder.
- Often, people tend to focus on the far end of the continuum and define mental disorders only by the most severe symptoms.
- A mental disorder can be difficult to acknowledge. Many people wait until their symptoms are severe before they seek help. Some people will never seek treatment.

Continuum *- A broad range.*

Diagnosing Mental Disorders

Many factors make a mental disorder challenging to diagnose.

- Unlike other medical issues, there is no medical test or physical exam that can determine if a person has a mental disorder.
- The fact that symptoms vary along a continuum, change often, and are not always visible.
- The health care provider does not always witness symptom(s).
- The person may not always be fully open, truthful, or aware of what is happening.
- Each person's tolerance of symptoms varies.

How a Mental Disorder is Diagnosed

To diagnose a mental disorder, the person has to discuss his or her symptoms with a health care provider. The person needs to inform the health care professional of the intensity of his or her symptoms, how often they last, and what functional impairment the person is experiencing because of the symptoms.

The clinician will perform a mental status exam and observe the person's behavior. The clinician studies the person's symptoms and behavior to determine if they can be grouped into a pattern or syndrome. If this pattern or syndrome meets the criteria for a specific diagnosis, a diagnosis is made.

Stigma and Mental Disorders

There is a long history of ***stigma***, misunderstanding, and confusion surrounding mental disorders.

Stigma — *a sign of shame or disgrace.*

Stigma related to mental disorders can greatly impact whether a person will seek treatment. Many people feel too ashamed or embarrassed to talk to anyone about what is happening and may try to conceal symptoms.

Stigma also affects how a person with a mental disorder is treated by others. Evidence that stigma exists can take many forms, such as:

- Treating the person with the disorder **as** the disorder. For example, thinking and talking about the person as a schizophrenic, not as a person who is living with schizophrenia and has family, hopes, dreams, and abilities.
- Thinking there is something essentially wrong, bad, dangerous, or weak about the person because he or she has a mental disorder.
- Thinking the person is personally responsible for his or her condition.
- Using language to refer to the person that is offensive or insulting, such as lunatic, nuts, crazy, or psycho.
- Thinking bad parenting causes mental illness.

Stigma and Caregiving

Stigma can prevent caregivers from providing the best care they are capable of giving.

Stigma can prevent caregivers from providing the best care they are capable of giving. If you believe some of the misinformation about people with mental disorders, you may:

- Be uncomfortable assisting the person.
- Treat the person differently from people with other illnesses, such as cancer or heart disease.
- Let the fear of the person's mental disorder stop you from finding new ways to understand and relate to the person.

It is important not to allow any of these things to happen. The best way to help you challenge stigma is to:

- Learn the facts about the various mental disorders. This course will give you a good start at this.
- Talk and think about mental disorders in the same way you talk and think about any other illness.
- Challenge and question your attitude towards mental disorders.
- Challenge people around you who reinforce myths, stereotypes, and misunderstanding about mental disorders.
- Be supportive of people who have been diagnosed with a mental disorder.

Differentiating Forms of Mental Disorders

There are five general categories of mental disorders. They are disorders of:

- **Mood**—such as depression and bi-polar.
- **Anxiety**—such as generalized anxiety disorder and Post Traumatic Stress Disorder.
- **Perception**—such as schizophrenia and delusional disorders.
- **Memory**—such as Alzheimer's and vascular dementia (covered in the *Dementia Care Specialty Training*).
- **Personality**—such as borderline and antisocial (not covered in this class).

Information will be presented in this class on some of the more common mental disorders including Anxiety Disorder, Depression, Bipolar Disorder, and Schizophrenia.

Anxiety

Family Friendly

What Is It?

Anxiety is a feeling of uneasiness, dread, or danger in anticipation or in response to a real or perceived threat. The feeling can be accompanied by physical symptoms, including increased heart rate, pounding or racing of the heart, difficulty with breathing, and sweating.

Anxiety disorders are the most common mental disorder in America. Symptoms of anxiety disorders can become chronic and debilitating, if not treated.

Anxiety disorders are the most common mental disorder in America.

There are five major types of anxiety disorders.

Generalized Anxiety Disorder — constant exaggerated worrisome thoughts and tension about everyday, routine life events and activities, lasting at least 6 months. Physical symptoms include:

- Fatigue
- Trembling
- Muscle tension
- Headache
- Nausea

A person with generalized anxiety disorder almost always anticipates the worst, even though there is little reason to expect it.

Panic Disorder — repeated episodes of intense fear that strikes often and without warning. Physical symptoms include:

- Chest pain, rapid heart beat
- Shortness of breath
- Dizziness
- Abdominal distress
- Fear of dying

Post-Traumatic Stress Disorder — persistent symptoms that occur after experiencing or witnessing a traumatic event, such as rape, assault, child abuse, natural disasters, or war. Family members of the victim can also develop this disorder.

Symptom of Post-Traumatic Stress Disorder include:

- Nightmares
- Flashbacks
- Numbing of emotions
- Depression
- Feeling angry, irritable
- Easily startled or distracted

Phobia *— a persistent, irrational fear of a particular object, class of objects, or situations.*

Social *Phobia* — an overwhelming and disabling fear of being judged, embarrassed, or humiliated in social situations. Social phobia leads the person to avoid social situations limiting his or her potential for pleasurable and meaningful activities.

Obsessive-Compulsive Disorder (OCD)—recurrent, unwanted thoughts and/or repetitive behaviors that seem impossible to stop or control.

People with OCD have persistent, upsetting thoughts (obsessions) and use rituals (compulsions) to control the anxiety these thoughts produce. Rituals are aimed at reducing distress or some dreaded event. Most of the time, the rituals end up controlling them. A common ritual is excessive hand washing.

Symptoms:

- Unrealistic or excessive worry
- Trouble falling asleep or staying asleep
- Difficulty concentrating or mind goes blank
- Irritability
- Muscle aches, headaches, tension
- Fear of contamination
- Restless or feeling keyed up or on edge
- Exaggerated, startle reactions
- Shakiness and trembling
- Dizziness or lightheadedness
- Easily fatigued
- Sweating, hot flashes
- Repeated thoughts or impulses

Progression:

- Usually starts in childhood or as a teenager but may start as an adult.

- Typically runs a fluctuating course, with periods of increased symptoms, usually associated with life stresses or impending difficulties.

Treatment:

- A careful diagnostic evaluation to determine whether symptoms are due to an anxiety disorder, and if so, which anxiety disorder, and what ***coexisting*** conditions may be present.
- Depression and/or substance abuse may accompany anxiety disorders and may require treatment along with the anxiety disorder.
- Most effective forms of treatment for anxiety disorders are anti-anxiety medications and psychotherapy or "talk therapy".

Coexisting — *to exist together at the same time.*

Resources:

- Visit www.nimh.nih.gov and search by anxiety disorders.
- Whenever possible, remove whatever triggered the anxiety or take the person away from the upsetting situation.
- Help the person recognize uncomfortable situations and how to avoid those situations if possible.
- Help the person relax and talk about his or her feelings.
- Help the person focus on breathing. Coach the person to breathe more deeply and slowly.
- Listen. Allow the person to discuss his or her fears and concerns while maintaining a calm, caring, and understanding attitude.
- Redirect attention away from anxious thoughts whenever possible.
- Remain non-judgmental.
- Give the person privacy and personal space whenever possible.
- Get professional help when necessary.

Depression

Family Friendly

What Is It?

Depression is a serious, but treatable, mood disorder that involves the body, mood, and thoughts. It affects the way someone eats and sleeps, the way one feels about oneself, and the way one thinks about things.

Depression is not the same as a passing sad mood. It involves serious symptoms that last for at least several weeks and make it difficult to function normally.

What Causes It?

Major depression is a biological brain disorder resulting from an imbalance in brain chemicals.

There is no single cause for the onset of depression. Scientific research has firmly established that major depression is a biological brain disorder that is the result of an imbalance in brain chemicals that regulate mood.

Psychological, genetic, and environmental factors also contribute to the onset of depression. An episode of depression can occur spontaneously or be triggered by:

- A stressful life event such as a significant loss, difficult relationship, or financial problems.
- Physical illness such as heart disease or cancer.
- Alcohol or drug abuse.
- Some medications.

Symptoms:

- Social withdrawal.
- Persistent sadness, irritability, or despair.
- Feelings of hopelessness, worthlessness, guilt, or helplessness.
- Decreased interest or pleasure in activities once enjoyed.
- Difficulty concentrating, remembering, or making decisions.
- Changes in appetite, with weight gain or weight loss.
- Changes in sleep patterns—either sleeping a lot or having difficulty sleeping.
- A loss of energy, feeling tired despite little activity.
- Persistent physical symptoms that do not respond to treatment, such as headache, chronic pain, weakness, or constipation.

Progression:

- Lasts at least two weeks. May become chronic and last for years.
- May stabilize for months at a time, even years, then return.

Treatment:

For most people, treatment for depression is highly effective.

Depression can be a devastating disorder. For most people treatment is highly effective. That is why it is critical that depression be recognized and treated as soon as possible.

Medications—there are many effective antidepressants.

*A word of caution regarding medication: Stay alert to the person's symptoms when he or she starts taking an antidepressant. The risk of suicide may temporarily increase during the early stages of medication treatment.

Therapy—has been shown to be effective for depression.

Without treatment, depression can be life threatening. The number one cause of suicide in the United States is untreated depression.

Resources:

Visit www.nimh.nih.gov and search by depression.
Visitwww.nami.org and click on depression.

Care Tips

- Encourage the person to participate in some activities he or she once enjoyed, such as hobbies, sports, or movies. Do not push the person to do too much too soon.
- Encourage the person to make healthy food choices, get enough fluids to prevent dehydration, and exercise.
- Concentrate on the person's feelings and offer emotional support.
- Encourage the person to take medications as ordered by the healthcare provider.
- Stay alert for any signs the person may be suicidal (see page 86) and alert the appropriate person where you work.
- Do not tell or expect the person to "cheer up" or "just get over it".

Bipolar Disorder

Family Friendly

Mania — *excessive and persistent elevated or irritable mood.*

What Is It?

Bipolar Disorder is a brain disorder that causes unusual shifts in a person's mood, energy, and ability to function. Bipolar disorder is a chronic and generally life-long condition with recurring episodes of ***mania*** and depression that can last from days to months.

Generally, these mood changes happen in cycles. The symptoms of bipolar are severe and are different than the normal ups and downs that everyone goes through.

What Causes It?

The psychological basis for bipolar disorder is better understood than other forms of depression. Contributing factors include:

- **Genetics and heredity** — people with a close relative with the condition are 10 to 20 times more likely to develop either depression or bipolar disorder than the general population.
- **Biological factors** — a disturbance in brain chemicals that regulate mood and activity.
- **Environmental factors** — stressful situations cannot cause the disorder but can trigger a manic-depressive episode in a person who is vulnerable to the disorder.

Symptoms of Mania:

- Increased energy, activity, restlessness, pacing, and fidgeting
- Either an elated happy mood or an irritable, angry, unpleasant mood
- Decreased sleep and decreased need for sleep
- Poor concentration
- Unrealistic beliefs in his or her abilities or power
- Poor judgment and impaired impulse control
- Increased sexual interest and activity
- Increased talking, more rapid or louder speech than usual
- Racing thoughts, jumping from one idea to another
- Denial that anything is wrong

Symptoms of depression can be found on page 10.

Some people have symptoms of mania and depression occurring at the same time or alternating frequently during the day. This is called a mixed episode. Mixed episodes can be very disabling as the person feels excitable or agitated but also irritable and depressed.

Progression:

- Typically develops in late adolescence or early adulthood, but some people have their first symptoms late in life.
- Is a chronic and life long condition.
- Without treatment, bipolar disorder tends to get worse.

Treatment:

- A combination of medication and psychosocial treatment works best.
- Bipolar disorder is better controlled if treatment is continuous rather than off and on.
- Education is crucial to helping the person, and his or her supports, learn how to manage bipolar disorder and prevent complications.
- Keeping a chart of daily mood symptoms, treatments, sleep patterns, and life events can help the doctor track and treat the disorder most effectively.
- Support groups offer help and understanding that can promote longer-term mood stability.

Education is crucial to helping the person learn how to manage bipolar disorder.

Resources:

Visit www.nimh.nih.gov. and search by Bipolar Disorder.
Visit www.nami.org and click on Bipolar Disorder.

Care Tips

- Encourage the person to take medication as prescribed.
- If Lithium is prescribed, blood levels must be taken periodically. Check with the person's healthcare provider and make sure you know the schedule.
- Let the person know when his or her behavior is a problem.
- Set limits.
- Help the person handle or work through any problems that may be causing them worry or stress. This may help prevent a manic episode as stress often trigger symptoms.
- Do your best to calm the person.
- As a caregiver, it is important to understand the cycling, roller-coaster aspect of mood swings the person experiences are part of the disorder.

Schizophrenia

Family Friendly

Schizophrenia is believed to result from a combination of environmental and genetic factors.

What Is It?

Schizophrenia is a chronic and disabling brain disorder that interferes with a person's ability to think clearly, distinguish reality from fantasy, manage emotions, and relate to others effectively. Schizophrenia can be treated but there is no cure.

What Causes It?

Schizophrenia is believed to result from a combination of environmental and genetic factors. It occurs in 1% of the general population and 10% of people who have a parent or sibling with the disorder.

Stress does not cause schizophrenia but it does make symptoms worse when a person has the disorder.

Symptoms:

- Speech may become garbled or hard to understand
- Difficulty organizing thoughts and connecting them logically
- Inability to concentrate or to cope with minor problems
- Behavior that does not make sense such as repeating gestures or walking in circles
- Inability to express joy, cry, or experience pleasure
- Laughing at inappropriate times
- Unusual sensitivity to noise, light, colors, textures, touch
- Poor personal hygiene
- Depression
- Social withdrawal and isolation
- Deterioration of social relationships
- Hallucinations may involve one or more senses, e.g., eyes (visual), ears (auditory), nose (olfactory), taste (gustatory), or touch (kinesthetic)
- Delusions may be of grandeur (exaggerated self-importance) or persecution (belief that someone intends to harm them in some way)
- May be suspicious and paranoid

Progression:

- Typically emerges in the teenage years or early twenties for men and ages twenty to thirty for women.
- Chronic and episodic throughout the person's life.
- Relapses occur most often when medication is stopped.

Treatment:

- Medications.
- Therapy.
- Education and illness management skills for both the person and his or her family.
- Social skills training.
- Rehabilitation and vocational counseling.
- Healthy nutrition, rest, and exercise.
- Self-help support groups.
- Hospitalization may be needed to treat severe delusions or hallucinations or for suicidal thoughts.

Resources:

Visit www.nimh.nih.gov and search by schizophrenia.
Visit www.nami.org and click on schizophrenia.

- The person's response time may be slowed. Allow him or her time to make decisions.
- Provide a peaceful and calm, structured, and predictable environment and routine.
- Ensure that medications are taken to prevent ***decompensation*** and relapse.
- Monitor closely for symptoms of decompensation and report to the healthcare provider.
- Observe for symptoms of medication side effects (especially Tardive Dyskinesia and Neuroleptic Malignant Syndrome) which may be fatal. See page 101 for more information).
- Be positive and supportive.
- Help the person set realistic goals.
- Prevent social withdrawal by encouraging the person to stay involved in meaningful activities.

Decompensation — the *decline or worsening of a mental health disorder.*

True/False – What Do You Know About Mental Disorders?

Refer back to your answers on page 3.

1. False. *Bad parenting causes mental disorders.*

Mental disorders are biologically based brain disorders. They are not the result of personal weakness, lack of character, or poor upbringing.

See Module 1 page 4 for more information.

2. False. *Mental disorders are rare***.**

Mental disorders are common in the United States and internationally. An estimated 26% of Americans over the age of 18 have a diagnosable mental disorder in a given year. The most serious and disabling conditions affect about 6% of the population.

See Module 1 page 4 for more information.

3. False. *Only uneducated and poor people develop mental disorders.*

Mental disorders are not related to a person's character or intelligence. They are not the result of a personal weakness. Mental disorders can affect people of any age, race, religion, or income.

See Module 1 page 4 for more information.

4. False. *People with mental disorders are dangerous.*

Research has shown that people receiving treatment for a mental disorder are no more violent or dangerous than the rest of the population. People with a mental disorder are more likely to harm themselves - or to be harmed - than they are to hurt other people. A person with schizophrenia is approximately 2,000 times more likely to commit suicide than they are to harm someone else.

See Module 1 page 5 for more information.

5. True. *Culture can influence whether a person with a mental disorder decides to seek treatment.*

Culture may influence the pathway to treatment. It is well documented that racial and ethnic minorities in the United States are less likely to seek mental health treatment. Research indicates that some minority groups are more likely to delay seeking treatment until symptoms are more severe. Mistrust has been identified as one of the main reason racial and ethnic minorities might not seek help.

See Module 2 page 25 for more information.

6. **True.** *When communicating with a person who is actively hallucinating, it is important to find out what the hallucination is about.*

When communicating with a person who is actively hallucinating, it is important to find out about the nature of the hallucinatory experience in case there is a safety issue to be concerned about.

See Module 3 page 32 for more information.

7. **True.** *A person with a mental disorder who is physically aggressive should not be physically restrained.*

The person's rights must always be respected and physical restraints must never be used. There may be times when a person with a mental disorder becomes agitated and may become physically aggressive. At these times it is important that you remain calm and do not aggravate the situation with inappropriate responses.

See Module 4 page 54 for more information.

8. **False.** *A person with a mental disorder that is decompensating will always experience a relapse.*

Decompensation can occur for many reasons. It does not have to result in a relapse for the person with a mental disorder. It is important that you are familiar with the person's baseline and recognize when the person is experiencing decompensation so that you can respond appropriately and help prevent a relapse.

See Module 5 page 62 for more information.

9. **False.** *Talking to a person with depression about suicide increases the risk that he or she will do it.*

Talking to someone about suicide actually decreases the risk that the person will do it. Often we are fearful of talking to someone about their desire to kill themselves because we are fearful that we will cause them to commit suicide. In reality, most suicidal people desperately want to live. They are just unable to see alternatives to their problems. Talking with someone helps.

See Module 6 page 86 for more information.

10. **False.** *Medications can cure mental disorders.*

Mental disorders are treatable but may not be curable. Often a person with a mental disorder can take medications which will help manage the condition and may even contribute to the symptoms disappearing. However, the condition is not cured, it is merely managed.

See Module 7 page 95 for more information.

Mental Health
Specialty Training

MODULE 2

Culturally Compassionate Care

Washington State Department of Social & Health Services

ADSA Aging & Disability Services Administration
www.adsa.dshs.wa.gov

Culture, Ethnicity and Its Impact on Care for Individuals with Mental Disorders

Module Goals:

To provide caregivers and managers information on how:

- Culture influences an understanding of mental disorders.
- To provide culturally sensitive care.

Overview of Culture and Ethnicity

Culture and ***ethnicity*** play critical roles in our understanding of mental health and mental disorders. All people have the right to be understood, respected, and treated as individuals.

Understanding the wide-ranging roles of culture and society enables caregivers and providers to offer culturally appropriate care that is responsive to the needs of the person.

Culture *— a common heritage or set of beliefs, norms, and values.*

Ethnicity *— a common heritage shared by a particular group.*

The challenge for caregivers is to understand the person with a mental disorder's perspective. This requires that caregivers:

- Develop an open style of communication.
- Be receptive to learning from multicultural residents.
- Demonstrate a tolerance for uncertainty inherent in cultural norms, which evolve and are continually changing. While many cultural characteristics are apparent, others are less obvious and need conscious exploration.

One of the challenges when getting to know more about a person's cultural characteristics is the possibility of creating or reinforcing ***stereotypes.*** Cultural characteristics of a given group may invite stereotyping of individuals based on their appearance or affiliation. These characteristics should be treated broadly and should not be treated stereotypes.

Stereotypes *— over simplified opinion, prejudiced attitude or critical judgment.*

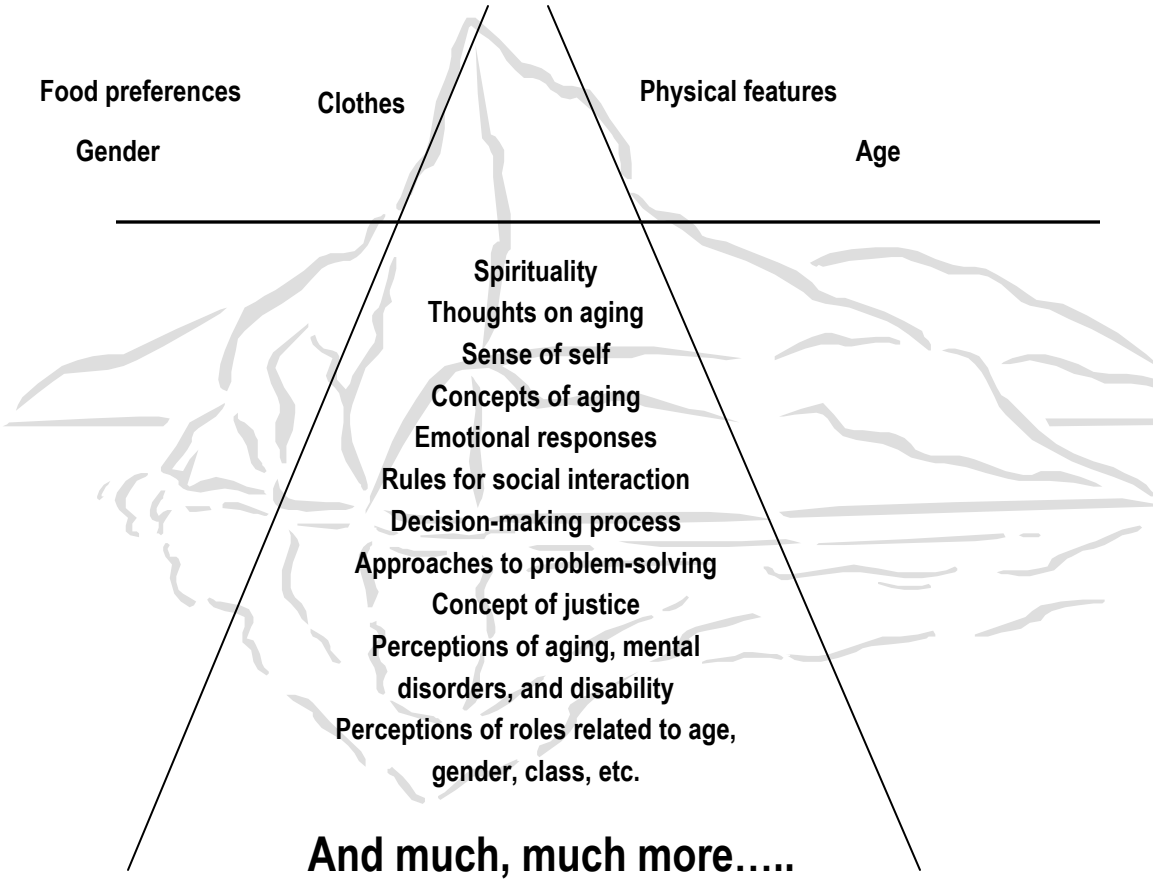
The following illustration of an "**ICEBERG"** represents cultural differences, perspectives, values, and beliefs that are unique to all cultures.

Oftentimes, it is the tip of the "iceberg" that is considered when caring for people of different cultural and ***heritages***. This, however, does not represent the entire person or the whole iceberg.

Heritage *— a similar history, language, rituals, and preferences for music and foods.*

To provide culturally appropriate care, you need to get to know the whole person (the entire "iceberg").

The Iceberg


Food preferences
Clothes
Physical features
Gender
Age
Spirituality
Thoughts on aging
Sense of self
Concepts of aging
Emotional responses
Rules for social interaction
Decision-making process
Approaches to problem-solving
Concept of justice
Perceptions of aging, mental disorders, and disability
Perceptions of roles related to age, gender, class, etc.
And much, much more…..

Getting to Know You

Activity

Take a few minutes and consider the things you would like others to know about you. Fill in the blanks and box below.

Age _____ **Gender** _____

The Iceberg

Food preferences

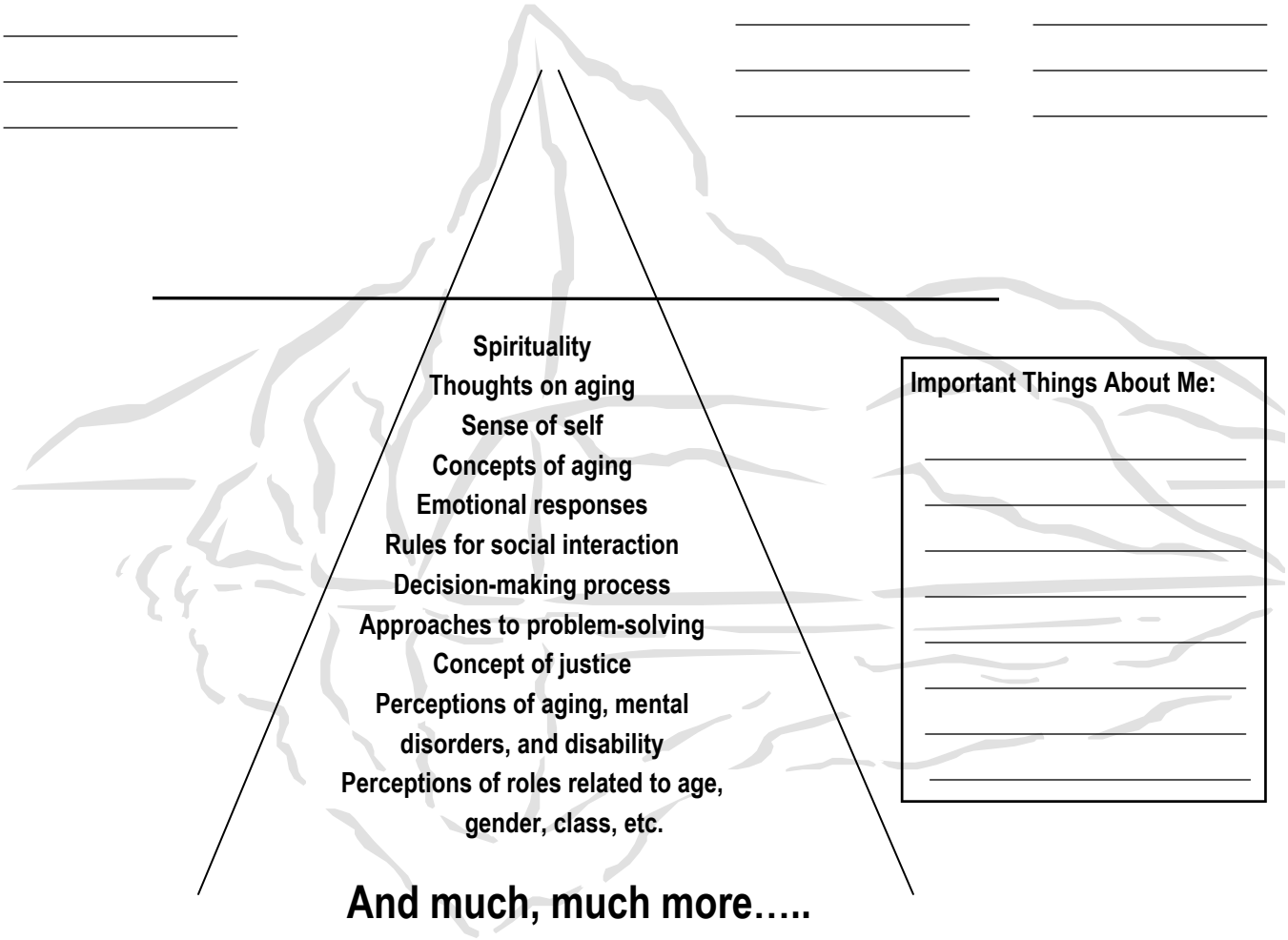
_____
_____
_____
_____

Clothes

_____
_____
_____
_____

Physical features

_____
_____
_____
_____



Spirituality
Thoughts on aging
Sense of self
Concepts of aging
Emotional responses
Rules for social interaction
Decision-making process
Approaches to problem-solving
Concept of justice
Perceptions of aging, mental disorders, and disability
Perceptions of roles related to age, gender, class, etc.

Important Things About Me:

_____
_____
_____
_____
_____
_____
_____
_____

And much, much more…..

Impact of Culture on Mental Health Care

The culture of the person influences many aspects of mental health and mental disorders. Many people from different cultures see mental illness as shameful and delay treatment until symptoms reach crisis proportions.

Culture may effect how people with mental disorders:

- **Describe or present his or her symptoms.**

  One way in which culture affects mental disorders is in how the person describes or presents his or her symptoms.

  People in different cultures tend to selectively express or present symptoms in culturally acceptable ways. Some people may describe physical distress (headaches, stomach ache) yet are reluctant to talk about their emotional distress (depression, sadness, anxiety).

  This may be because in some cultures it is "ok" to talk about physical illness but mental distress or a mental disorder is viewed as bad.

- **Give meaning, defines, or makes sense of a mental disorder.**

  Culture may also affect the way a person makes sense of his or her illness and of his or her distress.

  Often mental disorders may be viewed as conditions that reflects poorly on family or as a condition brought on by a bad deed committed by the individual.

  Deep seated attitudes and beliefs about mental illness may affect whether the disorder is viewed as "real" or "imagined."

- **Cope with a mental disorder**

  Culture will also affect how people cope with everyday problems and more extreme types of adversity, such as a mental disorder.

  There are some cultures who will attempt to handle distress and a mental disorder on their own, while others will rely more on spirituality to help. Yet, others rely on strong familial support to help in coping with and dealing with their mental disorder.

- **Seek treatment**

  Culture may influence the pathway to treatment. It is well documented that racial and ethnic minorities in the United States are less likely to seek mental health treatment.

  Research indicates that some minority groups are more likely to delay seeking treatment until symptoms are more severe.

  Mistrust has been identified as one of the main reason racial and ethnic minorities might not seek help. It is well noted that mistrustful attitudes are commonplace among various cultural and ethnic groups.

  Mistrust of treatment is often rooted in a sense of historical persecution and from present-day struggles with racism and discrimination. It also arises from documented abuses and perceived mistreatment in the present, as well as the past.

  When treatment is sought, culture may influence where treatment is received. Culture may influence whether a person turns to informal sources of care such as clergy, traditional healers, family and friends.

  For example, American Indians and Alaska Natives often rely on traditional healers, who frequently work with formal providers in tribal mental health programs. African Americans often rely on ministers, who may play various mental health roles within the spiritual context.

Stigma and Mental Disorders

Stigma is widespread and may affect not only how a mental disorder is viewed, but whether the person pursues treatment. Stigma may lead to the person to conceal symptoms and fail to seek treatment. Stigma can also lead to diminished self-esteem and greater isolation and hopelessness.

Stigma is so powerful that it can also affect relationships with family members and contribute to the disorder being viewed as a failure on the part of the entire family system.

For more information on stigma and mental disorders, see page 5 in Module 1.

Resources

For more information, read *The Stigma of Mental Illness in Communities of Color* at www.npr.org. Search by the title of the article.

Providing Care

Your reactions and feelings towards those who may be different may influence how you provide care.

When working with a person who is from a different culture or ethnic background and who has a mental disorder, it will be important that you get to know the person you are working with as a unique individual.

You will need to make an effort to learn about and understand how the person you are working with experiences his or her mental disorder. You will need to be aware of and question how your own beliefs impact how you deal with a person that is different from you. Getting to know the person you are working with will help you provide culturally relevant and competent care. And remember, you can learn more about the person if you ask questions and respect differences.

Guiding Principles When Providing Care to Individuals with Mental Disorders		
Guiding Principles	**Cultural Considerations**	**Care Tips**
Treat as an Individual	• Every person is unique in his or her social, cultural, and personal influences. Each person is an individual and should be treated accordingly.	• Use your communication skills to gain more information. • Call a person by his or her name with the degree of formality expected in their culture, and learn to pronounce it correctly. If in doubt, ask. • Show a person you are interested and curious in learning more about them.
Refrain from Using Stereotypes	• There are many differences among people of any cultural or ethnic group. • There is a difference between culture and race.	• Be aware of any tendency to stereotype and challenge assumptions. • Avoid generalizing. • Avoid making assumptions about a person based on the person's race, ethnicity or culture.
Respect Cultural Differences	• People from different cultures may seek treatment from informal or non-traditional sources.	• Do not stand in the way of person and family members who wish to utilize indigenous healers. • Remember that the use of humor or jargon may not be accepted or comprehended the same in every culture. • Do not use slang.
Be Aware of Cultural Differences Regarding Mental Disorders	• Behaviors considered a sign of a mental disorder in one culture, may be considered normal in other cultures. • Culture can influence how a person experiences and explains symptoms.	• Prepare the person for culturally unfamiliar services by offering the opportunity to practice the role that is unfamiliar. • Provide information on culturally appropriate resources, using materials the person can understand. • Use cultural translators. If you are not familiar with the person's culture or language, seek help from someone who is. • Use professionals and avoid using children as translators for adults.
Be Aware of Intergenerational Differences in Culture	• Age based conflict may be misinterpreted as cultural or ethnic conflict.	• Be alert to clues indicating inter-generational conflict.

Mental Health
Specialty Training

MODULE 3

Respectful Communication

Respectful Communication When Working with People with Mental Disorders

Module Goals:

To provide caregivers and managers with information and tips on:

- Techniques to respectfully and non-judgmentally communicate with a person with a mental disorder.
- Effective listening skills.

Communicating and Mental Disorders

Effective communication in the best of times can be difficult. Communicating with a person diagnosed with a mental disorder may at times become even more challenging. This may be because the person is:

- Preoccupied with other thoughts (either real or imagined).
- Withdrawn or depressed to the point that talking is difficult.
- Experiencing hallucinations or delusions.
- Having trouble concentrating.

A person with a mental disorder deserves to be communicated with clearly, respectfully, and without judgment. When situations become difficult, it is important to share feelings and thoughts in a way that is non-confrontational to avoid unwelcome responses. Remain open and genuine in your communication. It is okay to set limits on hostile or bizarre behavior, but make sure to always tell the person in a non-emotional, non-judgmental way what is inappropriate. Be clear, but calm, when telling the person about possible consequences of continuing the behavior.

Effectively communicating with a person with a mental disorder requires your best skills in:

- Concisely presenting information
- Actively listening to the other person
- Consistency matching your non-verbal expressions with the meaning of what you are saying
- Ensuring your messages are understood and accepted

The Importance of Listening

Be a good listener. Listening requires more than hearing words. Listening requires:

- A desire to understand another human being.
- An attitude of respect.
- A willingness to stay open to seeing things from another's point of view.

Understand that people want to feel heard more than they care about whether you agree with them. You do not have to accept the person's idea or point of view. Just be willing to hear what the person has to say.

- Listen with empathy and in a non-judgmental manner.
- Try to understand the other person's frame of reference and what is shaping his or her feelings.
- Listen not only to the content of what the person is saying, but also to his or her emotional meaning.

Listening takes energy, practice, and concentration.

Listening takes energy, practice, and concentration. It is important because it helps you:

- Have a better understanding of the person.
- Avoid misunderstandings.
- Show respect.
- Diffuse anger.
- More effectively problem-solve.
- Improve your relationship with the person.
- Provide more effective and compassionate care.

Listening Skills

- Make time to listen to the person. Stop what you are doing and show the person you are interested in what he or she is saying.
- Encourage the person to explain what he or she is thinking and feeling so you can better understand what he or she is going through.

  Use phrases such as "Tell me more", "What happened then?", "When did the problem start?"
- Listen without interrupting. Be patient if it takes the person a while to say what he or she wants to say.
- Allow the person to talk without showing shock, surprise, or expressing judgment. Accept the person's feelings without shaming the person.

- Reflect meaning—you can show you understand the person by reflecting his or feelings. If you do this, it is important to reflect correctly the intensity of the feeling.

  If a person is terrified say," You are really terrified", not "So, you are feeling a little scared". You might say "You are feeling terrified because the voices are telling you that people are spreading lies about you." Do not exaggerate, as this may alarm the resident

  Reflecting meaning is also a good way to clarify exactly what the person is saying. Put what you think you heard into your own words and repeat it back to the resident.
- Pay attention to the person's voice. Listen to the speed the person is talking. Changes in the rate of speed are important clues to a speaker's feelings.

  When a person is excited, angry, or frustrated, they tend to talk more rapidly. When a person is reluctant to talk, speech usually slows down. A higher pitched voice may indicate stress or anxiety. A louder than normal voice often indicates emotional intensity.

General Tips for Communicating with a Person with a Mental Disorder

Non-Verbal Communication

- **Posture**—maintain an open and relaxed posture.
- **Gestures**—avoid exaggerated movements, such as pointing, waving your arms, or putting your hands on your hips. These may be interpreted as confrontational or **aggressive.**
- Facial expressions—faces express feeling, facial expressions need to match the meaning of what you are feeling and thinking
- **Eye contact**—maintain a comfortable level of eye contact. Looking someone in the eye can show you are listening to them and are not bored or frightened. Staring can cause the person to become uncomfortable or feel threatened.
- **Personal space**— If the person is feeling vulnerable or not well, standing too close can make the person feel uncomfortable. Do not tower over the resident—communicate at eye level.
- Be specific and concrete but avoid oversimplifying. You do not want to seem patronizing.

Verbal Communication

- Present one thought at a time. Presenting too much information at once may overwhelm the person.
- Ask constructive questions to encourage the person to talk more about what he or she is feeling.
- Do not rush. Speak in a calm manner.
- Share your feelings in a non-confrontational way. Use "I" statements rather than "You" statements. "I" statements show that you are taking responsibility for your feelings and are not blaming the other person.
- Express positive feelings. Say exactly what the person did that pleased you.
- Recognize the difficulty of the person's situation. Acknowledge the person's strengths and abilities
- Maintain your normal tone and pitch when speaking. Your natural reaction to some situations may be to raise your voice. Try to avoid this as it can be more disturbing to the person.
- If you are having trouble getting a message across, come back to the issue another time. Don't argue about it, no matter how logical you feel your argument is. Don't discuss anything important when you are angry or upset.
- If you do not understand, do not fake it. Ask the resident to repeat.

Tips for Communicating with People with Anxiety Disorders

Anxiety is often accompanied by irrational thinking, such as fears that are not based in reality.

- Remain non-judgmental.
- Allow the person to talk about his or her fears and concerns while maintaining a calm, caring, and understanding attitude. Avoid giving advice or directing the conversation.

Remain non-judgmental.

- Use "active listening" skills. Being actively listened to often helps an anxious person see and think more clearly and overcome his or her anxiety.
- If talking about anxiety-provoking concerns and fears does not alleviate the anxiety, help the person redirect attention away from anxious thoughts as much as possible.

  This may be as simple as changing the subject to something more pleasant or engaging the person in an activity that requires close attention such as reading, putting together a puzzle, playing a game, or helping prepare dinner.

Activity

*Using what you know about communicating with a person with an anxiety disorder, mark whether you think the sentences below are **respectful or disrespectful**.*

	Disrespectful	Respectful
We have discussed it so many times already.		
Do you want to tell me about this situation that you are feeling anxious about?		
Your anxious feelings seem to be getting worse. What can I do to help?		
I do not understand why you worry so much. You'll be fine.		

In the space provided below, rewrite any of the sentences you thought disrespectful in a more respectful manner.

*Now mark whether you think the sentences below are **judgmental** or **non-judgmental**.*

	Judgmental	Non Judgmental
How many times do we have to talk about the same situation?		
Let's talk about what is making you anxious. I have some time.		
Why can't you just get over it?		
Is there anything you would like to do to get your mind off of this for a while?		

If there is a need to say anything at all, rewrite any of the sentences you thought judgmental in a non-judgmental manner.

Tips for Communicating with People with Depression

If the person doesn't want to talk, writing, poetry, art, or journaling are other good ways to express emotions.

- A person with depression may have an overall feeling of negativity and may respond to you in that way. Try not to take this personally or feel discouraged if the person seems withdrawn.
- You don't have to understand what the person is going through to be helpful. It is better to admit that you can not understand the person's experience (unless you have experienced something similar). Invite the person to share with you what it is like or what he or she is feeling. And, then actively listen!
- Acknowledge the person's depression and do not trivialize it. For example, don't tell the person that everyone gets depressed sometimes or that he or she has it better than some people.
- Use a calm and reassuring tone when communicating with a person who has depression.
- Often a person with depression feels very alone. Remind the person that you are there to support him or her.
- Offer hope but do not minimize the person's experience.
- Be honest and genuine. The best communication can be simply to ask "How can I help?"

*Using what you know about communicating with a person with a diagnosis of depression, mark whether you think the sentences below are **respectful or disrespectful**.*

	Disrespectful	Respectful
I noticed that you have been making statements about dying. Are you thinking of hurting yourself?		
Do not even think that way. Don't you know suicide is a sin?		
I cannot know how bad you feel, but you do appear to be very sad.		
Cheer up! Everything is going to be alright.		

In the space provided below, rewrite any of the sentences you thought disrespectful in a more respectful manner.

*Now mark whether you think the sentences below are **judgmental** or **non-judgmental**.*

	Judgmental	Non Judgmental
Stop feeling sorry for yourself. You really have quite a good life.		
I am sorry you are in so much pain.		
Everyone feels sad sometimes. If you really want to, you could get past this.		
I cannot fully understand what you are feeling, but I am here to support you.		

If there is a need to say anything at all, rewrite any of the sentences you thought judgmental in a non-judgmental manner.

Tips for Communicating with People with Bipolar Disorder

- Reduce stimulation.
- Communicate ways to help the person cope with the stress that may be causing a manic episode.
- Do your best to calm the person without "pushing" them to improve their behavior.
- Set limits and have structure. A few rules may keep things calmer.
- Deal with immediate issues. Do not try to reason or argue.
- Use direct and consistent language.
- Let the person know when his or behavior becomes problematic.
- Watch for verbal and non-verbal signs of anger.
- Do not try to convince the person that his or her plans are unrealistic. At the same time, take steps to ensure his or her safety.

Activity

*Using what you know about communicating with a person with a diagnosis of Bipolar Disorder, mark whether you think the sentences below are **respectful or disrespectful**.*

	Disrespectful	Respectful
Get to bed. You are keeping all the other residents awake!		
Would you like a cup of warm tea to help you sleep?		
I would appreciate it if you would stop swearing and lower your voice.		
If you do not stop swearing, you are going to get kicked out of this place.		

In the space provided below, rewrite any of the sentences you thought disrespectful in a more respectful manner.

*Now mark whether you think the sentences below are **judgmental** or **non-judgmental**.*

	Judgmental	Non Judgmental
Your mood is like a roller coaster. Calm down.		
I feel worried when your moods change so suddenly.		
So you feel a bit depressed today.		
I think you just want attention.		

If there is a need to say anything at all, rewrite any of the sentences you thought judgmental in a non-judgmental manner.

Tips for Communicating with People with Schizophrenia

Symptoms of schizophrenia include hallucinations and delusions.

- When communicating with a person who is actively hallucinating, it is important to find out about the nature of the hallucinatory experience in case there are safety issues to be concerned about.

  For example, if the person says to you, "Do you see those angels flying up there?" Say to the person, "No, I do not see them, but I know you do."
- Change the subject to a topic that is based in reality, for example, the weather, current events, or plans for the day.
- If the person has paranoid ideas, do not try to argue him or her out of it. Sympathize with the person and say that it must be upsetting to feel like that.
- If the person is delusional, find out the content of the delusion in the event of potential danger.
- Do not argue with the person or focus on the delusional content.

  Keep the conversation reality-based. For example, you are peeling potatoes in the kitchen in preparation for dinner. The person sees you with the knife peeling the potatoes. She says to you, "I know you are sharpening that knife to kill me!"

  Say to her, "I am peeling potatoes for dinner. I have no intention of hurting anyone." Continue peeling the potatoes, change the subject, and do not mention what you are doing again.
- Do not allow yourself to feel intimidated by the person's words or behavior.

Activity

*Using what you know about communicating with a person with Schizophrenia, mark whether you think the sentences below are **respectful or disrespectful**.*

	Disrespectful	Respectful
How are you feeling today?		
What's up? Do you still think someone is out to get you?		
I do not know what you are talking about. No one else hears voices.		
I am sorry that the voices are back. What are they telling you?		

In the space provided below, rewrite any of the sentences you thought disrespectful in a more respectful manner.

*Now mark whether you think the sentences below are **judgmental** or **non-judgmental**.*

	Judgmental	Non Judgmental
Just get over it. There are no voices.		
You are being rude. Knock it off.		
Tell me about what you are experiencing.		
It must be upsetting to hear voices saying people are spreading lies about you.		

In the space provided below, rewrite any of the sentences you thought disrespectful in a more respectful manner.

Communication Tips for Handling a Crisis

Your main communication goals during a crisis is to not make the situation worse and to help the person regain control. With a mental disorder, often crises happen when a person is terrified of losing control over his or her thoughts or feelings. Voices, caused by auditory hallucinations, may be giving life threatening commands. Messages could be coming to the person from light fixtures, electrical outlets, or a number of other places.

It is your duty to accept that the person is in an "***altered reality state***" and is responding to something that is not real to you, but may be very real to that person. It is imperative that you stay calm in this situation.

- Express concern, listen, and ask the person to share what is happening.
- Reassure the person that you are there to help.
- Speak softly and in simple sentences—Everything will go better if you do this.
- Do not shout—If the person does not appear to be listening, other voices may be interfering with the person's ability to be attentive.
- Avoid patronizing or using authoritative statements.
- Do not criticize—It will make matters worse and cannot make them better.
- Do not squabble with other staff or family about the best way to handle the situation—This is not the time to prove a point.
- Do not threaten the person—This will be interpreted as a power play and will increase fear, which may prompt assaultive behavior.
- Do not bait the person into acting out wild threats—The consequences could be tragic.
- Do not stand over the person—If the person is seated, take a seat yourself.
- Avoid continuous eye contact or touching.
- Do not block the doorway, but keep yourself near an exit.

Mental Health
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MODULE 4

Creative Approaches To Challenging Behaviors

Washington State
Department of Social
& Health Services

ADSA Aging & Disability
Services Administration
www.adsa.dshs.wa.gov

Creative Approaches To Challenging Behaviors

Module Goals:

To provide caregiver and managers with:

- A variety of tools and methods to help you explore and handle challenging behaviors.
- Creative approaches for providing care.

Introduction

In your role as caregiver, you will sometimes find it necessary to deal with challenging behaviors and situations. Your role is to try to understand what is causing the behavior and handle the situation competently and respectfully.

When dealing with an individual diagnosed with a mental disorder, there may be hidden causes contributing to challenging behaviors. For example, the person may be ***hallucinating***, delusional, experiencing medication side effects, or contemplating suicide.

Hallucinating *—hearing voices or seeing objects no one else hears or sees.*

To best respond to a challenging behavior, take a step back and try to understand, from the person's perspective, what message the behavior may be conveying.

Ask yourself the following questions:

- Is there something the person needs?
- What is happening in the person's living environment?
- Does the behavior put the person or anyone else at risk for harm?
- Is the person getting positive attention for the behavior?

There is no ***one size fits all*** solution for dealing with challenging behaviors with people with mental disorders. Different people will have different needs. There are, however, a number of methods and tools that have proven successful that will be presented in the rest of the section.

Exploring Challenging Behaviors

Framework for Action

Framework for Action is a four step method for dealing with challenging behaviors.

Step 1: Describe and try to understand the behavior.

Step 2: Decide if there is a problem and for whom.

Step 3: Decide what action, if any, needs to be taken.

Step 4: Check if your plan worked.

The following are some suggestions of helpful questions to ask yourself at each step when analyzing a challenging behavior.

Step 1: Describe and try to understand the behavior

- What exactly is the person doing, when, and with whom?
- Have you seen this behavior with this person before? Are there any patterns you can see?
- Is the person trying to communicate a need or desire?
- What happened in the environment or with other people at the time of the behavior that may have triggered the behavior?
- Have there been any changes in the person's physical health?

Step 2: Decide if there is a problem and for whom

- Is anyone in physical or other danger because of the behavior?
- Can the behavior be explained as a way a person with a mental disorder reacts to situations?
- Who is concerned or being impacted by the behavior (family members, caregiving staff, the person with a mental disorder, other residents)?
- Does the behavior need to change or can you help the person concerned better understand it?

Step 3: Decide what action, if any, needs to be taken

- Does anything need to be done?
- If yes, what other help do you need? What do you expect others to do?
- Is there something you expect the person to do?
- Are there any other resources you will need to carry out your plan?

Step 4: Check if your plan worked

- Did your plan of action work?
- What worked well? Is there anything that didn't work?
- Did you learn anything that might help you better understand or deal with this behavior in the future?
- Is there anything you want to do differently if the behavior happens again?

The following is a common situation you may see when assisting a person with a mental disorder. On the next page, you will find examples of how a caregiver could use the **Framework For Action** to help understand a challenging behavior.

Situation: *Sylvia is 56 years old and diagnosed with Schizophrenia. It is Saturday morning and she has been mildly agitated since Friday afternoon.*

She slapped another female resident for no apparent reason while they were walking together to the dining room for breakfast. She also refused to eat breakfast or take her morning medications.

Step 1: Describe and try to understand the behavior

- *Sylvia has been agitated for about 12 hours.*
- *Sylvia is refusing breakfast.*
- *Sylvia is refusing medications.*
- *Sylvia has slapped another resident.*
- *Sylvia's behaviors are new and have only presented in the last day.*

Step 2: Decide if there is a problem and for whom.

- *Sylvia's behavior is placing other residents at physical risk.*
- *Sylvia's behavior is placing her at the risk of de-compensation and relapse.*
- *Sylvia's relapse could result in her being kicked out of the adult family home.*
- *Sylvia's behavior places her at a physical and emotional risk and she needs to understand the consequences.*

Step 3: Decide what action, if any, needs to be taken

- *Assure that other residents are safe and not at risk from Sylvia.*
- *Talk to Sylvia about her behavior.*
- *Explain to Sylvia the risks of not taking medications.*
- *Monitor Sylvia for any changes or for relapse.*
- *Document behaviors and notify supervisor.*
- *Talk with Sylvia's therapist.*

Step 4: Check if your plan worked

- *Set a time to check with Sylvia to see how it is going.*
- *Talk to other residents.*
- *Read med charts to see if Sylvia is taking medications.*
- *Monitor meals to see if she is eating.*

Read the situation below. Then, using the information you have been given, fill out each of the steps as you see it using the **Framework for Action**.

Situation: *Matthew is 29 years old and diagnosed with depression. Matthew has refused to bathe, brush his teeth, or change clothes for the past 3 days. He stays in his room most of the day sleeping or sitting near the window. He refuses to talk about what he is feeling. He continually states, "I'm no good. My family would be better off if I were not here". Family members visit daily. Sometimes, he refuses to see them.*

Step 1: Describe and try to understand the behavior

Step 2: Decide if there is a problem and for whom

Step 3: Decide what action, if any, needs to be taken

Step 4: Check if the plan worked

Once you have had an opportunity to talk with other students in the class about Matthew, take a few minutes and reflect on how you filled out the **Framework For Action**.

Was there anything you missed? Something others felt was important that you didn't? Other things you might want to consider in your own caregiving situation(s)?

Fill in the space below with your thoughts.

The "ABC" Technique

The "ABC" technique is another problem solving tool to help you get a better understanding of what may be causing a behavior. This is done by using a simple *"ABC"* approach.

A - *Antecedent*** - What was happening before the behavior started?

B - *Behavior*** – What is the behavior?

C - *Consequences*** - What happens in response to the behavior?

Antecedent - *What was happening before the behavior occurs?*
• Were there things in the environment that were different (unfamiliar people, things, noises)? • Has anything changed in the person's schedule? • Has the person's physical or medical condition changed? • Was there anything different from the normal routine?

Behavior - *What is the behavior?*

- What is the person doing?
- What things are you seeing that cause you concern?
- What are you hearing that causes you concern?

Consequence - *What happens in response to the behavior?*

- How did others (staff, family, other residents) respond to the behavior?
- What was the person's reaction to this response?

This information will be easier to remember and think about if careful notes are documented in the person's records over a period of time.

The following is a common situation you may see when assisting a person with a mental disorder. After the situation, you will find examples of how a caregiver could use the **ABC Technique** to help understand a challenging behavior.

Situation: *John is 34 and diagnosed with Bipolar disorder. John's behavior has been increasingly challenging.*

For the past two days he has been awake throughout the night writing poetry, going in and out of the house numerous times to smoke cigarettes, and was asked twice to stay out of the bedroom of a female resident.

When redirected, he becomes argumentative, loud, and uses foul language. He refuses to accept a sedative ordered by his doctor.

Antecedent - *What was happening before the behavior occurs?*

- *John was instructed to stay out of a female resident's bedroom.*
- *John is refusing a sedative as ordered by his MD.*

Behavior - *What is the behavior?*
• *When redirected, John becomes argumentative, is loud and uses foul language.*

Consequence - *What happens in response to the behavior?*
• *John gets a lot of attention from staff.* • *John gets the other residents agitated and wound up.*

Read the situation below. Then, using the information you have been given, fill out each of the steps as you see it using the **ABC Technique**.

Situation: *Marilyn is 42 and has been diagnosed with Obsessive-Compulsive Anxiety disorder. She complains that her room is very dirty (although it is cleaned daily).*

She requests cleaning materials daily to clean the floor, windows, and her dresser. She insists her sheets be changed daily to get rid of the "germs". Marilyn washes her hands, at least, 40 times a day. When asked to not wash her hands or clean her room, she becomes very angry and ***combative.***

Antecedent - *What was happening before the behavior occurs?*

Behavior - *What is the behavior?*

Consequence - *What happens in response to the behavior?*

Once you have had an opportunity to talk with other students in the class about Marilyn, take a few minutes and reflect on how you filled out the **ABC Technique**.

Was there anything you missed? Something others felt was important that you didn't? Other things you might want to consider in your own caregiving situation(s)?

Fill in the space below with your thoughts.

Dealing With Challenging Behaviors

Challenging Behavior	Possible Causes	Care Tips
Hallucinations or delusions	• Person is not taking medications ordered by the MD. • Medical problems. • Side effects from medications. • Person is relapsing.	• Avoid trying to talk the person out of a hallucination or delusion. It will further upset the person. • Tell the person you do not see, hear, smell, feel, taste or believe what they do, but you know the sensation and belief is real to them. • Gently, change the topic of discussion to something based in reality, such as current events or the weather. • Encourage the person to take his or her medications. • If medications are not working, schedule the person for a medication review and update.
Easily upset/troubled	• Reaction to changes in the environment. • Feeling threatened or over-whelmed. • Feeling rushed, hungry, tired, lonely, or pain.	• Explore reasons for the behavior. • Encourage the person to communicate his or her feelings and thoughts. • Encourage the person to voice what help is needed from caregivers.
Aggression	• Auditory hallucinations. • Delusions of persecution. • Fear. • Medication toxicity. • Changes in the environment. • Changes in caregivers. • Feelings of being disrespected. • Intoxication or withdrawal.	• Do not attempt to physically restrain an aggressive person. • Ensure everyone is moved to safety. • Call for help if the behavior is out of control. • Call 911 if the person is threatening or has a weapon. • Keep your voice tone low and matter-of-fact.

Challenging Behavior	Possible Causes	Care Tips
Depression	• Family history. • Biological. • Major life events such as loss and separation, stress, medication side effects. • Not taking his or her anti-depressant.	• Assess for feelings of self harm. • Encourage involvement. • Avoid verbalizing sympathy or "feeling sorry for the person". • Allow/encourage the person to express his or her feelings. • Be an attentive listener.
Yelling/screaming, verbal abuse/foul language	• Anger. • Pain. • Feeling disrespected. • Lack of sleep. • Not taking medications. • Responding to hallucinations. • Fear.	• Respond early to prevent escalation to aggression. • Ask the person to slow down and lower their voice so that you can "hear" what the problems are. • Demonstrate sensitivity to the person's feelings. • Do not react to the words used, concentrate on the person's feelings. • Validate his or her feelings.
Resistive to care	• Lack of sleep. • Confusion. • Feeling rushed. • Misinterprets directions given. • Need for power and control of his or her own life.	• Gently explain care to be given and reason(s). • Speak slowly and clearly. • Empower the person by allowing input on care provided. • Explain consequences.
Sexual aggression or acting out	• Confusion. • Delusional. • Need for self gratification. • Lacks awareness of socially acceptable behavior.	• Set limits on sexual acting out behavior. • Direct the person to a more private area. • Avoid judgmental communication.

Challenging Behavior	Possible Causes	Care Tips
Withdrawal	• Loneliness. • Introversion. • Too much stimulation such as noise, loud talking, or music. • Feeling unwanted or needed.	• Promote involvement in activities, such as walks, games, or current events group. • Spend one-to-one time with the person; 5 or 10 minutes, four or five times a week. • Encourage peer to peer relationships. • Encourage the person to take his or her medications.
Suicidal or threats of self-harm	• Psychosis [hallucinations]. • Depression. • Despondency. • Hopelessness. • Medical problems.	• Encourage the person to talk about his or her feelings and thoughts. • Perform a suicide assessment – "Are you contemplating suicide?", "What method are you thinking of using?" • Ensure safety by removing dangerous objects from the environment. • Monitor the person's behavior at all times. • Contact 911 if necessary and contact the person's case manager or mental health professional.
Pacing	• Anxiety. • Worry. • Medication side effects. • Refusal to take medication. • Loneliness.	• Try to talk to the person about anxiety. • Check for medication side effects. • Give PRN medications to prevent severe anxiety or panic.

Challenging Behavior	Possible Causes	Care Tips
Accusations of theft and other false accusations	• Need for friendship. • Loneliness. • Absence of "favorite staff member".	• Investigate to determine reliability of accusation. • Communicate to the person that you have or have not found evidence substantiating the accusation. • Demonstrate sensitivity to the person's feelings. • Tell the person you will help if you can.
Refuses to eat or drink	• Loss of appetite. • Sickness. • Medication side effects. • Dislikes food given. • Delusional – belief food is poisoned.	• Check for food allergies and food preferences. • Evaluate for pain. • Evaluate for constipation. • Determine if the person is delusional. • Reassure the person the food is not poisoned.
Sleeplessness or sleep disturbance	• Napping during the day. • Hunger. • Pain. • Need to go to the bathroom. • Medication side effects. • Fear. • Manic episode.	• Keep the person active during the day to prevent napping. • Give the person a light snack prior to bedtime. • Ask MD to check for any physical problems. • Check medication side effects and change times medications are given, if necessary. • Encourage the person to take medications as prescribed. • Involve the person in relaxing activities.

Mental Health
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MODULE 5

Decompensation and Relapse Planning

Washington State
Department of Social
& Health Services

ADSA Aging & Disability
Services Administration
www.adsa.dshs.wa.gov

Decompensation and Relapse Planning

Module Goals:

To provide caregivers and managers with information on:

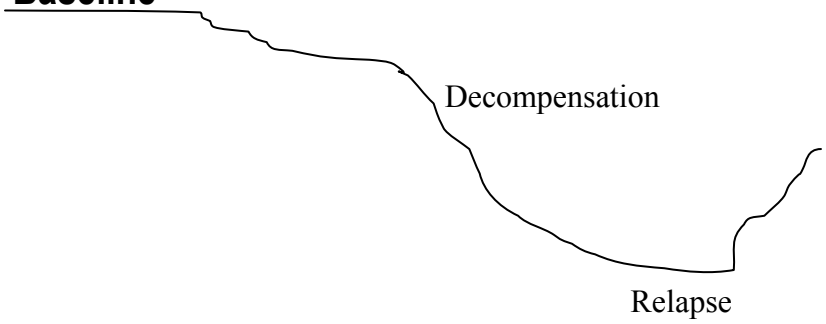
- Determining baseline.
- Identifying decompensation, possible causes, and symptoms.
- Ways to help when a person is decompensating.
- Identifying relapse and developing a relapse plan.
- Dealing with the risk of violence.
- Intervening in crisis situations.

Baseline is described as the times when a person with a mental health disorder is managing his or her symptoms and is functioning at his or her own highest level.

Baseline

Baseline *—when the person is functioning at his or her highest level.*

Baseline



Your goal is to help the resident get to his or her baseline, and to assist him or her to stay there.

Care Tips

You can help by:

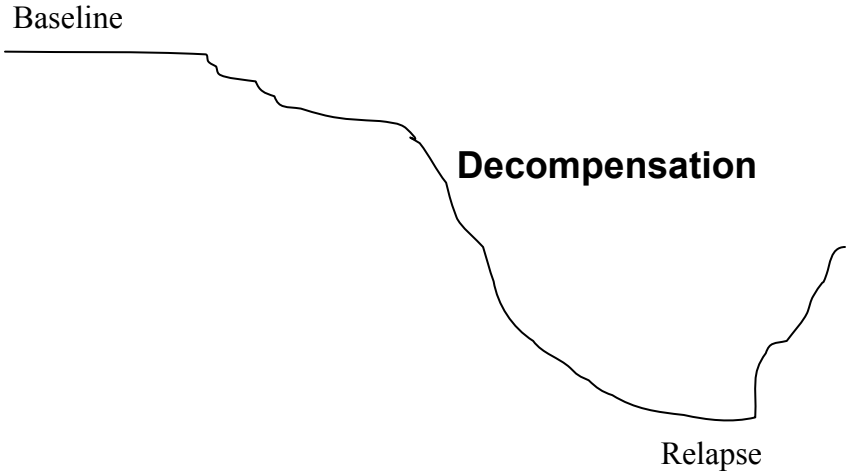
- Encouraging the person to continue treatment and take his or her medications.
- Helping the person set realistic goals. Encourage the person to take small steps towards the goal.
- Creating an atmosphere of support.
- Empowering the person by encouraging and assisting him or her to use problem solving techniques to help cope with obstacles as they arise.
- Being respectful, supportive, and kind. Tell the person what he or she is doing well. This is the best way to help him or her move forward.
- Encouraging the person to identify what causes him or her stress and help the person find ways to reduce it.

Decompensation

Decompensation *—downward slide in symptoms from the person's baseline.*

Decompensation is when symptoms of the mental health disorder begin to be more prominent, and the person is unable to manage or cope with his or her symptoms**.**

Think of decompensation as a "downward slide" from the person's baseline. This "downward slide" leads to a decline in the person's ability to think and carry on with daily activities.



Causes of Decompensation

- Stress is the number one cause of decompensation.
- Changes in a person's daily activities that might cause stress, including changes in the person's physical health, finances, relationships, or living environment.
- Fatigue.
- Illness.
- Life events, such as holidays, vacations, moving, or the death of someone close.

Symptoms of Decompensation

Without intervention, decompensation can lead to a relapse.

Early identification that the person is decompensating is vitally important to get the person appropriate treatment. Without intervention, decompensation can lead to a relapse.

It is therefore critical that you stay alert to symptoms that the person is decompensating.

Symptoms of decompensation are unique to each person. It is important to find out what symptoms the individual has experienced in the past so that you can watch for them.

Some general symptoms include:

- **Sensory changes**—in what the person tastes, smells, hears, and sees.
- **Perceptual changes**—the person may misinterpret or distort what is going on around him or her, and may experience more frequent hallucinations or delusions.
- **Emotional changes**—the person's feelings may appear extreme, opposite of what you might expect, or flat, showing little emotion.
- **Changes in speech**—the person may sound different and may be difficult to understand. The person may string phrases together that make little sense or don't seem to fit.
- **Changes in socialization**—the person may withdraw and stop talking to others.
- **Cognitive changes**—the person may have difficulty thinking and seem confused.

How to Help a Person Who is Decompensating

When the person is doing well, talk to him or her about techniques that have worked in the past so you can be prepared to use them when needed.

When the person is doing well, talk about techniques that have worked in the past so you can be prepared to use them when needed.

Some typical techniques people with a mental health disorder use to help prevent a relapse include:

- Calling the mental health case manager or other mental health professional for support.
- Calling family or friends.
- Using positive self-suggestions to overpower unwanted thoughts.
- Doing an activity the person enjoys, such as reading or playing a game,.
- Taking time to go for a walk, meditate, or pray.
- Getting adequate rest and sleep.

Some people may also use drugs or alcohol. This is not a good technique, as it makes symptoms worse and can be dangerous.

Care Tips

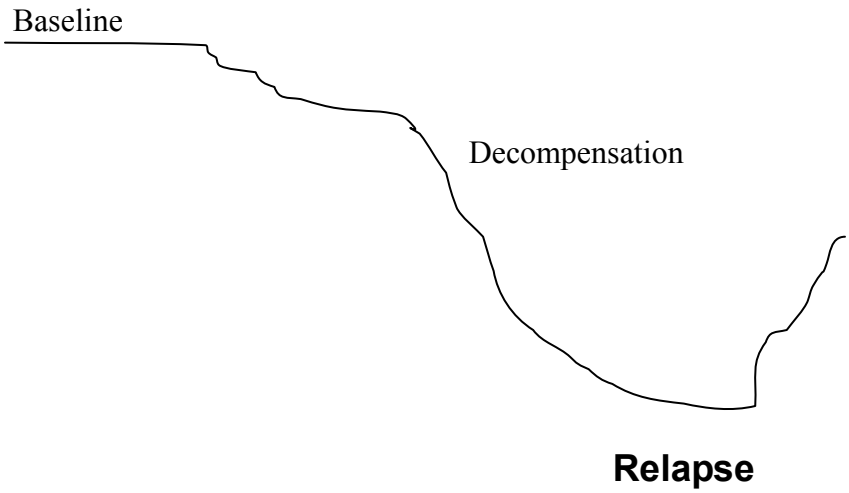
Some things you can do to help the person include:

- Talking to the person about what he or she is feeling.
- Encouraging the person to try some of the techniques that have helped in the past.
- Involving the person in an activity.
- Helping the person to stay focused when doing tasks.
- Being consistent and non-judgmental.
- Calling for assistance when needed.

Relapse

Relapse *—symptoms are severe enough to require professional intervention.*

A ***relapse*** is said to occur when the symptoms of the illness worsen or when previous symptoms return and are severe enough to require professional intervention.



Even with the best treatments and support, relapse can still occur. Sometimes, these symptoms come and go in cycles. Relapse may also occur without an apparent cause.

Prepare ahead of time and develop a plan with the person on what to do in the event of a relapse.

Since prevention is not always possible, it is imperative that you prepare ahead of time and develop a plan with the person on what to do in the event of a relapse.

Make a detailed written plan, then follow it if relapse occurs. This will make a difficult situation less stressful.

Relapse Plan

A ***relapse plan*** is a prearranged plan for what to do when a person experiences a relapse. It is often called a "crisis plan".

Relapse plan *— a plan for what to do when a person experiences a relapse.*

A relapse plan should include:

- Events or situations that have triggered a relapse in the past
- Early warning signs the person experienced in the past
- What has helped the person in the past when the person experienced those early warning signs
- Who the person wants contacted
- What each person's role is in the plan

On page 66 is a simple sample personal relapse management plan.

A relapse plan may be more comprehensive and include information about the person's preferences regarding:

- Treatment and facilities
- Physicians, mental health professionals, and other providers
- Hospitalization and alternative interventions
- Medication preferences and instructions

Mental Health Advanced Directive

A mental health advanced directive is a comprehensive legal document that a person with the mental health disorder can use to spell out his or her wishes, in advance, for what he or she would like to happen in case of a relapse.

On pages 67-81 is a **sample** mental health advance directive. Remember, the law prohibits the use of physical restraints in facilities.

Personal Relapse Management Plan

Resident Name: _____

Events or situations that triggered relapse in the past:
1.
2.
3.

Early warning signs that I have experienced in the past:
1.
2.
3.

What would help me if I experience early warning signs:
1.
2.
3.

Who I would like to assist me:	What I would like them to do:
NAME AND PHONE NUMBER	ROLE

_____ _____

Signature of Resident/Date *Signature of Staff/Date*

Mental Health Advance Directive

NOTICE TO PERSONS
CREATING A MENTAL HEALTH ADVANCE DIRECTIVE

This is an important legal document. It creates an advance directive for mental health treatment. Before signing this document you should know these important facts:

(1) This document is called an advance directive and allows you to make decisions in advance about your mental health treatment, including medications, short-term admission to inpatient treatment and electroconvulsive therapy.

YOU DO NOT HAVE TO FILL OUT OR SIGN THIS FORM.
IF YOU DO NOT SIGN THIS FORM, IT WILL NOT TAKE EFFECT.

If you choose to complete and sign this document, you may still decide to leave some items blank.

(2) You have the right to appoint a person as your agent to make treatment decisions for you. You must notify your agent that you have appointed him or her as an agent. The person you appoint has a duty to act consistently with your wishes made known by you. If your agent does not know what your wishes are, he or she has a duty to act in your best interest. Your agent has the right to withdraw from the appointment at any time.

(3) The instructions you include with this advance directive and the authority you give your agent to act will only become effective under the conditions you select in this document. You may choose to limit this directive and your agent's authority to times when you are incapacitated or to times when you are exhibiting symptoms or behavior that you specify. You may also make this directive effective immediately. No matter when you choose to make this directive effective, your treatment providers must still seek your informed consent at all times that you have capacity to give informed consent.

(4) You have the right to revoke this document in writing at any time you have capacity.

YOU MAY NOT REVOKE THIS DIRECTIVE WHEN YOU HAVE BEEN FOUND TO BE INCAPACITATED UNLESS YOU HAVE SPECIFICALLY STATED IN THIS DIRECTIVE THAT YOU WANT IT TO BE REVOCABLE WHEN YOU ARE INCAPACITATED.

(5) This directive will stay in effect until you revoke it unless you specify an expiration date. If you specify an expiration date and you are incapacitated at the time it expires, it will remain in effect until you have capacity to make treatment decisions again unless you chose to be able to revoke it while you are incapacitated and you revoke the directive.

(6) You cannot use your advance directive to consent to civil commitment. The procedures that apply to your advance directive are different than those provided for in the Involuntary Treatment Act. Involuntary treatment is a different process.

(7) If there is anything in this directive that you do not understand, you should ask a lawyer to explain it to you.

(8) You should be aware that there are some circumstances where your provider may not have to follow your directive.

(9) You should discuss any treatment decisions in your directive with your provider.

(10) You may ask the court to rule on the validity of your directive.

Mental Health Advance Directive

PART I.

STATEMENT OF INTENT TO CREATE A MENTAL HEALTH ADVANCE DIRECTIVE

I, _____being a person with capacity, willfully and voluntarily execute this mental health advance directive so that my choices regarding my mental health care will be carried out in circumstances when I am unable to express my instructions and preferences regarding my mental health care. If a guardian is appointed by a court to make mental health decisions for me, I intend this document to take precedence over all other means of ascertaining my intent.

The fact that I may have left blanks in this directive does not affect its validity in any way. I intend that all completed sections be followed. If I have not expressed a choice, my agent should make the decision that he or she determines is in my best interest. I intend this directive to take precedence over any other directives I have previously executed, to the extent that they are inconsistent with this document, or unless I expressly state otherwise in either document.

I understand that I may revoke this directive in whole or in part if I am a person with capacity. I understand that I cannot revoke this directive if a court, two health care providers, or one mental health professional and one health care provider find that I am an incapacitated person, unless, when I executed this directive, I chose to be able to revoke this directive while incapacitated.

I understand that, except as otherwise provided in law, revocation must be in writing. I understand that nothing in this directive, or in my refusal of treatment to which I consent in this directive, authorizes any health care provider, professional person, health care facility, or agent appointed in this directive to use or threaten to use abuse, neglect, financial exploitation, or abandonment to carry out my directive.

I understand that there are some circumstances where my provider may not have to follow my directive.

Mental Health Advance Directive

PART II.

WHEN THIS DIRECTIVE IS EFFECTIVE

YOU MUST COMPLETE THIS PART FOR YOUR DIRECTIVE TO BE VALID.

I intend that this directive become effective *(YOU MUST CHOOSE ONLY ONE)*:

_____Immediately upon my signing of this directive.

_____If I become incapacitated.

_____When the following circumstances, symptoms, or behaviors occur:

_____

_____

_____

PART III.

DURATION OF THIS DIRECTIVE

YOU MUST COMPLETE THIS PART FOR YOUR DIRECTIVE TO BE VALID.

I want this directive to *(YOU MUST CHOOSE ONLY ONE)*:

_____Remain valid and in effect for an indefinite period of time.

_____Automatically expire _____ years from the date it was created.

Mental Health Advance Directive

PART IV.

WHEN I MAY REVOKE THIS DIRECTIVE

YOU MUST COMPLETE THIS PART FOR THIS DIRECTIVE TO BE VALID.

I intend that I be able to revoke this directive *(YOU MUST CHOOSE ONLY ONE):*

_____Only when I have capacity.

I understand that choosing this option means I may only revoke this directive if I have capacity. I further understand that if I choose this option and become incapacitated while this directive is in effect, I may receive treatment that I specify in this directive, even if I object at the time.

_____Even if I am incapacitated.

I understand that choosing this option means that I may revoke this directive even if I am incapacitated. I further understand that if I choose this option and revoke this directive while I am incapacitated I may not receive treatment that I specify in this directive, even if I want the treatment.

PART V.

PREFERENCES AND INSTRUCTIONS ABOUT TREATMENT, FACILITIES, AND PHYSICIANS

A. Preferences and Instructions About Physician(s) to be Involved in My Treatment

I would like the physician(s) named below to be involved in my treatment decisions:

Dr. _____ Contact information:_____

Dr. _____ Contact information:_____

I do not wish to be treated by Dr._____

Mental Health Advance Directive

B. Preferences and Instructions About Other Providers

I am receiving other treatment or care from providers who I feel have an impact on my mental health care. I would like the following treatment provider(s) to be contacted when this directive is effective:

Name _____ Profession _____

Contact information _____

Name _____ Profession _____

Contact information _____

C. Preferences and Instructions About Medications for Psychiatric Treatment *(initial and complete all that apply)*

_____I consent, and authorize my agent (if appointed) to consent, to the following medications:

_____

_____I do not consent, and I do not authorize my agent (if appointed) to consent, to the administration of the following medications:

_____

_____I am willing to take the medications excluded above if my only reason for excluding them is the side effects which include:

_____

and these side effects can be eliminated by dosage adjustment or other means.

_____I am willing to try any other medication the hospital doctor recommends.

_____I am willing to try any other medications my outpatient doctor recommends.

_____I do not want to try any other medications.

Mental Health Advance Directive

Medication Allergies

I have allergies to, or severe side effects from, the following:

_____

Other Medication Preferences or Instructions

I have the following other preferences or instructions about medications

_____

Preferences and Instructions About Hospitalization and Alternatives
(initial all that apply and, if desired, rank "1" for first choice, "2" for second choice, and so on)

_____In the event my psychiatric condition is serious enough to require 24-hour care and I have no physical conditions that require immediate access to emergency medical care, I prefer to receive this care in programs/facilities designed as alternatives to psychiatric hospitalizations.

_____I would also like the interventions below to be tried before hospitalization is considered:

_____Calling someone or having someone call me when needed.

Name:_____ Telephone:_____

_____Staying overnight with someone.

Name:_____ Telephone:_____

_____Having a mental health service provider come to see me.

_____Going to a crisis triage center or emergency room.

_____Staying overnight at a crisis respite (temporary) bed.

_____Seeing a service provider for help with psychiatric medications.

_____Other, specify:_____

Mental Health Advance Directive

E. Preferences and Instructions About Pre-emergency

I would like the interventions below to be tried before use of seclusion or restraint is considered *(initial all that apply)*:

_____"Talk me down" one-on-one

_____ More medication

_____ Time out/privacy

_____ Show of authority/force

_____ Shift my attention to something else

_____ Set firm limits on my behavior

_____ Help me to discuss/vent feelings

_____ Decrease stimulation

_____ Offer to have neutral person settle dispute

_____ Other, specify _____

F. Preferences and Instructions About Seclusion, Restraint, and Emergency Medications

If it is determined that I am engaging in behavior that requires seclusion, physical restraint, and/or emergency use of medication, I prefer these interventions in the order I have chosen *(choose "1" for first choice, "2" for second choice, and so on)*:

_____Seclusion

_____Seclusion and physical restraint (combined)

_____Medication by injection

_____Medication in pill or liquid form

In the event that my attending physician decides to use medication in response to an emergency situation after due consideration of my preferences and instructions for emergency treatments stated above, I expect the choice of medication to reflect any preferences and instructions I have expressed in Part III C of this form. The preferences and instructions I express in this section regarding medication in emergency situations do not constitute consent to use of the medication for non-emergency treatment.

Mental Health Advance Directive

Authority to Consent to Inpatient Treatment

I consent, and authorize my agent (if appointed) to consent, to voluntary admission to inpatient mental health treatment for _____ days *(not to exceed 14 days)*
(Sign one):

_____If deemed appropriate by my agent (if appointed) and treating physician.

_____
(Signature)

or

_____Under the following circumstances (specify symptoms, behaviors, or circumstances that indicate the need for hospitalization)

_____

_____

_____
(Signature)

or

_____I do not consent, or authorize my agent (if appointed) to consent, to inpatient treatment.

_____
(Signature)

Hospital Preferences and Instructions

If hospitalization is required, I prefer the following hospitals:

_____

I do not consent to be admitted to the following hospitals:

_____

Mental Health Advance Directive

G. Preferences and Instructions About Electroconvulsive Therapy (ECT or Shock Therapy)

My wishes regarding electroconvulsive therapy are *(sign one)*:

_____I do not consent, nor authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy.

_____
(Signature)

_____I consent, and authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy

_____
(Signature)

_____I consent, and authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy, but only under the following conditions:

_____

_____
(Signature)

H. **Preferences and Instructions About Who is Permitted to Visit**

If I have been admitted to a mental health treatment facility, the following people are not permitted to visit me there:

Name: _____

Name: _____

Name: _____

I understand that persons not listed above may be permitted to visit me.

I. Additional Instructions About My Mental Health Care

Other instructions about my mental health care:

_____

_____

Mental Health Advance Directive

In case of emergency, please contact:

Name:_____ Address:_____

Work telephone:_____ Home telephone: _____

Physician: _____ Address: _____

Telephone: _____

The following may help me to avoid a hospitalization:

_____

I generally react to being hospitalized as follows:

_____

Staff of the hospital or crisis unit can help me by doing the following:

_____

J. Refusal of Treatment

I do not consent to any mental health treatment.

_____
(Signature)

PART VI.

DURABLE POWER OF ATTORNEY (APPOINTMENT OF MY AGENT)
(Fill out this part only if you wish to appoint an agent or nominate a guardian.)

I authorize an agent to make mental health treatment decisions on my behalf. The authority granted to my agent includes the right to consent, refuse consent, or withdraw consent to any mental health care, treatment, service, or procedure, consistent with any instructions and/or limitations I have set forth in this directive. I intend that those decisions should be made in accordance with my expressed wishes as set forth in this document. If I have not expressed a choice in this document and my agent does not otherwise know my wishes, I authorize my agent to make the decision that my agent determines is in my best interest. This agency shall not be affected by my incapacity. Unless I state otherwise in this durable power of attorney, I may revoke it unless prohibited by other state law.

Mental Health Advance Directive

A. Designation of an Agent

I appoint the following person as my agent to make mental health treatment decisions for me as authorized in this document and request that this person be notified immediately when this directive becomes effective:

Name:_____ Address:_____

Work telephone:_____ Home telephone: _____

Relationship: _____

B. Designation of Alternate Agent

If the person named above is unavailable, unable, or refuses to serve as my agent, or I revoke that person's authority to serve as my agent, I hereby appoint the following person as my alternate agent and request that this person be notified immediately when this directive becomes effective or when my original agent is no longer my agent:

Name:_____Address:_____

Work telephone:_____ Home telephone: _____

Relationship: _____

C. When My Spouse is My Agent *(initial if desired)*:

_____If my spouse is my agent, that person shall remain my agent even if we become legally separated or our marriage is dissolved, unless there is a court order to the contrary or I have remarried.

D. Limitations on My Agent's Authority

I do not grant my agent the authority to consent on my behalf to the following:

_____

_____

E. Limitations on My Ability to Revoke this Durable Power of Attorney

I choose to limit my ability to revoke this durable power of attorney as follows:

_____

_____

F. Preference as to Court-Appointed Guardian

In the event a court appoints a guardian who will make decisions regarding my mental health treatment, I nominate the following person as my guardian:

Name:_____Address:_____

Work telephone:_____ Home telephone: _____

Relationship: _____

The appointment of a guardian of my estate or my person or any other decision maker shall not give the guardian or decision maker the power to revoke, suspend, or terminate this directive or the powers of my agent, except as authorized by law.

_____
(Signature required if nomination is made)

PART VII.

OTHER DOCUMENTS

(Initial all that apply)
I have executed the following documents that include the power to make decisions regarding health care services for myself:

_____ Health care power of attorney (chapter 11.94 RCW)

_____ "Living will" (Health care directive; chapter 70.122 RCW)

_____ I have appointed more than one agent. I understand that the most recently appointed agent controls except as stated below:

Mental Health Advance Directive

PART VIII.

NOTIFICATION OF OTHERS AND CARE OF PERSONAL AFFAIRS

(Fill out this part only if you wish to provide nontreatment instructions.)

I understand the preferences and instructions in this part are **NOT** the responsibility of my treatment provider and that no treatment provider is required to act on them.

A. Who Should Be Notified

I desire my agent to notify the following individuals as soon as possible when this directive becomes effective:

Name:_____ Address:_____

Day telephone:_____ Evening telephone: _____

Name:_____ Address:_____

Day telephone:_____ Evening telephone: _____

B. Preferences or Instructions About Personal Affairs

I have the following preferences or instructions about my personal affairs (e.g., care of dependents, pets, household) if I am admitted to a mental health treatment facility:

_____

C. Additional Preferences and Instructions:

_____

PART IX.

SIGNATURE

By signing here, I indicate that I understand the purpose and effect of this document and that I am giving my informed consent to the treatments and/or admission to which I have consented or authorized my agent to consent in this directive. I intend that my consent in this directive be construed as being consistent with the elements of informed consent under chapter 7.70 RCW.

Signature: _____ Date: _____

Printed Name:_____

Mental Health Advance Directive

This directive was signed and declared by the "Principal," to be his or her directive, in our presence who, at his or her request, have signed our names below as witnesses. We declare that, at the time of the creation of this instrument, the Principal is personally known to us, and, according to our best knowledge and belief, has capacity at this time and does not appear to be acting under duress, undue influence, or fraud. We further declare that none of us is:

(A) A person designated to make medical decisions on the principal's behalf;
(B) A health care provider or professional person directly involved with the provision of care to the principal at the time the directive is executed;
(C) An owner, operator, employee, or relative of an owner or operator of a health care facility or long-term care facility in which the principal is a patient or resident;
(D) A person who is related by blood, marriage, or adoption to the person, or with whom the principal has a dating relationship as defined in RCW 26.50.010;
(E) An incapacitated person;
(F) A person who would benefit financially if the principal undergoes mental health treatment; or
(G) A minor.

Witness 1: Signature: _____ Date: _____

Printed Name:_____

Telephone _____ Address_____

Witness 2: Signature: _____ Date: _____

Printed Name:_____

Telephone _____ Address_____

PART X.

RECORD OF DIRECTIVE

I have given a copy of this directive to the following persons:

_____

_____

Mental Health Advance Directive

DO NOT FILL OUT PART XI UNLESS YOU INTEND TO REVOKE
THIS DIRECTIVE IN PART OR IN WHOLE

PART XI.

REVOCATION OF THIS DIRECTIVE

(Initial any that apply):

_____I am revoking the following part(s) of this directive (specify):

_____

_____I am revoking all of this directive.

By signing here, I indicate that I understand the purpose and effect of my revocation and that no person is bound by any revoked provision(s). I intend this revocation to be interpreted as if I had never completed the revoked provision(s).

Signature: _____Date: _____

Printed Name:_____

DO NOT SIGN THIS PART UNLESS YOU INTEND TO REVOKE THIS DIRECTIVE IN PART OR IN WHOLE

Mental Health
Specialty Training

MODULE 6

Suicide Prevention

Washington State
Department of Social
& Health Services

ADSA Aging & Disability
Services Administration
www.adsa.dshs.wa.gov

Suicide Prevention

Module Goals:

To provide caregivers and managers with information on:

- The facts regarding suicide.
- Suicide warning signs.
- What to do if a person is suicidal.

Facts About Suicide

There are many myths and misconceptions about suicide and it is often a difficult topic to discuss. The following are some of the things known about suicide.

- Suicide is the eleventh leading cause of death in the U.S.
- Four times as many men kill themselves as women, but three to four times as many women attempt suicide as do men.
- Suicide cuts across all ethnic, economic, social, and age boundaries.
- The suicide rate is higher for the elderly than any other age group. Among the highest rates, are white men age 85 and older.
- Suicide is preventable. Most suicidal people desperately want to live; they are just unable to see alternatives to their problems.
- Most suicidal persons give definite warning signs of their suicidal intentions.
- Talking to someone about suicide does not cause someone to be suicidal.

Risk Factors

Although the great majority of people who suffer from a mental disorder do not die by suicide, having a mental disorder does increase the likelihood of suicide. Other risk factors include:

- Previous suicide attempts
- History of mental disorders, particularly depression
- Alcohol or substance abuse
- Family history of suicide or violence
- A serious or terminal illness
- Having experienced a recent, severe loss such as death, divorce, job, money, health

Suicide Warning Signs

- Talking about committing suicide
- Withdrawing from friends and/or social activities
- Being preoccupied with death and dying
- Drastic changes in behavior
- Losing interest in hobbies, work, etc.
- Giving away prized possessions
- Taking unnecessary risks
- Arranging for care of pets
- Losing interest in personal appearance
- Preparing for death by making out a will or making final arrangements
- Beginning to feel better—a person with depression may be most likely to attempt suicide when a depression begins to lift

Be Aware of Feelings

A person who is suicidal may express or experience some of the following:

- Intense emotional pain that he or she cannot stop
- Sadness that he or she cannot make go away
- Feeling trapped, like there is no way out
- An inability to eat, sleep, or work
- An inability to think clearly or make decisions
- Feeling worthless, hopeless, or guilty

Suicide and Mental Disorders

*An estimated 2-5% of people diagnosed with **major** depression die by suicide.*

Depression

Studies consistently show depression substantially increases the risk for suicide.

Depression is also one of the most common conditions associated with suicide and older adults, yet it often goes untreated. In fact, several studies have found that up to 75% of older adults who die by suicide visited a physician within a month of their suicide.

Because, in older adults, depression often co-occurs with other serious illnesses, health care providers, and the person suffering from depression, often mistakenly think it is a normal consequence of the physical problems.

These factors show how urgent it is to make sure that depression is detected and treated to reduce the risk of suicide in older adults.

Also at high risk are individuals who have depression at the same time as another mental disorder. Specifically, substance abuse, anxiety disorders, schizophrenia, and bipolar disorder put those with depression at greater risk for suicide.

Bipolar Disorder

Both bipolar disorder and depression tend to co-occur with other disorders, such as anxiety, panic attacks, alcohol, and/or substance use, and insomnia. Any of these other disorders are considered to be risk factors for suicidal behaviors.

An estimated 3-20% of people diagnosed with bipolar disorder die by suicide.

People with bipolar disorder are at the highest risk, especially when they are in a mixed episode (symptoms of mania and depression occurring at the same time or alternating frequently during the day).

Schizophrenia

Suicide is unfortunately on of the leading causes of death for people with schizophrenia.

- Studies have shown that 40%-53% of people with schizophrenia have had thoughts of suicide at some point in their lives.
- 23%-55% reported previous suicide attempts.
- Suicide is the leading cause of premature death in those diagnosed with schizophrenia. Between 75 and 95% of these individuals are male.

An estimated 6-15% of people diagnosed with schizophrenia die by suicide.

People with schizophrenia tend to be suicidal:

- In the earlier years of schizophrenia.
- During periods of depression.
- During periods when they are out of touch with reality.
- In a period of improvement after a relapse.

The risk of suicide continues throughout the person's life and seems to be higher when the person has a chronic physical illness, multiple psychiatric hospitalizations, or a previous suicide attempt.

Anxiety Disorders

People with anxiety disorders are 6-10 times more likely than the general population to commit suicide. One study showed that 11% of people who committed suicide had an anxiety disorder. This estimate may be low due to factors that mask anxiety, such as alcohol use or other mental disorders.

Alcohol/Substance Use Disorders

At least 30% of people who commit suicide were dependent on or abused alcohol. Unlike other mental disorders, the risk of suicide for people who abuse alcohol increases with age.

Between 40 to 60% of people who die by suicide have alcohol in their blood at the time of their death.

Between 40 to 60% of people who die by suicide have alcohol in their blood at the time of their death. Sometimes, a person may use alcohol or substances deliberately as part of an attempted suicide. While intoxicated, the person may also be more likely to act on a suicidal impulse.

Additionally, substance use can make some medications more lethal and make it more likely that a suicide attempt by overdose will be deadly.

What to Do If a Person Is Suicidal

When you see any warning signs that a person may be suicidal (see page 86), take it seriously and don't hesitate to take immediate action.

Always treat threats of self-harm seriously, regardless of how many times the person has threatened in the past.

There is no set script of what to say and do in these situations. Each person and situation is different. The seriousness of the situation may make you uncomfortable or you may feel uncertain what to do. This is human nature.

It is important to remember the person is in intense emotional pain and needs your help. Most suicidal people don't want to die so much as he or she want the pain to end.

The following information will give you some suggestions on how best to handle the person and the situation. See pages 88-89 for more communication tips on handling a crisis.

If you are concerned that a person may be suicidal, learn as much as possible about what is going on in his or her mind. The more planning the person has put into a suicide, the greater the risk. If the person has a method and a time planned, the risk is very high.

Talk openly about the possibility of suicide. Ask the person directly,

- "Are you thinking about suicide?"
- If the answer is yes, ask, "Have you thought about how you would do it?"
- If the answer is yes, ask, "Do you have what you need to do it?"
- If the answer is yes, ask, "Have you thought about when you would do it?"

*excerpted from www.suicide.org.

There are four important questions to ask a person you think may be suicidal.
1. Thinking about suicide?
2. Method?
3. Have what you need?
4. When?

High Risk

Your first priority is to keep the person safe if you feel the person is at high risk of suicide. Never leave a person at high risk for suicide alone. If you must leave for any reason, make sure there is another person you trust to stay with the person until you return.

If you feel the person is in immediate danger, there are several actions you should take depending on your situation. A person who is suicidal needs **immediate professional help**.

Depending on your situation, you should:

- Call 911.
- Call the crisis team at the facility.
- Take him or her to the hospital emergency room.

Always be familiar with your facilities policies and procedures for handing this type of crisis before it happens.

While Waiting For Help to Arrive or If the Person is Not in Immediate Danger

- Remain calm and be as gentle and caring as possible. Comfort the person and let him or her know you care and he or she is not alone. Let the person know that you are very concerned.
- Listen and give the person your full attention. Allow the person to express his or her feelings and talk as much as he or she wants.
- Reassure the person that with time and help he or she will feel better and that problems can be solved.
- Remove any firearms, drugs, or sharp objects from the area.
- Do not moralize or make judgments. Do not say, "You will go to hell" or "You're being selfish" or "Your family will be so hurt by this".
- If the person is not at high risk, encourage him or her to get professional help as soon as possible. Help him or her arrange the appointment and take them there, if necessary.

Always report your concerns to the appropriate people in your situation once the situation and the person is safe.

Suicide Scenario

Mr. Jackson has a bi-polar disorder and appears depressed lately. He tells you he does not want to be a burden to his family and he thinks they would be better off without him.

Describe:

- What questions you could ask to determine if Mr. Jackson is at risk for suicide.
- What you would do to keep Mr. Jackson safe.
- At what point you would get outside help for Mr. Jackson.

Demonstrate:

Your interaction with Mr. Jackson.

Caregiver Grief After Suicide

Despite everyone's best efforts at helping, the person may still commit suicide. This may be very difficult to deal with. It is important for you to take care of yourself while going through this process. You may experience:

- Intense feelings of grief. These feelings can be overwhelming and frightening, but they are normal. You are not going crazy—you are grieving.
- Feelings of guilt, confusion, anger, betrayal, or fear. These feelings are common responses to grief.
- Thoughts of suicide. Sometimes, this happens. It doesn't mean you'll act on the thoughts.
- Forgetfulness. This is often a side effect of grief.
- Nightmares and flashbacks — especially if you witnessed the suicide or found the person.

Grieving takes so much energy that other things may fade in importance. The path of grief is one of twists and turns. You may feel like you are getting nowhere, but healing takes time. Find ways to take care of yourself during the process.

Finding Ways to Cope

If you try to ignore your feelings, deny yourself the time and space you need to grieve, or don't seek the support you need, other problems can develop. Try to find healthy ways to cope.

Remember to:

- Be patient with yourself. Grief has no predictable pattern or timetable.
- Allow yourself all the time you need to grieve.
- Seek out people who are willing to listen when you need to talk and who understand your experience.
- Make healthy choices in eating and get plenty of rest.
- If you think it might be helpful, talk to your supervisor or the case manager about professional help or support groups that may be available to help you deal with your grief.

Resources

National and State Suicide and Crisis Hotlines

1-800-SUICIDE	1-800-273-TALK
1-800-784-2433	1-800-273-8255

These hotlines operate 24-hours a day and are available to anyone in suicidal crisis. They will route the person to the closest possible crisis center in their area.

A listing of crisis centers throughout Washington State can be found at http://suicidehotlines.com/washington.html.

Other Informational Resources

- The Center for Disease Control has an entire section on suicide at http://www.cdc.gov/ncipc/dvp/suicide/.
- www.suicide.org has a website with information on suicide prevention, awareness, and support.

Mental Health
Specialty Training

MODULE 7

Medications and Mental Disorders

Washington State
Department of Social
& Health Services

ADSA Aging & Disability
Services Administration
www.adsa.dshs.wa.gov

Module Goals:

To provide managers basic information regarding medications:
- Prescribed to treat mental disorders.
- Side-effects.

Introduction

Medications used for mental disorders do not cure mental disorders, but can help the person function better. The extent to which it helps can range from little relief of symptoms to complete, depending on the person and the disorder being treated and may be influenced by:
- Age
- Sex
- Body size
- Body chemistry
- Physical illness
- Diet
- Habits, i.e. smoking and alcohol consumption

The length of time a person has to take a medication will also depend on the individual and the disorder.

The following are basic rules that must be followed whenever a medication is prescribed:
- Only a licensed medical or mental health practitioner can determine and prescribe what medication to use, how often, and in what dosage.
- Medications must be taken exactly as prescribed.
- Never stop giving a medication, or reduce the dosage of a medication without permission from the doctor or a licensed nurse. There can be undesirable side effects and drastic changes in the person's abilities because of changes.
- Always be aware of each medication's side effects or possible ***adverse*** reactions.
- Report any side effects or adverse reactions to the licensed health practitioner. Adverse reactions may include a drug overdose, drug side effects, drug and food interactions, intolerance, or an allergic response.

Only a licensed health practitioner can determine and prescribe what medication to use, how often, and in what dosage.

Adverse—*creating unfavorable, harmful, or undesirable results.*

Medications Used with Mental Disorders

Antidepressant Medications

One way to treat depression is with medications called antidepressants. Fortunately, there are a variety of medication available for treating depression. Most people can find an antidepressant that works for them. Six out of every ten people feel better with the first antidepressant they try. About 40% of people need to try another antidepressant to find one that is right for them.

Medical research continues to increase the number of medications available. Stay current with new medications, as well as to changes in the recommended usage of medications.

Usually medication for depression must be taken regularly for 6-8 weeks before the full therapeutic effect occurs. Some people may notice improvement in the first couple of weeks after taking an antidepressant. If there is little change in symptoms after 6-8 weeks, the person should talk with his or her doctor or psychiatrist.

Remission *- Disappearance of the symptoms of a disease.*

For about 70% of people, antidepressants are effective in reducing the symptoms of depression. But, even for those who respond well to medications, complete ***remission*** is rare. This is important because, unless a full remission is achieved, depression is likely to recur.

The most common medications used to treat depression include:

- Zoloft (Sertraline)
- Prozac (Fluoxetine)
- Paxil (Paroxetine)
- Celexa (Citalopram)

Most people taking antidepressants experience at least one side effect. Some of the common side effects include:

- Constipation
- Daytime sleepiness
- Diarrhea
- Dizziness
- Dry mouth
- Headache
- Nausea
- Sexual Problems
- Shakiness
- Trouble sleeping
- Weight gain

People taking antidepressants should never stop taking them suddenly, as it might make a person feel sick. Instead, the person should work with his or her doctor or psychiatrist to decrease the dose a little at a time.

Anti-psychotic Medications

People who are experiencing psychosis may hear "voices" or may have strange and illogical ideas. They may get excited or angry for no apparent reason, or spend a lot of time by themselves. They may neglect their appearance, not bathe or change clothes, and may be hard to talk with, barely talk, or say things that do not make sense.

Antipsychotic medications act against these symptoms. The medications cannot cure the disorder, but they can take away many of the symptoms or make them milder, and can allow the person to function more effectively and appropriately.

There are a number of antipsychotic medications available. Some of the antipsychotic medications include:

- Geodon (Ziprasidone)
- Abilify (Aripiprazole
- Seroquel (Quetiapine)
- Zyprexa (Olanzapine)
- Risperdal (Risperidone)

All of these medications have been shown to be effective for reducing the symptoms of schizophrenia. The main differences are in the potency of the medication and some of their side effects. Some of the side effects include:

- Drowsiness
- Rapid heartbeat
- Dizziness when changing positions
- Weight gain
- Decrease in sexual interest or ability
- Sunburn or skin rashes

Adherence-*the degree to which a person follows a prescribed treatment plan*

It is important that people with schizophrenia work with their medical or mental health professional to follow their treatment plan. Good ***adherence*** involves taking prescribed medication at the correct dose and proper time each day, and keeping all appointments. Adherence is often difficult for a person with schizophrenia, but it is very important as it leads to improved quality of life for the person.

You can help by reminding the person to take his or her medications, working with the person to develop strategies to do this on his or her own, and by helping to motivate the person to take his or her medication as prescribed. Some strategies might include: medication calendars, electronic timers that beep when medications should be taken, or pairing medication taken with a routine daily event, like meals.

Anti-manic Medications Anticonvulsants

The medication used most often to treat bipolar disorder is lithium. Lithium acts as a mood stabilizer and evens out mood swings. It is not just for periods of mania, but is often used for ongoing maintenance treatment of bipolar disorder.

Regular blood tests are an important part of the treatment with lithium. The range between an effective dose and a toxic one is small. Once a person is stable, and is on a maintenance dose of lithium, the lithium level should be checked every few months. How much lithium someone needs may change over time, depending on the severity of the person's bipolar disorder, the person's body chemistry, physical condition, and weight gain or loss.

Report any side effects or adverse reactions to a drug to the appropriate person where you work.

With regular monitoring lithium is a safe and effective drug, but a lithium overdose can be life-threatening. Signs of lithium toxicity may include: nausea, vomiting, drowsiness, mental dullness, slurred speech, blurred vision, confusion, dizziness, muscle twitching, irregular heart beat, and ultimately seizures.

Anticonvulsant Medications

Not everyone with manic symptoms gets relief through lithium. People who do not benefit from or would prefer to avoid lithium, have been found to respond to anticonvulsant medications.

Some anticonvulsant medications include:

- Depakote (Divalproex)
- Depekene (Valproic acid)
- Tegretol (Carbamazepine)
- Lamictal (Lamotrigine)

The evidence for the effectiveness of anticonvulsants is stronger for acute mania than for long-term maintenance of bipolar disorder.

Possible side effects include:

- Weight gain
- Drowsiness
- Dizziness
- Blurred vision
- Nausea

Anti-Anxiety Medications

Most people with bipolar take more than one medication. Along with a mood stabilizer, they may take a medication for agitation, anxiety, insomnia or depression. Finding the best possible medication, or combination of medications, is of utmost importance to the person's well-being, and requires close monitoring by a medical or mental health professional.

Both antidepressants and anti-anxiety medications are used to treat anxiety disorders, as anxiety disorders often occur with depression. Anxiety disorders may also appear with eating disorders or substance abuse problems. All these disorders must be treated in order to control the person's symptoms and help him or her to lead a more fulfilling life.

Anti-anxiety medications can relieve symptoms within a short period of time, and have relatively few side effects. Some anti-anxiety medications include:

- Ativan (Lorazepam)
- Klonapin (Clonazepam)
- Xanax (Alprazolam)
- Valium (Diazepam) - not as commonly used

Some of the more common side effects include:

- Drowsiness
- Loss of coordination/falls
- Fatigue
- Mental slowing or confusion

People taking these medications should also not drink alcohol, as the interaction between the medication and alcohol can lead to serious and possibly even life-threatening complications.

People taking anti-anxiety medications for weeks or months may develop a tolerance for and dependence on these medications. For this reason, they are generally prescribed for brief periods of times, such as days or weeks. Some people may need long-term treatment however.

It is essential to work with a medical or mental health professional before discontinuing an anti-anxiety medication. A withdrawal reaction may occur if the treatment is stopped abruptly. Symptoms of a withdrawal reaction may include: anxiety, shakiness, headache, dizziness, sleeplessness, loss of appetite, and in extreme cases, seizures. A withdrawal reaction may be mistaken for a return of the anxiety because many of the symptoms are so similar.

Side Effects

A person with a mental disorder, who is taking any drug must be monitored closely by staff, and his or her health care providers, to ensure that the drug is working as prescribed and is not causing adverse reactions or side effects. Side effects can be lessened to reduce discomfort by working with the person's health care practitioner. Older adults are especially sensitive to medications, and may require a lower or less frequent dose of the medication to maintain an effective level of medication.

It is important to know that:

- There is a higher risk of side effects when a medication's dosage is increased.
- Side effects can be made worse if a medication is not taken exactly as prescribed.
- Side effects may increase if the individual is taking more than one medication, and it is more difficult to assess.
- Side effects can be lessened to reduce discomfort by working with the person's health care practitioner.

Reporting Side Effects

Reporting Side Effects

Report any side effects or adverse reactions to the appropriate person where you work. The person's health care practitioner should be involved to make changes to the medication or prescribe another medication if the side effect(s) do not improve or are causing a great deal of discomfort.

Any life threatening drug reaction or side effect should be treated as a medical emergency—call 911.

Life threatening side effects include:

- Trouble breathing
- Trouble swallowing
- High fever
- Bleeding
- Seizures
- Delirium

Extrapyramida Side Effects

Extrapyramidal side effects **(**EPS) are a group of symptoms that occur in persons taking antipsychotic medications. These symptoms are movement disorders that are caused by the effect of the medication on the central nervous system. Different types of EPS and their symptoms are described in the following section.

Tardive Dyskinesia

Tardive Dyskinesia is involuntary movements of the tongue and facial muscles. This condition is the result of taking anti-psychotic medication for many months or years and is irreversible. The medication is usually stopped unless the drug is vital to the person with the mental disorder.

What you may see:

- Jerks or tics of the mouth, tongue, face, arms, or legs.

Dyskinesia

Dyskinesia is an impairment of control over ordinary muscle movement.

What you may see:

- Sudden involuntary muscle movements or tics.
- Rhythmic movements of the limbs and trunk.
- Pill rolling.

Dystonia

Dystonia is a ***neurological*** disorder that causes involuntary muscle spasms and twisting of the limbs.

Neurological—*dealing with the brain*

What you may see:

- Strange facial expressions, facial grimaces, distortions, as well as spasms of the muscles of the lips, tongue, face, throat, or the tongue sticking out or curling.
- Difficulty with speech and swallowing.
- The eyes may involuntarily roll up in the head.
- Spasms of the larynx (also called the "voice box").

  Laryngeal spasms are life threatening. When spasms occur, the air can be shut off to the lungs making it impossible for the person to breathe.

Call 911 immediately!

Parkinsonism

Parkinsonism is a nervous disorder marked by symptoms of trembling limbs and muscular rigidity that resemble Parkinson's disease. This disorder may be caused by the frequent use of some drugs or by exposure to certain chemicals.

What you may see:

- Muscular rigidity
- Slow movements
- Stooping posture
- Shuffling gait
- Tremors
- Falls
- Mask-like expression
- Difficulty swallowing, choking, drooling
- A significant lack of interest, drive, or motivation

Akathisia

Akathisia is uncontrollable limb and body movements, usually caused by drugs, especially some anti-psychotic drugs. Symptoms may be difficult to see.

What you may see:

- A feeling of restlessness – an urge to move or an inability to sit still - often accompanied by anxiety or agitation.
- Unprovoked violent behavior.

Medications to Treat Mental Disorders and Their Side Effects

Diagnosis	Medication	Possible Side Effects
Depression	• Zoloft (Sertraline) • Prozac (Fluoxetine) • Paxil (Paroxetine) • Celexa (Citalopram)	• Constipation • Daytime sleepiness • Diarrhea • Dizziness • Dry mouth • Headache • Nausea • Sexual Problems • Shakiness • Trouble sleeping • Weight gain
Anxiety	• Ativan (Lorazepam) • Klonapin (Clonazepam) • Xanax (Alprazolam) • Valium (Diazepam)	• Drowsiness • Loss of coordination • Fatigue • Mental slowing or confusion
Bipolar	• Lithobid (Lithium) • Depakote (Divalproex) • Depekene (Valproic acid) • Tegretol (Carbamazepine) • Lamictal (Lamotrigine)	• Weight gain • Drowsiness • Dizziness • Blurred vision • Nausea
Schizophrenia	• Geodon (Ziprasidone) • Abilify (Aripiprazole • Seroquel (Quetiapine) • Zyprexa (Olanzapine) • Risperdal (Risperidone)	• Drowsiness • Rapid heartbeat • Dizziness when changing positions • Weight gain • Decrease in sexual interest or ability • Sunburn or skin rashes

Mental Health
Specialty Training

MODULE 8

Getting Help and Self Care

Washington State
Department of Social
& Health Services

ADSA Aging & Disability
Services Administration
www.adsa.dshs.wa.gov

Module Goals:

To provide managers basic information regarding:

- Dealing with Physical Violence/Aggression
- Identifying Stressors
- Crisis Resources
- Intervening and Seeking Outside Help

Dealing with Mental Health Disorders

Helping a person with mental health disorder can be exhausting and overwhelming. Here are some things to keep in mind that can help both of you:

- Try to get other people involved in helping a person who has the illness, since doing it on your own can be difficult.
- People with depression or other mental health disorder often resist attempts to be helped.
- It's okay to feel angry and frustrated, but don't confuse the person you are caring for with the illness.

Research has shown that people with a mental health disorder are more likely to harm themselves, or be harmed, than they are to hurt others. Although there is a weak association between mental health disorders and violence, there may be times that you will be faced with challenging situations that warrant your concern and attention.

Dealing with Crisis

Crisis Situations

If the person with a mental health disorder is in danger of physical injury, out of control, talking about suicide, posing a threat to the safety of other persons, you need to know what steps to take. There are things you can do before a situation becomes a crisis:

- ***Watch for early warning signs.*** Occasionally, everyone has a bad day. If you sense deterioration in the person's mental condition, try to find out what is going on. There are usually early warning signs that signal problems such as: changes in sleep or social activities, increasing hostility or suspiciousness. Try to get the person to see a psychiatrist or social worker. The objective is to avert crisis.

Dealing with Crisis
continued

- ***Have the person's medical information on hand.*** If you should need to phone for help, have with you written information about the person's diagnosis, medications, and the specific event or behavior that caused you concern. It may be useful to have several copies to give to the police and to mental health professionals.
- ***Remember, no-one is at fault in a mental health crisis.*** The person with a mental health disorder may be at a loss as to how to react when someone is in crisis. Remember that the illness is no one's fault, nor is it the fault of the person who is in crisis.

There are some additional things you can do in a crisis. These include:

- **Evaluate the situation.** If you feel there is a danger to any person, either call the Crisis Center for help in assessing the seriousness of the situation or seek assistance from local law enforcement officers.
- Call your local National Association of Mental Illness (NAMI) for assistance and support with taking these steps.

If the person with a mental health disorder is seeing, hearing or feeling things that are not real, do not argue, deny or reason with the person at this time. Instead, assure the person that you love him or her, understand that what he or she is experiencing is real to him or her, and that you want to help.

Dealing Anger/ Physical Violence

Anger/Physical Violence

The possibility that the person with a mental health disorder may become violent should not be ignored or minimized. Violent behavior for the person with a mental health disorder is the result of impaired thinking and judgment or strange and bizarre beliefs that are caused by illness, disease, drugs, toxic chemicals, or a severe medical problem.

Critical Risk Factors

Before you encounter anger or physical aggression, there are certain factors that you can be aware of that may help you avert or deal with the risk of violence:

- Has the person made a direct threat or been violent recently?
- Has the person made any destructive or threatening statements?
- Hs the person intentionally frightened someone?
- Has the person been stalking or following people?
- Is the person preoccupied or dwelling on injustices or unrealistic fears?
- Does the person have a history of anger problems bordering on violent behavior?
- Has the person been increasingly angry, aggressive or violent over time?
- Has the behavior or any threats become increasingly lethal?
- Has the person made statements or implied they might have a plan?
- Has the person made statements or implied they might already have a weapon?

Dealing with the Risk of Violence

When there is violence, it is important to determine if there is immediate danger or non-immediate danger, because this will determine how you react and respond to the situation. In situations where there is immediate danger of violence, it is always appropriate to contact the police, sheriff's department or call 911 for immediate help. Follow the instructions given to you by law enforcement, particularly when there is a life threatening danger. If you are unable to call 911, ask somebody to call for you. Avoid being alone or in areas in which you could be surprised and could not easily escape.

If there is not immediate danger, there are three steps that will help you deal with the risk of interpersonal violence.

1. Identify the risk factors and discuss these with people who can be supportive and offer constructive advice.
2. Report and document any information regarding violent or threatening behavior.
3. Prevent violence by paying attention to warning signs, seeking advice from a qualified mental health professional or supervisor.

Crisis Resources

Calling a Mental Health Professional or the Crisis Team

If you need to call a mental health professional or the crisis team, remember to stay calm and:

- Give clear, objective examples of how the person's behavior or train of thought is seriously impacting his or her own safety of that of others.
- Give the person's disagnosis and a brief history of the build up to the crisis situation.
- Make sure to give a total picture of the person's mental health relapse.
- If the person has been hospitalized before and appears to need that level of care again, be certain to share this information.

Example of telephone call for the person who is having a dangerous train of thought:

Unclear presentation

I cannot get Jim to come into the house. He wants to be left alone. Jim likes sitting on the roof to scare me. I have tried to tell him to come in the house but he just yells at me to leave him alone.

Clear presentation

Jim is sitting on the roof and threatening to jump. Jim believes he can jump off the roof and not get hurt. Jim has been diagnosed with bipolar and his thoughts have been racing. When I try to speak to him, he becomes more agitated. I do not feel Jim is safe.

Situation: *Alice has schizophrenia and is expiencing visual hallucinations. She tells you that she sees men entering her windows and she thinks they are going to hurt her. Alice appears frightened. You are afraid for her safety as she is so distraught. You decide that it is time to call the mental health crisis team. What will you say?*

Your Mental Wellness

Over time, caregivers may feel overwhelmed, exhausted, frustrated, resentful, and guilty. Do not ignore the signs of burnout in yourself or the caregivers you supervise.

Remember:

- Caregivers strive to meet the needs of the person they are caring for at the expense of their own needs.
- Caregivers often experience higher stress, illness, and burnout than non-caregivers.

The reality is at one point or another you may well be faced with what is often referred to caregiver burnout. There are ways to minimize the burnout we may incur while caring for a loved one. No matter how overwhelmed you feel, it is important that you make and take time for yourself.

Caregiving will undoubtedly bring upon stress and symptoms of caregiver burnout. The good news is that there are strategies to manage the increased stress and help you cope.

Strategies to Cope with Caregiver Burnout

Caregiver burnout can be controlled. Here are some suggestions to combat the caregiver burnout you may be experiencing:

Set your own goals: You should decide what you can and cannot do. Be realistic. For example, it may be impossible for you to complete every task on schedule, but it is realistic to set goals and attempt to meet those goals.

Evaluate the situation: Ask yourself realistically how much time you can designate to specific caregiving task.

Understand that it is acceptable to have mixed feelings: Your emotions should be mixed. For example, allow yourself to feel angry that the care recipient is not appreciating the care you are providing and, at the same time, you may be feeling guilty that you're angry when your client is physically or mentally ill.

Understand that you cannot create or cure illness: As much as we all would like to be capable of controlling our pain, it is beyond our control. As a caregiver, we can only make it more comfortable.

Strategies to Cope with Caregiver Burnout

continued

Talk about it: Do not keep your emotions inside - develop a support system. Friends, relatives, or support groups can be a tremendous benefit to you and your well-being. Due to the increase in caregivers and the increase of those in need of care, there are now caregiver support groups in most communities. Contact your local Department of Health and Social Services for more information.

Be proactive: Plan ahead, although it may be difficult to do so, it is important to be proactive rather than reactive. Begin to discuss topics with your client's family that are directly related to the client's care.

Seeking Outside Help

You do not have to do everything on your own. It is okay to ask for help. There are many services that can help you in assisting the person with a mental health disorder available to assist you when you are in need.

Who to Get Help From and What They Do

Organization	Services Provided	Care Tips
Adult Protective Services	• Evaluates reports of vulnerable adults 18 years and older. Includes physical, sexual, emotional and financial exploitation.	• Report any suspected abuse to your supervisor and to the proper authorities. You do not have to give your name when reporting and you do not have to prove the abuse.
Community Mental Health Center	• Assess for mental health services • Provide case management to help with behavior maintenance, independent living skills, etc. • Provide therapy • Monitor and prescribe medication • Provide support and referral	• Familiarize yourself with your local community mental health care system. Take the time to become familiar with the community resources in your area.
Crisis Staff/Crisis Line	• Provide phone crisis intervention • Refer to crisis team, if needed	• If you must call the crisis line, provide only the facts as you understand them. It is not your responsibility to diagnose or determine a plan of treatment.
Crisis Team	• Provide crisis intervention • If needed, refer Designated Mental Health Professional (DMHP)	• Introduce yourself to the crisis team as a member of the client's care team. • You are an important source of information.
Mental Health (MH) Therapist/Counselor	• Conducts Mental Health evaluations and diagnosis • Provides therapy/treatment for residents and families • Helps problem solve • Provides consultation • Determines if evaluation for involuntary commitment is necessary • Conducts face to face interview to determine if involuntary commitment is necessary	• Familiarize yourself with the client's therapist/counselor. • You are an important source of information.

Organization	Services Provided	Care Tips
Psychiatrist	• Medical doctor specializing in diagnosis and treating psychological/mental health illnesses, disorders, etc. • Prescribes medications • Provides consultation	• Keep record of the client's psychiatrist's name and contact information. • Make sure the information is easily accessible.
Psychologist	• Doctorate of Psychology (or closely related field) • Evaluates and diagnoses mental health disorder and disorders • Provides psychological testing • Provides therapy/treatment • Provides consultation	• Keep record of the client's psychologist's name and contact information. • Make sure the information is easily accessible.
WAMI – Washington Alliance for the Mentally Ill	• Provides support, groups and information to families and those caring for people with mental illness	• Keep the number of the local WAMI posted. • Remind staff that WAMI is a good resource to help with education and information for staff and for family.