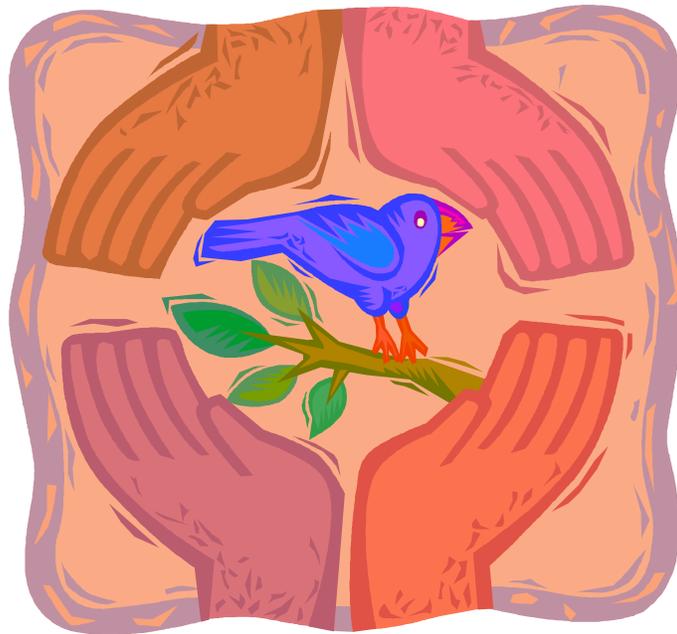


Family Peer Support Buddy Program



**Families of persons with a mental illness
helping one another**

Buddy Information Guide

Peer Support Buddy Information Guide

2005 Produced by the BC Schizophrenia Society on behalf of BC Partners for Mental Health and Addictions Information. Project Manager: Nicole Chovil, PhD, Director of Education, BC Schizophrenia Society; Writer/Researcher: Sophia Kelly, DVATI

BC Partners for Mental Health and Addictions Information is a collective of seven provincial mental health and addictions agencies working together. We represent the Anxiety Disorders Association of BC, Awareness and Networking Around Disordered Eating, British Columbia Schizophrenia Society, Canadian Mental Health Association BC Division, Centre for Addictions Research of BC, FORCE Society for Kids' Mental Health and the Mood Disorders Association of BC. Our reason for coming together is that we recognize that a number of groups need to have access to accurate, standard and timely information on mental health, mental disorders and addictions, including information on evidence-based services, supports and self-management.

Acknowledgements

The Family Support Buddy Toolkit was made possible through funding provided by the Provincial Health Services Authority.

The section on communication skills and portions of the section on boundaries in this guide is adapted with the generous permission of the 411 Seniors Centre Society.

Welcome to the Peer Support Buddy Program

Thank you for agreeing to help support other family members and friends of persons with mental illness.

In this binder you will find information that will help you to be an effective "Buddy". The sections on Communication Skills, Boundaries, Sharing Your Experience, Support VS Counselling, and Buddy Do's and Don's provide information on some of the skills and guidelines you will need. Please review these materials and ask your Program Coordinator if you have any questions about any of the content. The later sections provide information and resources that you can refer to when providing information to your "Match". Your Program Coordinator can also provide information on referrals to you or your Match. We hope you will find these materials useful.

Remember you don't need to be an expert or a professional counsellor to provide a listening ear. You already have all the qualifications you need, experience supporting a family member or friend who is ill. If you have any questions about this material or the program, or need help with anything to do with your match, please contact your Program Coordinator.

Program Phone Numbers

Program Coordinator:

Main office:

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Additional Resource: FAMILY TOOLKIT

The complete “How you Can Help – A Toolkit for Families” is available in pdf format at: <http://heretohelp.bc.ca/helpmewith/ftoolkit.shtml>

Communication Skills

Communication skills are essential to the role of Buddy.¹ The way we communicate forms the basis of our relationships with other people — the way others view us, respect us, feel toward us, expect us to act, trust or do not trust us, consider us as friends, etc. In a helping relationship, communication skills are absolutely crucial.

By understanding how effective communication works, by developing listening skills and practising helpful ways to respond, and by bringing to the helping relationship respect for other people's experiences and feelings, we enhance the chance for good communication and successful outreach work.

The Nature of Communication

All through our lives, we communicate: we speak, write, use body language, and thereby convey our thoughts, attitudes, and feelings. At the same time, we listen, observe, read, and learn about other people's thoughts, attitudes, and feelings.

Effective Communication

To communicate effectively means that the message a person wants to communicate is received as it was intended it to be received.

It is common for messages — and thus for people — to be misunderstood or misinterpreted. This happens because all people have special ways of expressing themselves, because a word or a gesture can mean different things to different people, there is often more left unsaid than is put in words, and also we are not always very attentive.

In a successful communication process, people feel understood, respected, and cared for. It is a positive experience. If the communication process is not successful, negative feelings are generated because at least one of the parties involved feels unheard or unconnected.

¹ The following section on communication skills is adapted with permission of the 411 Seniors Centre Society from the Seniors Outreach Counsellor Toolkit.

Elements of an Effective Communication Process

Attending: By being attentive we show the other person our involvement and interest as well as making sure that we are open to receive both verbal and non-verbal messages.

Attending attitudes include:

- Facing the other person squarely.
- Adopting an open posture (crossed arms or legs can be interpreted as defensiveness or withdrawal).
- Maintaining eye contact. Eye contact is a strong indicator of involvement.
- Assuming a relaxed attitude. This requires that we eliminate fidgeting behaviour that may suggest that we are preoccupied, nervous, or uncomfortable with the topic being discussed.



Listening: Listening is more than remaining silent when the other person speaks. Good listening is hard work.

The goal of a good listener is to arrive at some degree of shared understanding on the topic under discussion with the other person.

People under stress generally

- Need to talk.
- Need to be heard.
- Need to feel cared about.
- Need to feel a real connection with another person.



Listening is one of the greatest gifts we can give to another person, because it shows them that we care about them. Being listened to boosts the self-esteem of the person being listened to.

A Good Listener Will:

LISTEN...

— not work miracles.

HELP PEOPLE DISCOVER WHAT THEY ARE FEELING...

— not make their feelings go away.

HELP PEOPLE IDENTIFY THEIR OPTIONS...

— not decide what they should do.

DISCUSS STEPS WITH PEOPLE...

— not take those steps for them.

HELP PEOPLE DISCOVER THEIR OWN STRENGTH...

— not rescue them and leave them still vulnerable.

HELP PEOPLE DISCOVER THEY CAN HELP THEMSELVES...

— not take responsibility for them.

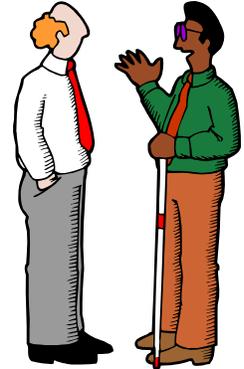
HELP PEOPLE LEARN TO CHOOSE...

— not make it unnecessary for them to make difficult choices.

EMPOWER...

— not create dependency.

PROVIDE SUPPORT FOR CHANGES.



Quality Communication and Outreach Services

Ideally, communication is reciprocal:

- Both parties contribute
- Both parties listen
- Both parties feel good



Yet, when providing a support service to others, outreach workers may at times not experience much reciprocity: volunteers and staff often spent the majority of their time listening.

The following ideas may help to minimize negative effects of communication experience while enhancing the chance for quality communication:

- ⇒ Outreach workers may need to clarify their goals and expectations. Sometimes, the `reciprocity' may lie in knowing that the other person has received help, has experienced relief from social isolation, or simply has had the need to be listened to met.
- ⇒ If communication between the buddy and the match proves difficult, with frustration and resentment being created on an ongoing basis, then a change in the match should probably be considered.
- ⇒ Helpers also need to find other people who will listen to them. While this may occur privately, of course, this need also points at the role of debriefing sessions with a coordinator and of sharing experiences and feelings in a group with other staff and volunteers.



Empathy

Responding with Empathy

When we listen well, we can understand both what the other person is saying and what he/she is feeling. When we respond with empathy, we acknowledge both the content and the emotion.

Simply put, empathy is a method of seeing the world through another person's eyes; a way to understand another person's experience and the feelings that accompany that experience. Empathy says: "I understand what you are trying to say and how you feel... In doing this I am not saying that I see it the same way or that I agree with it..."

Responding with empathy has many benefits:

- ⇒ It gives permission to the other person to share feelings, often ones that were previously denied, forgotten, or suppressed;
- ⇒ It contributes to the development of the helping relationship by communicating acceptance and understanding;
- ⇒ It promotes an exploration of issues that can lead to insight.

Words are not the only way in which we can communicate to others that we care. We can say and help a lot by:

- ⇒ Just being there
- ⇒ Through body language
- ⇒ By smiling
- ⇒ By holding a person's hand

Example

Match: "I'm worried about my son, he came home from the hospital two months ago and all he wants to do is stay in bed all day. I'm worried he'll never get back to his old self."

Content: son is staying in bed all day

Feeling: anxiety, worry

Responding with empathy: "It sounds like it is hard to trust that he'll recover when it seems so slow."

A Vocabulary for Feelings

In order to use empathy properly, we may want to enhance our ability to differentiate between nuances of feelings. For building a more extensive treasury of feeling words, the following list may be helpful.

| | | | | |
|------------------|-------------|--------------|--------------|------------|
| SADNESS | | | | |
| dejected | depressed | hopeless | unhappy | desperate |
| pessimistic | down | glum | troubled | lonely |
| forgotten | rejected | neglected | dismal | gloomy |
| downcast | | | | |
| HAPPINESS | | | | |
| excited | thrilled | glad | ecstatic | elated |
| optimistic | terrific | great | pleased | delighted |
| fantastic | good | marvellous | overjoyed | relaxed |
| WEAK | | | | |
| helpless | insecure | frail | vulnerable | useless |
| timid | unworthy | fragile | unprotected | worthless |
| burned out | small | exhausted | sick | powerless |
| STRONG | | | | |
| tough | confident | powerful | healthy | secure |
| competent | qualified | self-reliant | healthy | to cope |
| courageous | | | | |
| FEAR | | | | |
| afraid | alarmed | frightened | scared | worried |
| wary | hesitant | threatened | nervous | edgy |
| terrified | overwhelmed | | | |
| ANGER | | | | |
| mad | aggressive | hostile | outraged | furious |
| irritated | critical | offended | revengeful | enraged |
| annoyed | cross | | | |
| UNCERTAIN | | | | |
| confused | sceptical | unsure | puzzled | bewildered |
| baffled | flustered | muddled | perplexed | doubtful |
| ambivalent | hesitant | | | |
| LOVING | | | | |
| thankful | tolerant | trustful | warm-hearted | caring |
| devoted | fond of | gentle | involved | kind |
| passionate | nice | generous | forgiving | warm |
| appreciative | | | | |



2

² Source: Counselling Skills for Social Service Workers

Helpful Attitudes and Behaviours

The primary purpose of any helping relationship is to be supportive to persons in need — to persons facing problems and challenges in their lives.

There seem to be three elements that help to provide support and contribute to a beneficial communication between the two parties and that the helper in particular should be aware of:

Respect:

Respect can be defined as the explicit communication of regard. Respect can take the form of expressions of warmth, acceptance, or of active valuing of the family member. The helper respects the family member's feelings and perceptions; the seriousness of the problem from the other's point of view; and the family members' strength and ability to solve the problem.

Genuineness:

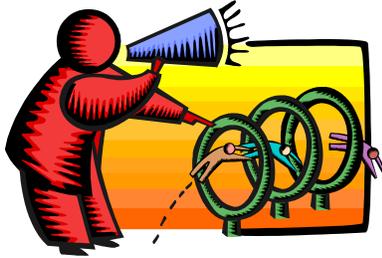
The helper must be sincere and real, not artificial.

Patience and a Positive Attitude:

Sometimes listening to others' complaints and worries can be frustrating and even produce a sense of failure, especially when dealing with persons who are non-communicative and very negative in their attitudes. Patience and a positive attitude will determine our communication style and the chance to develop a relationship with the other person. On the other hand, communication will be hurried, inattentive, and ultimately fail to convey the respect that forms the basis of a meaningful relationship, including helping, if the helper becomes overwhelmed with the sense of frustration.

Communication Blocks

There are modes of communication that can block interaction and understanding. These blocks must be avoided if effective helping is to occur. Notice the many similarities with the previous section "Unhelpful Responses — Poor Substitutes for Empathy." The most common blocks are:



Ordering

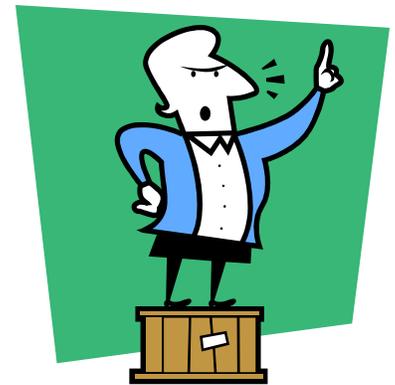
This involves telling the person what to do. For example, if a sentence is started with "you should" then it is likely that what is said will come across as an order.

Advice

This usually involves giving a solution to a problem. For example, if a sentence starts by "If I were you" or "You should try" then it is usually some kind of advice. Essentially, the helper should always try to get the person to generate his/her own solutions to problems, which will give him/her a greater sense of personal power.

Moralizing

Statements that are designed to make a persons feel guilty by proclaiming an `appropriate behaviour' often result in the person acting out of a sense of obligation. In so doing, the person's sense of responsibility is undermined.



Reassuring

An attempt to be "jolly" or make the person feel better may give a false sense of security. Sometimes a person needs to be reassured (especially in an acute crisis situation), but be aware that, in reassuring, the problem is not explored. Also, the person may feel that it's not okay to feel "sad" or "angry," for example.

Question Bombarding

This involves asking one question after another. When this happens the person may feel that he/she is on the spot or getting the third degree. A lot of questions are often used by helpers if the person seems hesitant to talk,

but it conveys little acceptance of the other person and the other person often resents having to provide the information.

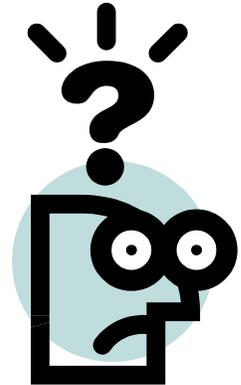


Arguing

This can happen if the helper says “yes, but...” or “I’m not sure...,” or in other ways challenges the person's view and feelings. This can make the person feel defensive or inadequate.

Criticizing

Although at times some criticism can be justified, in the long run it is best avoided. It usually produces negative feelings and defensiveness. The helper should try to help the person explore thoughts and feelings, but usually withhold judgment on them.



Withdrawing

When a helper turns away or does not attend to the person, it may result in the person being diverted from the topic. The person may feel that he/she is not being accepted, which not only blocks communication, but lowers the self-esteem of the person.

Interpretation

This involves explaining what is going on with the person. The inappropriate message is “I understand, so let me tell you what you are feeling or what will happen.”³

³ Source: Adapted from *Peer Counselling Handbook*, by Honoré France.

Risks of Advice-Giving

The funny thing about advice is that people usually do not follow it. They seemingly ask, or beg, for advice, but in fact they are really asking themselves the question "what shall I do?" By offering simplistic advice, the helper may fail to appreciate the complexity of the other person's feelings and needs, or of the defenses that are pulling them in opposing directions. There are other risks involved in advice-giving:

- The person may become dependent on the helper for the answers to their problems. Such dependency works against the important principle of self-determination, a basic value that recognizes and promotes the rights of the person to make their choices.
- When the responsibility for decision-making is taken away, feelings of inadequacy may be increased. The family member may experience frustration because he/she did not think of a solution or because he/she feels unable to follow the "good advice".
- The family member may feel misunderstood when advice is given without full exploration of the situation.
- If the client follows the advice and it does not work out the way he/she expected, the helper may be blamed. This may cause legal problems for the volunteer or the community partner organization.

Unhelpful Attitudes, Behaviours, and Elements in a Helping Relationship

- × Intellectualizing;
- × Advice giving;
- × Pretended understanding;
- × Rescuing;
- × Use of clichés;
- × Poorly timed humour;
- × False reassurance;
- × Unnecessary protection;
- × Subject changes;
- × Speaking of others;
- × Negative or positive bias;
- × Imposition of beliefs or values;
- × Fatigue or burnout;
- × Over-identification, over-involvement;
- × Unresolved problems of the helper;
- × Lack of self-awareness;
- × Defensiveness;
- × Name calling;
- × Inability to respond to cultural differences;
- × Failure to recognize/reach for strengths;
- × Unresolved conflict in the helper/client relationship;
- × Lack of empathy or inability to articulate empathy;
- × Poor attending;
- × Improper use of questions;
- × Use of jargon;
- × Timing (too quick or too slow);
- × Fostering/allowing excessive dependency;
- × Making assumptions.

Alternatives to Advice-Giving in a Non-Crisis Situation

In non-crisis situation, there are a number of responses that are helpful when we feel pressured by a client to tell them "what to do":

Reflecting: "You are feeling so confused right now that you don't think you can make a good decision."

This shows your understanding for the person's confusion while at the same time encouraging him/her to explore feelings and thoughts about different options more fully.

Levelling: "I hear you asking me to tell you what to do, but I'm not sure I can do that. I think this is something for you to decide. "

This clarifies that the person wants advice but that the decision is his/her responsibility.

Exploring: "What are some things you can think of?" "What do you want to happen?"

This encourages the person to consider their feelings, wishes and options.

Note on crisis situations: The purpose of the peer support buddy program is to provide regular peer listening and support, not crisis services. If a person is in crisis it is best to refer them to crisis resources (e.g.: 911, the Crisis Line) or the program coordinator.

Information-Giving Versus Advice-Giving

Information-giving differs from giving advice.

Advice-giving involves telling the other person what to do, with the advice often based on a combination of fact and opinion.

For example:

Match: "My daughter has been recovering for six months and she's still not leaving the house much. I'm worried that she won't ever be able to look after herself again."

Buddy: "What you need to do is get your daughter into a pre-employment program. There's a good one my brother went to and it really worked for him."

Information-giving involves giving the client information that can help him/her to make a decision. Information on community resources, benefits they might be entitled to, etc., show the clients the options that they have available to them and can facilitate their problem-solving and decision-making.

For example:

Match: "My daughter has been recovering for six months and she's still not leaving the house much. I'm worried that she won't ever be able to look after herself again."

Buddy: "What worries you the most about her being home so much?"

Match: "Well, she doesn't seem motivated to do anything, and she never used to be like that. She's not hearing voices any more but she's not herself."

Buddy: "Do you have any information about whether this is a normal rate of recovery?"

Match: "Not really, I mean, they said it could take awhile but I don't know how long 'awhile' is."

Buddy: "Who do you think would have that information?"

(Offer information here if you know of resources that the person does not.)

Buddy: "What resources do you think would be helpful?"

(Offer information here if you know of resources that the person does not.)

***4*Boundaries: Outreach Work and Saying "Yes"**

Why do we say "Yes" when we would rather say "No"?

Why Do We Say "Yes" When We Would Rather Say "No?"

- × We have good intentions;
- × We feel coerced into it;
- × We feel it's easier to comply than to argue;
- × We feel flattered that we are needed;
- × We want to protect the relationship;
- × We do not want to hurt the other person;
- × We do not know how to say "no";
- × We have always tried to meet every request;
- × We give in when the other person is persistent ;
- × We feel guilty if we do not comply;



Outreach Work and Saying "Yes"

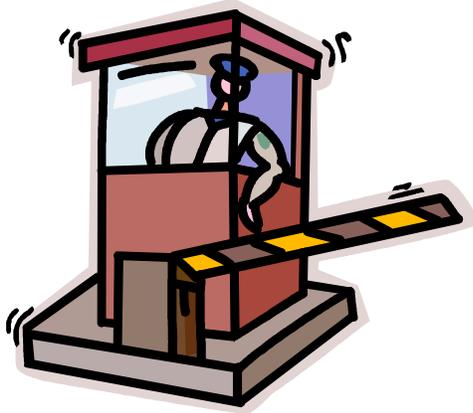
In outreach work, both staff and volunteers may have a particular difficulty in saying "no" to such requests as visiting longer/more often, allowing the person to call them frequently, helping with personal tasks, etc., and generally to be more available and of more assistance:

- × The person asks directly;
- × The person is isolated;
- × The person has so many unmet needs;
- × The person needs help;
- × We feel we are so much better off;
- × We feel sorry for the person;
- × We hope that someone will do the same if we are in a similar situation;
- × We do not want to upset the person;
- × We do not know how to refuse the request;
- × The lines between the helping relationship and friendship have become blurred.

⁴ This page adapted from the Seniors Outreach Counsellor Toolkit (see reference section for source)

Clarifying Boundaries

When things feel murky and you are not sure whether to say yes or no, or you want to say no but don't know how, the following questions may be helpful:



- What is your responsibility? What is not your responsibility?.
- Do I feel resentful or angry? (If you feel resentful or angry you may have exceeded your own boundaries.)
- Am I feeling like the other person's needs are more important than my own?
- Can this decision wait till I am clear about what to do? Delaying giving a response can give you time to make the right choice for you.

Nobody's Perfect

Sometimes people make mistakes, and agree to do things they should not do. In this situation it is sometimes necessary to let the person know you have made a mistake, and will not be able to do as you have promised.

Self-Care for Volunteers and Staff

We need to care for ourselves before we can help others. If we don't, we may find ourselves becoming less effective, dissatisfied, disillusioned, and, ultimately, burnt out. In all helping professions, the rate of burnout is high—and outreach work is no exception.

Factors in helping that can promote stress and burnout:

- Client/match needs exceed staff/volunteer time;
- Lack of supporting resources;
- Volunteers and/or staff have a great sense of responsibility for the clients' well-being;
- Frustrations over limits of the assistance that can be rendered;
- Difficulty in detaching from the clients and their problems;
- Over-commitment (e.g. too many volunteer jobs, too great a workload for staff);
- Lack of opportunity for debriefing, for sharing concerns and frustrations with others.



Some ways of coping with stress that people have found helpful:

- ✓ Set realistic goals. Remember that you are an helper, not a magician;
- ✓ Set reasonable limits for yourself;
- ✓ Develop a personal support system; learn to ask for support when you need it and to offer it to others;
- ✓ Recognize the value in socializing with others;
- ✓ Remember to keep your sense of humour;

Try to focus on the positive.

How to Set Limits, How to Say No

People have found that the best way to set limits is to assert themselves. When we assert ourselves, we recognize our own needs and values and are honest and open about it. We are clear about our tasks, abilities and our limits, and we inform others.

Sample Scenarios Requiring an Assertive Response

Copy and cut apart for the training role play or fill in your answers.



Handout 1

*Match to Peer Support Buddy: "Could you come again on the weekend?
Sundays are so difficult for me."*

Response:



Handout 2

*Match to Peer Support Buddy: "Please, just take me to the supermarket. I need
some milk. It's only 5 minutes for you and
makes it so much easier for me."*

Response



Handout 3

*Match to Peer Support Buddy: "Sometimes I just wish I could call you more
than once a week, especially when I things are
so hard right now. You have time to talk to me
again tomorrow, don't you?"*

Response:

Sample Scenarios Requiring an Assertive Response

Copy and cut apart for the training role play or fill in your answers.



Handout 4

Match to Peer Support Buddy "I'm so nervous about calling around for information about my son. Could you do it for me?"

Response:



Handout 5

Support Buddy to Support Buddy: "I agreed to meet with my match today but now my daughter wants to take me to lunch. Could you take over for me?"

Response:



Handout 6

Program Coordinator to Peer Support Buddy:

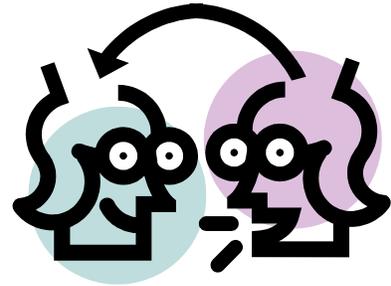
"I know that you have two matches right now already. But I spoke to Mr. Smith and he sounds like he really needs help. I told him someone would come over and see him soon."

Response:

Sharing Your Experience

Benefits of Sharing Your Story

Mental illness can be a very isolating experience for everyone affected – we feel as though no one else has experienced this and we are all alone in dealing with it.



Being able to talk with another who has a similar life experience can be very empowering. It is “safer” to talk with someone who has a family member with mental illness; there is no need to worry about how that person might react or be stigmatized.

By sharing their personal experience, Buddies can help

- increase knowledge of mental illness;
- increase knowledge of services available;
- demystify the illness;
- enhance problem solving capacity;
- increase coping skills; and
- shift illness attributions.

What you can provide:

- **A sense of belonging, of fitting in, of not being the only one who has a relative with mental illness.**

There's a special bond among people whose lives have been disrupted by the same problem. You share a sense of camaraderie. Once a person has the experience of being accepted just as they are, they begin to feel more accepting toward themselves.

- **Someone who understands what they're going through.**

Friends and doctors can empathize with problems, but in many cases they haven't experienced what the family member is going through. Their experience is unique, but it shares many common threads with others who are dealing with mental illness in their family. Because you

as a family member have a good idea of what the Match is feeling and experiencing, the Match may feel freer to speak their mind and voice their frustrations, disappointments and anger.

- **Information about Community Resources**

One of the most important pieces of information you can provide as a buddy is information about local resources. The mental health system is comprised of many different agencies and organizations, each providing a different service. It can be a complicated maze to learn. Undoubtedly you have learned much about what services are available in your community and have likely had some experience with them. This information can be invaluable to your Match. Don't forget that in your binder is a resource listing that will also assist your Match in finding the services they need for their family member.

- **Opportunity to make new friends.**

Many families risk becoming quite isolated when a family member develops a mental illness. Opportunities to share with people who understand can help to lessen feelings of being alone.

Tips for Sharing Your Story

We encourage you to pace your sharing in order to avoid frightening or overwhelming your Match early on with too much information.

Before sharing a part of your story, ask yourself: How will this help my Match? Share aspects of your experience that parallel the issue your Match is concerned about.

Share positives more than negatives. It can be reassuring to know that someone else experienced a difficult time but too many examples can lead to feelings of pessimism and hopelessness. It is important to instill and maintain hope. When sharing your story, look for situations where you were able to effectively resolve the situation; bright spots on otherwise gloomy days and small miracles and successes.

Beware of the dangers of telling "war stories". If your family member has had mental illness for many years, your experience with the mental health

system may be quite different from what it is like nowadays. To find out how much in common you have with your match, we recommend asking gentle questions and letting the other person share what they are comfortable with. Throughout your conversations, you can look for “opportunity moments” to share pieces you have in common.

It is important to provide optimistic, hopeful stories to your Match, to help them to be positive about their family member’s future. ‘War stories’ can have the effect of undoing some of the benefit of the support that is being provided, and should be avoided.

"Newcomers also learn something from veterans that visibly upsets them. They actually wince, shake their heads in disbelief, and sometimes audibly gasp when they learn many of the regulars have been dealing with the ill person in their life for years, sometimes decades. Although the talk of the regulars is peppered with optimistic references to new drugs, new treatments, and the progress made by a loved one, their expressions of hope seem fundamentally contradicted by their own biographies" (p16)⁵.

⁵ Karp, D.A. & Tanarugsachock, V. (2000) Mental illness, caregiving, and emotion management, *Qualitative Health Research*, Vol.10, No.1, 6-25

Support VS Counselling

Comparing a professional counselling and peer support

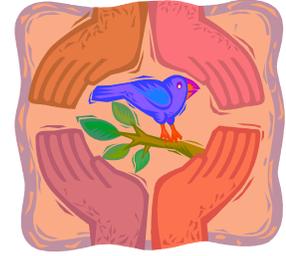
The following chart helps to clarify the difference between the support a buddy might provide, and the services of a professional counsellor.

| | Support | Counselling |
|---|---|--|
| <u>Who does it?</u> | May be a person with lived experience/knowledge or family, friend, etc. | Professional third party counsellor |
| <u>Training necessary for role</u> | Can range from no formal training to limited hours in workshop and practicum format. | Typically has graduate degree with academic and clinical coursework |
| <u>Scope and Limitations</u> | Deals with emotional support, practical assistance, and alleviating isolation | Helps individual come to terms with issues in their personal and/or working life. |
| <u>Central Focus</u> | Possibility centred | Problem centred |
| <u>Direction</u> | Based on an individual's self-defined needs and/or goals | Often directed by therapist / counsellor or psychological theories / approaches |
| <u>Time frame</u> | Present and future | Past and future |
| <u>Relationship</u> | Based on equality | May be more hierarchical |
| <u>Areas for Discussion</u> | Very diverse | Generally centred on person's thoughts, feelings, actions |
| <u>When does it work best?</u> | When the need is for understanding, information, a listening ear, and/or a sense of connectedness | When the individual faces a personal and/ or life crisis, significant interpersonal difficulties, or a dysfunction in some key aspect of his / her life. |
| <u>Learning</u> | Relies on development of relationships and exchange of knowledge/learning | Low level of mutuality; focus is exclusively on client. |

'Do's and Don'ts' for Peer Support Buddies

Tips for making the first call

- ♥ Identify yourself as a volunteer with family peer support buddy program and briefly describe yourself.
- ♥ Ask if this is a good time to talk
- ♥ Ask about how the person's family is doing.
- ♥ Ask "To start, is there any information I can help you find?"
- ♥ If you'd like to set up a face to face meeting, instead of calls, do so.
- ♥ Ask the person if they would like contact via email.
- ♥ If you contact with the family will be by phone, give them your phone number and invite them to call. It is a good idea to set a time and date for the next call.



Things to do

- ♥ Encourage them to express their concerns and their questions.
- ♥ Accept their feelings and attitudes.
- ♥ Learn to repeat or paraphrase.
- ♥ Be a good listener. Keep all information confidential.
- ♥ Act as a friend and share similar feelings, fears, apprehensions etc.
- ♥ Boost morale and self-image. Compliment the family member on positive steps they have already taken.
- ♥ Tactfully relate your own positive experiences, but allow them to find their own solutions.
- ♥ Inform them of support services relative to their family members' illness, but don't overload them with information at first.
- ♥ Encourage them to take time out for themselves, with a view toward balance in caring for all the family members.
- ♥ Agree with them if they say "this is a terrible thing that has happened to us and our family member".

Things NOT to do

- × Do NOT give medical advice or psychoanalyse.
- × Do NOT try to give final answers or solutions. You may tell what you have done, but let them reason things out. You may try to present various alternatives.
- × Do NOT criticize or judge (no matter what the issue or your feelings about it.)
- × Do NOT overpower them.
- × Do NOT "run down" professionals or agencies.
- × Do NOT 'dump' your problems on them. (If you are having a difficult time, call your buddy program coordinator for help locating resources for yourself.)⁶

⁶ Adapted with permission from the Parents Helping Parents program 'Summary of Do's and Don'ts for Mentor Parents'

Mental Illness Treatments

What Are the Treatments Available?

Most people who have a mental or substance use disorder can be effectively treated—including those with disorders that are very disabling such as schizophrenia. The future is even more promising as we better understand mental illness and develop new treatments.

Treatments for the various disorders depend on the disorder itself. We have listed here the various types of treatment options that are generally available. The particular treatment options that will be available for your family member depend on the diagnosis, community resources and types of services that are available in your community. Families should consult with a doctor or other mental health professional for help in identifying which treatments are applicable in their family member's circumstances.

Behavioural Therapy

Behavioural therapy relies on basic principles of learning to change problematic behaviour patterns by substituting new behaviours to given stimuli for undesirable ones. For example, systematic desensitization works on reducing a person's anxiety to a feared source (e.g., dogs) by teaching them relaxation skills and then gradually and repeatedly exposing the person to the feared source until they no longer fear it.



Cognitive-Behavioural Therapy (CBT)

Cognitive-behavioural therapy involves identifying and managing disruptive patterns of thinking and behaving that make symptoms worse. CBT also helps a person to develop new patterns of thinking that can help a person to better manage their disorder.

Detoxification or Withdrawal Management

Detoxification or Withdrawal Management is the initial and acute stage of treatment for drug/alcohol problems. The goal is to achieve withdrawal and stabilization in as safe and comfortable a manner as possible. While many people can be supported in outpatient or community-based programs, some will require medical supervision in short-stay residential facilities. Withdrawal management is seldom effective on its own and should be regarded as the first phase of treatment.

Electroconvulsive Therapy (ECT)

Electroconvulsive therapy involves the use of electrical stimulation to the brain. ECT has been proven to be useful in the treatment of depression when it is severe or life-threatening or in cases of severe depression that does not respond to any other treatment.

Family Therapy

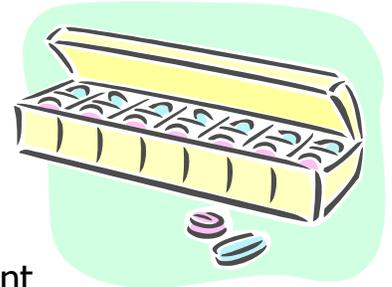
Family therapy works with the family as a unit to help resolve problems and to change patterns of behaviour that may contribute to difficulties or conflict within the family. The goal is to help families identify resources and solutions that work for their particular situation.

Interpersonal Therapy

Interpersonal Therapy focuses on improving aspects of the person's relationships within the family, social or work environments. Goals may include building communication and conflict resolution skills, and helping the person resolve interpersonal problems in a structured way

Medications

Medications can be very useful in the treatment of mental disorders and are often used in conjunction above. Sometimes medications are used to alleviate severe symptoms so that other forms of treatment (e.g., cognitive-behavioural therapy) can be used successfully. Medication is effective for many people and may be either a short-term or long-term treatment option, depending on the disorder, symptom severity and availability of other treatments. The most common types of medications include antipsychotic medications, antidepressants, anti-anxiety medications and lithium. Medications prescribed for substance use disorders include medications to treat withdrawal symptoms, ones that provide a safer substitution (such as methadone or nicotine patch), and ones that discourage the use of substances.



Psychotherapy

Psychotherapy refers to psychological therapies used for treating a broad range of mental health problems. These therapies are focused on helping people explore concerns they may have by talking about them, thinking about them in new ways, and learning new ways of responding and behaving. There are many styles of psychotherapy, including both individual and group therapies.

Rehabilitation

Rehabilitation covers various services and programs designed to help a person restore or improve their level of functioning in the community to an optimal level. Training may be provided in such areas as daily living and independent living skills, housing issues, vocational counselling and job placement, communication skills, recreation and leisure.

Relaxation Techniques

Relaxation techniques involve the ability to more effectively cope with the stresses that contribute to anxiety, as well as with some of the physical symptoms of anxiety. Examples of techniques taught include breathing re-training and exercise.

Self-Help and Support Groups

Self-help and support groups help individuals by connecting them with others who face similar challenges. They can help in the recovery process by providing mutual support as well updated information about treatment and local services available. Many people find that self-help groups are an invaluable resource for recovery. These groups are operated on an informal, free-of-charge and non-profit basis. They are voluntary, anonymous and confidential.⁷

Evidence Based VS Non Evidence Based Treatment

While particular treatments may have worked for your family member, unless there is broader evidence to support it, it is not correct to assume they will work for others. A professional is in a better position to evaluate the fit of a treatment with a particular person, and may know of options a support buddy will not. Peer support buddies are not qualified to give medical advice. Part of your volunteer agreement states that any treatment information given to clients must be evidence based and approved by program coordinator.

Think About / Research / Discuss

What are the pros and cons of each treatment type? Which are supported by evidence showing they work? Which are available in your area?

⁷ Source: How you Can Help – A Toolkit for Families – Module 1

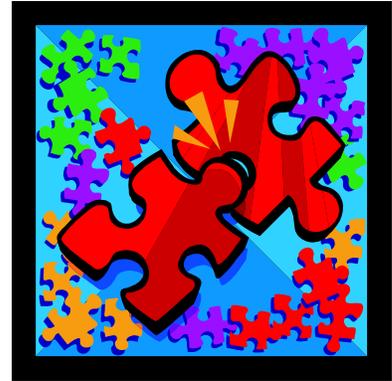
http://www.heretohelp.bc.ca/publications/toolkits/family_toolkit_m1.pdf

Mental Illness Information - Schizophrenia

Fact Sheet on Schizophrenia⁸

Although it affects around 40,000 people in British Columbia (about 1 in 100 Canadians), schizophrenia is one of the most widely misunderstood of all mental illnesses, reports the BC Schizophrenia Society.

A 2001 study by Calgary researchers for the World Psychiatric Association's campaign against stigma found that nearly half of Albertans surveyed still confuse schizophrenia with multiple personality disorder, a less common and entirely different psychiatric disorder.



Most people in BC do not recognize the signs of schizophrenia, nor do they understand that it is a serious mental illness caused by a chemical disturbance of the brain's functioning. As a result, people with untreated schizophrenia are sometimes mistaken for alcoholics or drug addicts because onlookers have no other explanation for their unusual behaviour which may include acting paranoid or talking to someone who isn't there.

The confusion arises from a lack of public education and from gaps in medical knowledge about schizophrenia.

Researchers do not fully understand what causes the illness, but the consensus is that schizophrenia involves changes in the chemistry and structure of the brain, as well as genetic factors, writes Dr. Nancy Andreasen, author of *The Broken Brain: The Biological Revolution in Psychiatry*.

Each of the billions of nerve cells in the brain has branches that transmit and receive messages from other nerve cells. These branches release chemicals called neurotransmitters which carry messages between cells. Researchers believe that schizophrenia interferes with this chemical communications system. Incoming perceptions get routed along the wrong path, get jammed or end up at the wrong destination, much like a short-circuit in a telephone switchboard.

⁸ Source: <http://heretohelp.bc.ca/publications/factsheets/schizophrenia.shtml>

As a result, people with schizophrenia often have difficulty thinking and talking in a consistently clear and organized manner. They may feel anxious and disoriented, and may lose the ability to relax, sleep and experience



pleasure. Although schizophrenia affects each person differently, some people with this illness hear voices that comment on their behaviour, insult them or give commands. Others experience a blurred sense of reality involving hallucinations that may be enjoyable or extremely frightening.

Maurizio Baldini, a 44-year-old lawyer recovering from schizophrenia, says he heard demonic voices during an acute period of his illness. "These grotesque distortions tormented me day and night until I could no longer distinguish between reality and nightmares," he says.

At times, his unusual thoughts jeopardized his personal safety. "In hindsight, one of my most dangerous delusions was probably the belief that I could fly, because if I had found a tall building, I might have easily climbed to the top and tried to jump off to test it out."

Baldini's symptoms came on suddenly at the age of 22. However, acute schizophrenia often appears after a gradual build-up of symptoms that sometimes begins in childhood. According to the BCSS, schizophrenia affects both men and women and usually strikes between the ages of 15 and 30.

Although there is no known cure for the illness, schizophrenia can be treated with a combination of medication and supportive therapies. Key to recovery is recognizing the signs and symptoms of the illness and getting help immediately, particularly at the first episode of psychosis. This can help prevent delusions from "hardening" and reduce the impact of the illness on the person's vocational and social goals. Another important aspect of a modern treatment plan is psycho-education which provides the person with the information and skills needed to adequately understand and deal with the illness in the context of their daily lives. The newer medications also represent a giant step forward since they enable people to think and function at a much higher level than older drugs allowed.

About one-third of people with schizophrenia have a severe episode of the illness only once during their lifetimes. Another third have long periods of stability and are able to live independently in the community with occasional

help. The last third require more support and longer periods in the hospital to deal with their on-going symptoms.

Although Baldini has experienced several acute episodes of schizophrenia, he leads a full life and is an active member of his community. In the 22 years since the onset of his illness, he has worked as a lawyer, a legal research assistant for the BC government and a mental health advocate.

He says the support of other people has been a major part of his recovery. "The other person acts as a sounding board and gives feedback on a day to day basis and helps one grow and gain insight," Baldini says. "I feel that successful relationships are a key factor in overcoming serious illnesses like schizophrenia."

Symptoms of Schizophrenia

- changes in appetite and weight
- extreme lethargy and lack of motivation to complete tasks
- an emotional "flatness" and difficulty experiencing pleasure
- a strong desire for solitude
- unusual tearfulness and deep sadness
- scattered attention and difficulties with concentration
- frequent thoughts of death or suicide
- difficulty making decisions, even small ones
- a sense of failure and a loss of self-esteem
- difficulty maintaining personal hygiene
- a sense of being watched or followed
- hallucinations or delusions (e.g. hearing "voices" in one's head)

Resources for More Information on Schizophrenia

- Basic Facts About Schizophrenia <http://www.bcscs.org/information/centre/schizophrenia/facts.html>
- Learning About Schizophrenia: Rays of Hope: A Reference Manual for Families and Caregivers <http://www.schizophrenia.ca/famref/szref1.pdf>
- Schizophrenia mental health fact sheet http://www.camh.net/about_addiction_mental_health/schizophrenia_mhfs.html
- Expert Consensus Treatment Guidelines for Schizophrenia: A Guide for Patients and Families <http://www.psychguides.com/sche.pdf>

Mental Illness Information - Bipolar Disorder & Depression

Fact Sheet⁹

We all experience shifts in our mood: some days we feel happy and ready to take on the world; other days can be discouraging, filled with sadness and frustration. Our emotional state of being varies constantly, and fluctuates between these two extremes on a daily basis.

Although some fluctuation in mood is normal, when it becomes so extreme that the person feels like their mood state shifts through low and high periods, this can indicate the presence of bipolar disorder.



Bipolar disorder, formerly known as manic-depression, is a form of clinical depression that affects 1 to 2% of the population in a lifetime or about one in every five people with mood disorders. It does not discriminate among socioeconomic groups and, unlike other kinds of depression, seems to affect men and women equally. What can elevate your risk though — by about 15% — is being the close relative of someone with the disorder.

Robert Winram, who has lived with bipolar disorder since he was a young adult, says that for him, receiving the diagnosis was a very important first step. "For 25 years, I had no diagnosis, and didn't understand what was happening. It was a great relief to finally know what it was," he says.

The experience of bipolar disorder can look different from person to person depending on how fast the person moves through periods of depression and mania, how severe each extreme gets, and what else happens during each state (for instance, is the person experiencing psychosis, or a break with reality, during mania or depression?)

Despite these differences, an episode of bipolar disorder will feature a person experiencing cycles of moods, including periods of depression, normal mood and mania. Depressive symptoms are similar to those experienced by people undergoing a major depression. During this time, a person can feel a range

⁹ Source: <http://heretohelp.bc.ca/publications/factsheets/bipolar.shtml>

of bodily symptoms affecting sleep, appetite, concentration and energy levels and a range of psychological symptoms including worthlessness, helplessness, hopelessness and apathy.

In contrast, a person in a manic phase may suddenly experience an excessively high or elated mood. They may begin to talk rapidly, have little need for sleep, make grandiose plans and even start to carry them out. Such uncharacteristically risky or ambitious behaviour can sometimes land the person in trouble. For example, someone may spend money very freely and get into debt, or show disregard for the law. They may also show an uncharacteristic lack of judgment in their sexual behaviour and, as already mentioned, some people also have psychoses (delusions and hallucinations) during this time.

For Robert, the mania would manifest itself as loss of sleep, fatigue, cold sores, and fast speech. "I would become overly busy, impulsive, talkative and take on too many projects," he says. "Eventually, my thinking became so muddled that I started having delusions and became paranoid that I was seeing signs directed at me. For example, I thought that my neighbours were watching me and that newspaper articles or advertisements had special meanings meant just for me."



Although the illness can first strike at any age, it is most commonly developed in young adulthood, especially in one's 20s. Many people with the illness take years to be properly diagnosed because doctors often only see the patient when they are depressed and may fail to ask the right questions to diagnosis bipolar disorder.

Bipolar disorder can take a mild, moderate or severe form depending on the number and intensity of the symptoms. Though people may struggle with the illness for many years, an episode itself is never permanent, lasting from several days to a number of months. With professional treatment, however, it may end much more quickly.

There are a number of possible causes of bipolar disorder. Biochemical factors are thought to play a large role. Since a person's risk of developing bipolar disorder increases if they have a close relative with the disorder, genes are

thought to play an important part too. In addition, stress related to work, relationships, finances and other areas of life can trigger a bipolar episode.

Medications can often help to reduce, if not stop, the extreme mood swings associated with manic depression. Psychological therapy and the support of family, friends, support groups and other self-help strategies can also help people to lead fuller and more active lives.

Robert's late diagnosis gave him much insight into his illness and enabled him to seek appropriate treatment. He found effective medication and began to learn how to manage the illness. He recently retired as the Executive Director of the Mood Disorders Association of BC. "I find my work both difficult and empowering, as it teaches me that I am no longer a victim and allows me to use my experiences to reach out to others so that they can begin their own paths to recovery."

Symptoms of Bipolar Disorder and Depression

Symptoms of Depression

- feeling worthless, helpless or hopeless
- sleeping more or less than usual
- eating more or less than usual
- having difficulty concentrating or making decisions
- loss of interest in taking part in activities
- decreased sex drive
- avoiding other people
- overwhelming feelings of sadness or grief
- feeling unreasonably guilty
- loss of energy, feeling very tired
- thoughts of death or suicide

Symptoms of Mania

- excessively high, elevated or irritable mood
- unreasonable optimism or poor judgment
- hyperactivity or racing thoughts
- talkativeness, rapid speech (sometimes becoming incoherent)
- decreased sleep
- extremely short attention span
- rapid shifts to rage or sadness



Resources for More Information on Mood Disorders

- Mood Disorders Association of BC
<http://www.mdabc.net>
- CAMH – Mood disorders: Help for partners and families
http://www.camh.net/about_addiction_mental_health/mood_disorders_partfamilies.html
- CAMH Depression Fact Sheet
http://www.camh.net/about_addiction_mental_health/depression_mhfs.html
- Understanding Bipolar Disorder fact sheet
http://www.camh.net/about_addiction_mental_health/bipolar_disorder_mhfs.html

Mental Illness Information - Anxiety Disorders

Fact Sheet¹⁰

It can drive us to be creative under pressure, warn us of danger or spur us to take action in the face of a crisis. It can also freeze us in our tracks. But like it or not, anxiety is an intense state that most Canadians experience from time to time.



Anxiety affects us physically, emotionally and in all aspects of our life situations, according to the Anxiety Disorders Association of BC (ADABC). Normally, it plays an important role in survival. When we encounter a threatening situation, our bodies prepare for danger by producing more adrenaline and increasing the blood flow and heart rate, among other things. This instinctive "fight or flight" response can help a person survive a physical attack or an earthquake, for example.

Nevertheless, most modern "dangers" such as unemployment are not ones a person can fight with their fists or run away from. With no outlet for release, the body may remain in a state of constant mental and physical alertness that can be extremely draining over the long term.

When anxiety persists for weeks and months, when it develops into a relentless sense of dread or starts to interfere with a person's daily life, then anxiety has moved beyond the realm of ordinary anxiety, according to ADABC.

"A person with this degree of anxiety may require outside help to feel safe in the world again," says Elen Alexov, ADABC President.

Emotionally, people with anxiety may feel apprehensive, irritable, or constantly afraid that bad things will happen to them and people close to them. Depending on its intensity, anxiety can make people feel trapped in their homes, too frightened to even open the door.

Anxiety is the most common form of mental disorder, affecting 12% of the population in any given year. Besides general anxiety, described above, anxiety can take many forms. Major types of anxiety disorders include

¹⁰ Source: <http://heretohelp.bc.ca/publications/factsheets/anxietydisorders.shtml>

phobias, panic disorder, obsessive-compulsive disorder, social anxiety and post-traumatic stress disorder.

A number of different factors can increase the risk of developing an anxiety disorder including past experiences, learned behaviours (e.g. avoidant coping style) and a genetic predisposition, to name a few. There is not one single cause and it is usually a combination of these types of risk factors that lead to the onset of an anxiety disorder for any one individual.

Sometimes anxiety exists alongside other mental disorders such as depression and bipolar disorder. When this happens, a person's abilities are more impaired by illness and the risk of suicide increases dramatically. For example, a 1999 study found that although more than a quarter of people with anxiety disorders reported having made a suicide attempt at some time in their lives, the greatest risk for suicide was the co-existence of their disorder with another mental illness such as depression, schizophrenia or an addiction.

Panic attacks involve a sudden onset of intense apprehension, fear and terror, as well as feelings of impending doom. These attacks may cause shortness of breath, rapid heartbeat, trembling and shaking, a feeling of disconnect from reality and even a fear of dying. Though they last only a short time, panic attacks are frightening experiences that may increase in frequency if left untreated.

People with phobias have overwhelming feelings of terror or panic when confronted with a feared object, situation or activity. Many phobias are common — such as a fear of enclosed spaces, airplanes or fear of spiders or snakes — and have a specific name.

For example, people with agoraphobia feel terrified of being in crowded situations or public places, or any situation where help is not immediately available. Their anxiety may become so intense that they fear they will faint, have a heart attack or lose control. These people often avoid any situation in which escape may be difficult (e.g., in an airplane), impossible or embarrassing. In some cases, people with agoraphobia may become house-bound for years.

Obsessive-compulsive disorder is another type of anxiety disorder. A compulsion or compulsive act becomes a way of coping with the anxiety created by an obsession, which is a recurring unpleasant thought. For example, a recurring thought such as "I am dirty" may lead to repeated acts of hand-washing as a means of dealing with the obsession and the resulting

anxiety. Washing one's hands provides a momentary respite from the anxiety of the obsessive thought, but since the relief is usually short-lived, the compulsive behaviour is often repeated over and over. People caught in this cycle may wash their hands repeatedly until the skin is rubbed raw.

Other compulsive acts include repeatedly checking that a door is locked or that a stove is switched off. Common obsessions include recurring thoughts of specific images, numbers or words.

Some people who have survived a severe and often violent physical or mental trauma may have a sense of reliving the trauma many years later. They may develop post-traumatic stress disorder, which involves re-experiencing traumatic events such as a car crash, rape or a life-threatening robbery through nightmares, night terrors or flashbacks.

Among the symptoms of post traumatic stress disorder are numbing one's self emotionally, experiencing an overall sense of anxiety and dread or feeling plagued by guilt about one's own survival. War veterans are particularly vulnerable to this form of anxiety which can affect one's memory and ability to concentrate and sleep.

Though people with clinical anxiety often feel trapped in a cycle of fear, anxiety disorders are among the most successfully treated forms of mental disorder, according to ADABC. Many people benefit from cognitive-behavioural therapy which is based on the idea that people can alter their emotions and even improve their symptoms by re-evaluating their attitudes, thought patterns and interpretations of events. An effective treatment plan may include medication, self-help groups, and relaxation techniques. Also beneficial is education about the nature of anxiety, its effects on the body and the role it can play as part of a healthy survival instinct. With time, most people can learn to identify the early signs of a fear episode and manage their symptoms before they develop into full-blown anxiety.

Does Someone You Know Have an Anxiety Disorder?

- They are often startled by the smallest thing
- They worry that something terrible will happen to them or others
- They are easily irritable
- They get sudden fears of dying or doing something out of control
- They often worry that something has not been done correctly even though they know they completed the task properly
- They are extremely worried about disease (e.g. germs, infections, dirt, dust, contaminants, cleanliness)

- They need constant reassurance
- They often find themselves doing things repeatedly (e.g. hand washing, showering, tooth brushing)

Body Relaxation Technique

Encourage your family member to Use this exercise to relax whenever they need to. Many people also find it helpful before falling asleep to:

- Breathe slowly and deeply, making your abdomen rise and fall with your breaths.
- Tighten your foot muscles, curling your toes, and hold for as long as you can then release, feeling the warm sensation as your muscles loosen.
- Repeat with your calf muscles, then work up through the rest of the body.
- End by tightening your forehead and scalp muscles.
- As you release your body tension, release all thoughts.¹¹



Tips for Talking to Your Doctor

The average patient asks only two questions during an entire medical visit lasting an average of 15 minutes. However, studies demonstrate that patients who are actively involved in decision-making are more satisfied, have a better quality of life and have better health outcomes. Since most people's treatment path for a mental disorder begins in the family doctor's office, below are some tips for your family member to empower themselves and starting a conversation about disabling anxiety in their life:

- Plan — Think about what you want to tell your doctor or learn from your doctor today. Once you have a list, number the most important things.
- Report — When you see the doctor, tell your doctor what you want to talk about during your visit.
- Exchange Information — Make sure you tell the doctor about what's wrong. Printing out an online screening tool (e.g., www.freedomfromfear.org), or bringing a diary you may have been keeping can help. Make sure to include both physical and



¹¹ Source: BC Medical Association

emotional symptoms. Sometimes it can help to bring a friend or relative along for support and to help describe your behaviour and symptoms if you're unable to.

- Participate — Discuss with your doctor the different ways of handling your health problems. Make sure you understand the positive and negative features about each choice. Ask lots of questions.
- Agree — Be sure you and your doctor agree on a treatment plan you can live with.
- Repeat — Tell your doctor what you think you will need to do to take care of the problem.¹²

The Anxiety Disorders Association and the BC Mental Health Information Line can also give you a list of possible places for referral that you could suggest to your doctor. If you want to find a new family doctor, the College of Physicians and Surgeons of BC can provide you with a list of doctors accepting patients in your area. (College of Physicians and Surgeons' Website: https://www.cpsbc.ca/cps/physician_directory/search)

Resources on Anxiety

- Anxiety Disorders Association of BC <http://www.anxiety.bc>
- Anxiety Disorders Toolkit
<http://www.heretohelp.bc.ca/helpmewith/adtoolkit.shtml>

¹² Source: Bayer Institute P.R.E.P.A.R.E Patient Education Program

Referral Resource Information

BC-Wide Information Resources

- BC Partners - BC Mental Health Information Line: (604) 669-7600 or 1-800-661-2121 outside the Lower Mainland 24 hours to hear information, for personalized referrals leave a message or call 9-4 pm weekdays. <http://www.heretohelp.bc.ca/connectmeto/infoline.shtml> (for description of services)
- BC Alcohol and Drug Information and Referral Service operated by Information Services Vancouver (604) 660-9382 or, outside the Lower Mainland, 1-800-663-1441
- Ministry of Health - Mental Health and Addictions
<http://www.hlth.gov.bc.ca/mhd/>

Greater Vancouver Resources

- Red Book Online – online and print directory compiled by Information and Referral Services Vancouver
<http://www2.vpl.vancouver.bc.ca/DBs/Redbook/htmlPgs/Search/rbSearch.html>

Provincial Treatment and Assessment Resources

Children's Hospital BC Children's Hospital

4480 Oak Street, Vancouver, BC V6H 3V4

604-875-2010 Intake: 604-875-2719 Fax: 604-875-2099

Offers inpatient programs and a psychiatric emergency short stay unit for children and youth up to 17 years of age. Also offers assessment, consultation, and short-term treatment through the following outpatient specialty clinics: General Psychiatry, Mood Disorders, Neuropsychiatry, Attention Deficit Hyperactivity Disorders, Infant Psychiatry, Urgent Assessment, and Youth Substance Use Disorders Clinic. Medical referral required.

Riverview Hospital

Provides <http://www.bcmhs.bc.ca>

Info on specific services <http://www.bcmhs.bc.ca/programs/>

As at September 2005, services offered were: Adult Tertiary Psychiatry, Neuropsychiatry and Geriatric Psychiatry. A medical referral is required. Reasons for referral included: Acute/Intermediate Assessment and

Treatment; Diagnostic Clarification; Pharmacological Review /
Treatment Trials; Behavioural Assessment / Management

Obsessive Compulsive Disorder Clinic at UBC

<http://www.ocdtreatment.ca/>

Psychological treatment for unwanted, repulsive thoughts, images, or urges. Day treatment as part of a study for persons with Primary Obsessions. People can self-refer, no medical referral required. Phone: 604-822-7676. No fee for treatment.

Mood Disorder Clinic at UBC <http://www.psychiatry.ubc.ca/mood/>

The following is an extract from the clinic's frequently asked questions page at: http://www.psychiatry.ubc.ca/mood/mdc_faq.htm

1. What is the Mood Disorders Centre?

The Mood Disorders Centre is a tertiary psychiatric program located at the UBC Hospital of the Vancouver Hospital and Health Sciences Centre (VHHSC). The mission of the Mood Disorders Centre is to improve clinical care for patients with mood disorders through clinical research and education. For more information, please check our web site at www.psychiatry.ubc.ca/mood

2. What services are provided by the Mood Disorders Centre?

We have a 15-bed inpatient unit dedicated to mood disorders (Mood Disorders Clinical Research Unit), and an active outpatient clinic (Mood Disorders Clinic, MDC) that focuses on consultations – single-visit assessments and treatment recommendations – of adult (including geriatric) patients. We follow a limited number of patients for brief management (2-3 months), usually in research protocols. The focus of the MDC is on psychopharmacologic management, but we also provide limited short-term group interpersonal psychotherapy for suitable patients. We conduct a number of research studies on the psychobiology of mood disorders, outcome of geriatric depression, PET studies of mania and depression, clinical antidepressant trials, biological and clinical effects of light on mood, genetic studies, group psychotherapy protocols, electroconvulsive therapy, and treatment algorithms.

The clinical programs in the outpatient MDC are divided into several subclinics, with individual psychiatrists responsible for the program. These are:

1. Bipolar Disorders Program (Dr. Yatham)
2. Clinical Trials Program (Drs. Lam/Yatham)
3. Interpersonal Group Psychotherapy Program (Dr. MacKenzie)
4. Mood Disorders Consultation Program (Dr. Solomons)
5. Outpatient ECT Program (Dr. Zis)
6. Seasonal Affective Disorder (SAD) Program (Dr. Tam)

3. How long is the wait for an appointment?

The wait between referral and appointment in the outpatient clinic is usually between 2 and 4 weeks. If patients are willing to participate in a clinical drug trial (e.g., with new antidepressants), we are usually able to schedule an appointment within one week.

4. Who can refer to the MDC?

We accept referrals from all physicians (family physicians, specialists) within the Vancouver region (Vancouver, North Shore, Burnaby, Richmond). Outside the Vancouver region, we limit referrals to tertiary care patients referred by psychiatrists or mental health teams. Tertiary referrals are also accepted from family physicians if patients have seen a psychiatrist within the past 6 months, and another opinion is required.

5. Which patients can be referred?

To ensure a reasonable (2-4 week) wait period for assessment, the MDC limits referrals to patients with a primary mood disorder diagnosis – depression and bipolar disorder (manic-depression). We have “subclinics” that assess seasonal affective disorder (SAD), geriatric depression, and bipolar disorder.

6. What are exclusion criteria for referral?

We are NOT able to see patients with primary diagnoses of anxiety disorders (panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder) or active alcohol / substance abuse. We are unable to provide ongoing counselling or individual psychotherapy. We do not do disability or insurance assessments. Also, we are not staffed to provide urgent care. If

patients require urgent care (e.g., acutely suicidal), they should be directed to appropriate emergency services.

7. How do I make a referral to the MDC?

Outpatient referrals must be made on our referral form and can be faxed to the clinic. We can fax or mail forms to your office (e-mail referrals may be coming in the future!). Please call our clinic secretary at (604) 822-7512. Our fax number is (604) 822-7922. Referrals are screened and accepted/returned within a few days. To refer to the inpatient unit, please contact the unit clerk at (604) 822-9745 for a referral form. All inpatient referrals are screened by Dr. Lakshmi Yatham.

Local Mental Health Resources

The following list is compiled and updated by the local Program Coordinator

| Type of Resource | Details | Address/ Contact Info |
|---|----------------|------------------------------|
| Mental Health Centre | | |
| Hospital Emergency | | |
| Police | | |
| Car 87 / specialized mental health police service | | |
| Early Psychosis Intervention Program or Worker | | |
| Rehabilitation Programs | | |
| Housing Programs | | |
| Educational Support | | |
| Family Outreach | | |
| Local BCSS Branch | | |
| Local CMHA Branch | | |
| Other Mental Health Agencies | | |
| Local Support Groups | | |
| Other local resources | | |
| Library Resources | | |
| Educational Programs | | |

Common Side Effects of Medications and Strategies

Most side effects of antipsychotic medications are mild. Many common ones lessen or disappear after the first few weeks of treatment. These include drowsiness, rapid heartbeat, and dizziness when changing position.

Source: <http://www.nimh.nih.gov/publicat/medicate.cfm#ptdep0>

The most common side effects of tricyclic antidepressants, and ways to deal with them, are:

Dry mouth—it is helpful to drink sips of water; chew sugarless gum; clean teeth daily.

Constipation—bran cereals, prunes, fruit, and vegetables should be in the diet.

Bladder problems—emptying the bladder may be troublesome, and the urine stream may not be as strong as usual; the doctor should be notified if there is marked difficulty or pain.

Sexual problems—sexual functioning may change; if worrisome, it should be discussed with the doctor.

Blurred vision—this will pass soon and will not usually necessitate new glasses.

Dizziness—rising from the bed or chair slowly is helpful.

Drowsiness as a daytime problem—this usually passes soon. A person feeling drowsy or sedated should not drive or operate heavy equipment. The more sedating antidepressants are generally taken at bedtime to help sleep and minimize daytime drowsiness.

The newer antidepressants have different types of side effects:

Headache—this will usually go away.

Nausea—this is also temporary, but even when it occurs, it is transient after each dose.

Nervousness and insomnia (trouble falling asleep or waking often during the night)—these may occur during the first few weeks; dosage reductions or time will usually resolve them.

Agitation (feeling jittery)—if this happens for the first time after the drug is taken and is more than transient, the doctor should be notified.

Sexual problems—the doctor should be consulted if the problem is persistent or worrisome.

Where to Get Specific Information about Medications

BC Nurse Line: 1 866 215-4700

<http://www.healthservices.gov.bc.ca/bchealthcare/nurseline.html>

Involuntary Admission and Committal Criteria

Arranging for Involuntary Admission

The following is an excerpt from the Guide to the Mental Health Act, April 2005 Starting at page 17 of the document (Section 2 Page 7)

<http://www.healthservices.gov.bc.ca/mhd/pdf/MentalHealthGuide.pdf>

“There are three methods of arranging for involuntary admission:

- Through a physician's Medical Certificate. This is the preferred method.
- Through police intervention. If a person will not go to a hospital or a physician's office, or if a physician cannot visit the person, the police may be able to help.
- Through an order by a judge. If the police cannot help, a judge may be able to assist.”

Committal Criteria

“In order for a physician to fill out a Medical Certificate, the physician must have examined the patient and be of the opinion the patient meets ALL four of the criteria. The opinion must be based upon information from the examination and preferably includes information received from family members, health care providers or others involved with the person. The criteria are that the patient:

- is suffering from a mental disorder that seriously impairs the person's ability to react appropriately to his or her environment or to associate with others;
- requires psychiatric treatment in or through a designated facility;
- requires care, supervision and control in or through a designated facility to prevent the person's substantial mental or physical deterioration or for the person's own protection or the protection of others; and
- is not suitable as a voluntary patient.

The words “in or through” a designated facility mean that a patient initially requires inpatient treatment as an involuntary patient, but may subsequently be placed on leave and continue to receive psychiatric treatment in the community. The patient's care, supervision and control may be retained by the designated facility or delegated to an authorized physician in the community.

Validity of the Medical Certificates

Unless the person is admitted, a Medical Certificate is valid for only 14 days following the date of the examination. If the person is not admitted during this 14-day period, the certificate becomes invalid.

Only a physician licensed to practice medicine in British Columbia may complete a Medical Certificate. An educational license is not sufficient. The physician does not have to be a psychiatrist.”

From the “Guide to the Mental Health Act, April 2005”

<http://www.healthservices.gov.bc.ca/mhd/pdf/MentalHealthGuide.pdf>

The Role of Police in Mental Health

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The following is an excerpt from the Guide to the Mental Health Act, April 2005 Starting at page 99 of the pdf file, which is Sec2, page 89 of the document

<http://www.healthservices.gov.bc.ca/mhd/pdf/MentalHealthGuide.pdf>

Involuntary Admission Method 2: Police Intervention

When Can Police Intervene?

If it is not possible for a person who apparently has a mental disorder to see a physician, the Act authorizes the police to intervene in some circumstances. Police involvement with people with mental disorders can arise from complaints about the person by others, direct observation of the person’s behavior by the police or in response to requests for assistance from health professionals or family members. There is no need for the person to have

committed a criminal offence before the police can be involved under the *Mental Health Act*.

Requests for police assistance often involve emergency or urgent situations where the usual procedures of seeing a physician or going to the hospital are not possible.

Police Authority

Police have powers under section 28 (1) of the *Mental Health Act* to apprehend a person and take the person to a physician for examination. The word "apprehend" is not defined in the Act, but it does not mean arrest. The courts have generally found the existence of a common law authority for police to enter a private dwelling, by force if necessary, when there are reasonable grounds for believing that there is a situation inside which involves the need to protect life and prevent injury. Since section 28(1) describes the police power in terms of a person likely endangering the safety of self or others, the police can clearly enter using force without requiring a warrant. Before a police officer can apprehend a person under section 28(1), the officer must be satisfied, on the basis of personal observations, and/or on information received from others that the person is apparently a person with a mental disorder and acting in a manner likely to endanger their own safety or the safety of others.

Where a police officer takes a person into custody under section 28(1) the police officer must immediately take the person to a physician for examination. Usually, the police will take the person to a hospital rather than to a physician in the community. The physician applies the involuntary admission criteria and, if the criteria are met, fills out a Medical Certificate. This Certificate is legal authority for the officer to take the person to a designated facility and for the admission of the person for examination and psychiatric treatment for up to 48 hours.

During this period, the person will be examined by a physician and a second Medical Certificate may be written, extending the patient's involuntary admission for one month from the date of admission. If the admission is to an observation unit, the patient must be transferred to a psychiatric unit or to a Provincial mental health facility before the end of the .five-day period from the date the director receives the second Medical Certificate. If the criteria of section 22 are not met, the person must be changed to voluntary status or discharged from the designated facility.

The criteria used by police officers (section 28 (1)) are different from those used by physicians (section 22). A police officer must be satisfied the person is likely to endanger their safety or the safety of others. This “safety” element is a higher standard to meet than the criteria used by physicians.

For More Information

A more detailed outline of the role of police under the *Mental Health Act* is provided in Appendix 5.

Appendix 17 contains examples of triage forms used by some municipal police departments and some RCMP detachments to assess a person to determine if the person should, under Section 28, be conveyed to a physician for an examination. These forms are not required under the *Mental Health Act*.

Questions About the Role of the Police

16. To be taken into custody by police under the Mental Health Act, must a person with an apparent mental disorder commit a crime or be physically violent?

No. The person need not commit a crime or be physically violent. The police officer must be satisfied the person is apparently suffering from a mental disorder, as defined in the Act, and is acting in a manner likely to endanger their own safety or that of others.

The term safety is not restricted to the potential of physical violence to self or others. For example, it also covers situations where the person’s safety is endangered because of exposure to extreme cold weather conditions or gross self-neglect.

17. If a police officer or an ambulance is involved, does it mean the person will be automatically admitted and kept in hospital?

No. Regardless of how a person is transported to a hospital, the decision to admit the person is made by the director or designate after a physician has examined the person and completed a Medical Certificate.

18. Is there authority under the Mental Health Act for police to assist health workers, who are conducting an examination or providing treatment, in managing a patient?

No. However, the police have authority under both the Criminal Code and common law to protect life and property, preserve the peace and enforce the law. Therefore, if a patient is causing a disturbance or is becoming violent,

the police may intervene to help hospital staff. Police can use the same authority to accompany a mental health worker to a patient's residence where there is reason to believe that the safety of the worker or the patient is threatened.

19. When can police leave after bringing a person with an apparent mental disorder to hospital?

The *Mental Health Act* provides no direction on this. However, the logical interpretation of section 28 is that the police must retain custody until the examination is completed.

The hospital has no authority to hold the person and prevent them from leaving or restraining them until a Medical Certificate has been completed. Also, staff safety during this period may require that police assistance be provided.

Given the demand for police services in the community, it is important that the hospital assume responsibility for the patient as quickly as possible. Because of the seriousness of patients' disorders, rapid assessment is recommended.

20. Are police required to fill out a written report for the physician when a person is brought under section 28 of the Act to a physician for examination?

The Act does not require it, however, it has become a practice in some communities where an understanding has been reached between the police and the sta. of a designated facility. The report contains any relevant information obtained by police which would be useful to physicians and hospital staff. The use of a written report by police is therefore strongly recommended. Examples of reports are in Appendix 17.

21. Do police require a separate warrant (e.g., "Feeney warrant") to enter a private dwelling to take a person into custody under the Mental Health Act?

A police officer's determination that section 28(1) applies, or a warrant in Form 10 issued by a judge or justice of the peace or a warrant in Form 21 issued by the director of a designated facility, provide adequate authority under the *Mental Health Act* for police to enter a private dwelling. "Feeney warrants" are related to Criminal Code offences.

22. Does the Mental Health Act apply to people arrested by police for criminal offences?

Appendix 8 details the points at which a person arrested for an alleged offence may receive voluntary or involuntary mental health services. People with a mental disorder who are on remand or detained under the Criminal Code can, by court order, be taken to Forensic Psychiatric Services. Treatment may then be authorized under the *Mental Health Act*. For further information about these services, contact Forensic Psychiatric Services at (604) 524-7700 or at www.forensic.bc.ca.

3.3 Assistance from Relatives and Others

People with an apparent mental disorder who appear to meet the involuntary admission criteria might refuse to be examined by a physician or reject appropriate treatment. Ways in which family members, friends or others may help are outlined in Appendix 2.

Questions Asked by Relatives and Others

23. Are there alternatives to physicians and police that family members can turn to for advice or assistance?

Yes. The nearest mental health service or hospital emergency department or designated facility (Appendix 1) may be able to assist. Mental health services may be listed in local telephone directories under the Health Authority. Advocacy and support groups may also be of help.

24. What can be done if a person with a mental disorder is apparently in need of protection because the person has stopped taking medication and refuses to see a physician?

See Appendix 2, Assistance from Relatives and Others in Obtaining Treatment.

25. Is it true my son's doctor cannot tell me anything about my son, who has been involuntarily admitted to a designated facility?

It is preferable for a person to consent to the release of information. However, where disclosure is required for continuity of care or for compelling reasons, such as if someone's health or safety is at risk, a public body such as a hospital should release necessary personal information without the client's consent. See Appendix 13.

3.4 Emergencies in Rural/Remote Areas

Psychiatric emergencies in rural or remote areas are not specifically addressed in the *Mental Health Act* but present special challenges. The

designated facilities may be located far from the community where a person needs psychiatric help, and immediate transportation of the person to a designated facility is not always possible. Health Authority protocols which provide for the safety and treatment of patients consistent with the Act are needed. Health regions are encouraged to develop local protocols. They should plan in advance additional steps for dealing with emergencies.”

Other useful sections

Other sections of the Guide to the Mental Health Act, April 2005 that may be helpful are:

- Questions about the Treatment of Involuntary Patients – Page 29 of pdf file, Section 2, page 19 of document
<http://www.healthservices.gov.bc.ca/mhd/pdf/MentalHealthGuide.pdf>
- Appendix 5 – Role of Police Officers Under the Mental Health Act - Section Sec2:89 Page 99 of pdf file
<http://www.healthservices.gov.bc.ca/mhd/pdf/MentalHealthGuide.pdf>

What can families do to make interacting with the police more productive?

- a. Family can keep a diary or record of what is happening
- b. Choose the most composed person to speak with police – sometimes this means siblings rather than parents.
- c. Give info on what's been going on.
- d. Give specific history to police: person's diagnosis, who they've been seeing, why you think they've gotten ill again, if they've gone off their meds etc....
- e. Make sure police take meds with them to hospital or jail.