

Mental Health First Aid – Reference Guide



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

Welcome to Mental Health First Aid (MHFA)

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

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

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

The Mental Health First Aid (MHFA) training course was developed to help people provide initial support to someone who may be

experiencing a decline in their mental well-being or may be in crisis. The philosophy behind MHFA is that mental health and substance use crises, such as suicidal and self-harming actions, may be avoided through early intervention. If crises do arise, then members of the public can take action that may reduce the harm that could result.

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

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

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

Enjoy the course!

Contents

Background 7 Mental Health Commission of Canada 7 Acknowledgements 8

Section 1: Introduction to MHFA 9 Mental health and substance use problems in Canada 10 Why is MHFA needed? 11 Impacts 14 Mental health and substance use and specific populations 16 Recovery to improved mental well-being 18 MHFA Actions 19 Applying MHFA Actions 21 Spectrum of interventions for mental health and substance use problems 22 Resources 26

Section 2: MHFA for Declining Mental Well-being 29 2.1 Depression 30 MHFA Actions for Depression 38 Resources 44 2.2 Anxiety Problems 45 MHFA Actions for Anxiety Problems 51 Resources 54 2.3 Psychosis 55 MHFA Actions for Psychosis 62 2.4 Substance Use Problems 67 MHFA Actions for Substance Use 75 Resources 81

[Page 4 of 6 | MHFA Canada: Reference Guide | Contents](#)

2.5 Gambling Problems 82 MHFA Actions for Gambling Problems 87 Resources 91

2.6 Eating Disorders 92 MHFA Actions for Eating Disorders 98 Resources 102

Section 3: MHFA for Crisis Situations 103 Introduction 104 3.1 MHFA for Suicidal Thoughts and Behaviours 105 3.2 MHFA for Non-Suicidal Self-Injury (NSSI) 111 3.3 MHFA for Panic Attacks 116 3.4 MHFA Following a Traumatic Event 118 3.5 MHFA for Severe Psychotic States 122 3.6 MHFA for Severe Effects of Alcohol Use 124 3.7 MHFA for the Effects of Severe Drug Use 127 3.8 MHFA for Aggressive Behaviours 130

Appendices 133 Appendix 1: MHFA Key Terms and Concepts 134 Appendix 2: Summary of Communication Strategies 138 Appendix 3: Cultural Considerations and Communication Techniques

Background

Mental Health Commission of Canada

Who We Are

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

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

How We Work

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

include, among others, the justice system, primary health care, workplaces and housing.

Each of MHCC's initiatives and projects is led by experts from across the country who bring a range of experience and a variety of perspectives to the table. Consulting with

people who have experience living with a mental health or substance use problem as well as their families is a key aspect in all of the MHCC's work. This work includes offering a host of resources, tools and training programs aimed at increasing mental health and substance use literacy and improving the mental well-being of all people living in Canada.

MHFA Program

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

method of dissemination best suited to local conditions. The MHFA Canada program came under the leadership of the Mental Commission of Canada (MHCC) in February 2010.

An important factor in the MHFA Program's

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

Acknowledgements

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

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

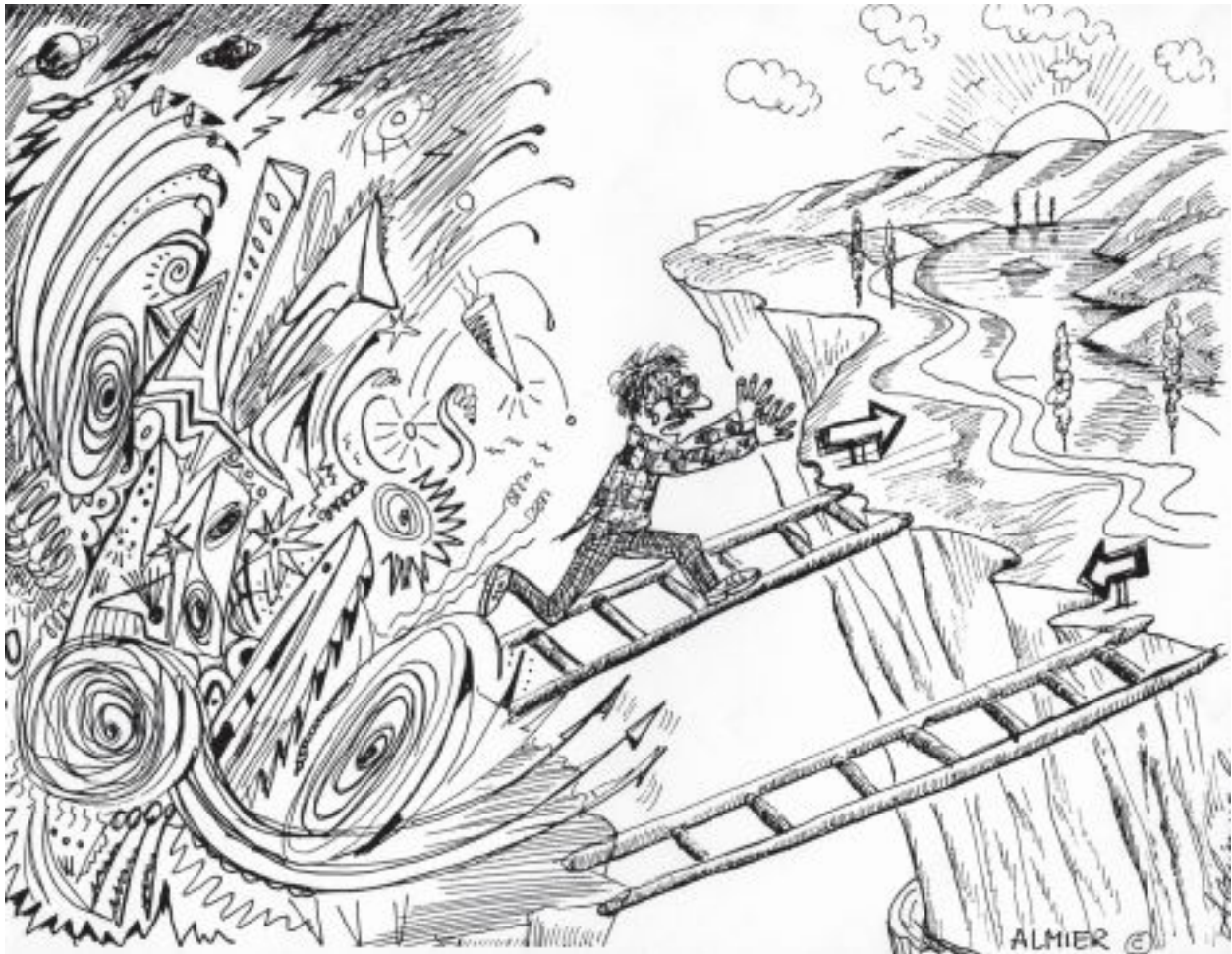
international spread has been the continuing attention to research and evaluation. The MHFA course has been thoroughly evaluated using randomized controlled trials and a qualitative study and been found to be effective at:

[MHFA Canada: Reference Guide | Background | Page 7 of 8](#)

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

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

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Mental health and substance use problems in Canada

What is mental health?

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

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

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

For many, mental health also incorporates a spiritual dimension along with the physical, mental and social aspects of wellness. Mental health influences how we think and feel about ourselves and others and how we interpret events. It affects our capacity to learn, communicate, and form, sustain or end relationships. Good mental health buffers us from stresses and hardships that are part of life for us all. It can help reduce the risk of developing mental health and substance use problems or disorders. Even when someone develops a problem or disorder, they can nonetheless experience good mental health, and this can contribute to their journey of recovery (Provencher & Keyes, 2011).

Mental well-being or mental wellness

These two terms are often used interchangeably with mental health when referring to positive mental health. Our mental health/

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

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

What are mental health disorders?

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

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

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

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

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

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

What are "problems"?

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

A variety of terms are used to describe mental health and substance use problems: mental illness, mental ill-health, mental health

and substance use condition, psychiatric illness, nervous exhaustion, mental breakdown, nervous breakdown and burnout. Slang terms such as crazy, psycho, mad, loony, nuts, cracked-up and wacko promote stigmatizing attitudes and should not be used.

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

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

Why is MHFA needed?

There are many reasons why people need training in MHFA.

1. Mental health and substance problems are common

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

problem

or illness (Mental Health Commission of Canada, 2013; Smetanin et al., 2011).

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

Over 1 million Canadians with a mental health-related disability say they require counselling services from a psychologist, psychiatrist, psychotherapist, or social

MHFA Canada: Reference Guide | Section 1 | Page 11 of 28
worker (Statistics Canada, 2019). These results reflect the general population.

Research on subpopulations may show higher or lower rates of mental health and substance use problems. For example, the rate of mental illness in prisons is 4 to 7 times higher than in the general community (Centre for Addiction and Mental Health, n.d.-b). A 2016 study reported that 44% of newly admitted male offenders in federal correctional system in Canada met the criteria for anxiety disorders and 49% met the criteria for substance use disorders (Beaudette & Stewart, 2016).

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

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

2. Professional help is not always on hand

Family doctors/physicians, counsellors, psychologists, psychiatrists and other professionals can all assist people with mental health and substance use problems. However, as with injuries and other medical emergencies, such assistance is not always available when a problem first arises. This is when members of the public who are trained

in MHFA can offer immediate aid and support the person until appropriate professional help is received.

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

Even in an emergency, a person wishing to give assistance at a motor vehicle crash may be reluctant to help for fear of doing the “wrong thing.” Similarly,

in a mental health and substance use situation, the first aider's actions may determine how quickly the person with the problem gets help and/or recovers. In any first aid course, participants learn how to help someone who is injured or ill. The first aider learns how to remain calm and confident and to respond in an appropriate way to give the best help until the crisis is resolved or professional help is obtained.

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

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

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

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

The prejudice and discrimination they face often becomes internalized. They begin to believe the negative things that other people and the media say about them (self-stigma) and they have lower self-esteem because

they feel guilt and shame. As a result, they often do not seek the help they need (Centre for Addiction and Mental Health, 2007).

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

Not all mental health and substance use problems require professional help. However, people who do require treatment may not seek professional help for a variety of reasons, such as an inability to recognize their mental health and substance use problems, a lack of health professionals, or a lack of knowledge about what services are available. According to the Canadian Community Healthcare Survey (2012), only 10.5 per cent of all respondents who had experienced a mental health disorder, or a substance dependency problem said they had accessed a professional consultation or used services in the 12 months preceding the study (Statistics Canada, 2012).

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

5. Many people are not well informed

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

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

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

Impacts

How disabling are mental health and substance use problems?

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

Research in the Netherlands has looked at the amount of disability caused by a large number of both physical and mental health and substance use problems (Stouthard et al., 1997). It helps to understand the amount of disability that mental health and substance

use problems can cause by comparing them to physical health problems that cause the same amount of disability. Here are some examples:

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

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

The graph below (Figure 2) shows the burden of disease in Canada, as measured by Disability Adjusted Life Years (DALY). DALY combines years lost due to premature death and years lived with a disability. Between 1990-2006 "mental and substance use" in Canada ranked third and more recently was ranked fourth in 2016 behind neoplasms (cancer), cardiovascular diseases, and musculoskeletal diseases (Lang et al., 2018). In Canada, mental and behavioural disorders account for 23% of years of life lost due to disability and 13% of years of life lost due to disability and premature mortality (Public Health Agency of Canada, 2015). Higher mortality rates due to opioid-related mortality in Canada have contributed to increases in burden of disease measurements (Public Health Agency of Canada, 2015).

Rank in number of DALYs	Rank in number of DALYs Change in all-age	DALYs		DALYs Change in age standardized (90-06)%	Rank in number of DALYs
		Change in age standardized Change in all-age	DALYs (06-16)%		
1990	Transport Injuries	5. Other noncommunicable			12. Diarrhea/LRI/other 13. -52.8 -0.2
1. Cardiovascular disease	10. Chronic respiratory	6. Neurologic disorders	7.	20. Maternal disorders 21. -15.8 -5.6	Neonatal disorders 14. -16.0 3.1
2006	Self-harm and violence	12. Diabetes/urog/blood/endo	8.	NTDs and malaria -15.1 -35.4 -15.2 -9.3	Cirrhosis 3.6
1. Neoplasms	Neonatal disorders	13. Unintentional injuries	19.	-11.8 20.2 27.3 14.2	15. Digestive diseases -0.5
19.4 DALYs (90-06)% -16.6	Diarrhea/LRI/other	14. Chronic respiratory	10.	35.5 47.4 11.5	16. HIV/Aids and -3.9
2016	Digestive diseases	Self-harm and violence	11.	26.8 -0.9	222.4 30.1
1. Neoplasms (06-16)% 14.3	15. Cirrhosis	Transport Injuries		-23.5 11.9	-14.1
-9.9	16. HIV/Aids and	12. Diarrhea/LRI/other	13.	-14.2 27.2 17.4	2. Cardiovascular disease 3. -9.8
2. Neoplasms	tuberculosis	17. Nutritional	Neonatal disorders	14. -49.4 7.6	19. Maternal disorders 20. -4.8
3. Mental and substance	deciencies	18. Other group	Cirrhosis	16.6	5. Other noncommunicable War and disaster -16.8 -5.2
use 4. Musculoskeletal	1	15. Digestive diseases		239.6 29.3 0.3	6. Neurologic disorders 7. 21. NTDs and malaria -2.3
disorders 5. Other	19. Maternal disorders	20. HIV/Aids and		-40.7 2.3	8.0
noncommunicable 6.	War and disaster	tuberculosis	17. Nutritional	-3.2	Diabetes/urog/blood/endo 8. -7.2
Neurologic disorders 7.	21. NTDs and malaria	deciencies	18. Other group	-7.8	21.2 14.5 16.4 15.0 15.6
Diabetes/urog/blood/endo 8.	2. Cardiovascular disease	3.		1.8	Unintentional injuries 19. -6.5
Unintentional injuries 9.	Mental and substance use	1		1.8	18.6 10.3 4.4
	4. Musculoskeletal disorders	19. War and disaster		5.9	Chronic respiratory 10. -28.0 5.5
					-5.7
					Self-harm and violence 11. -2.8
					15.5 11.7 14.4 16.4
					Transport Injuries -11.2 -60.3 -10.2
					-19.2 14.9 10.3 -4.0

Figure 2: Rank of disability-adjusted life years (DALYs) and percent change for diseases and injuries in 1990, 2006 and 2016 for both sexes combined, showing percent change of counts and age-standardized rates per 100 000. (Lange et al., 2018) Canada, 2015. p.3).

Impact of mental health and substance use problems

Mental health and substance use problems affect people of all ages, cultures, and education and income levels. “Mental illnesses have the potential to impact every aspect of an individual’s life, including relationships, education, work, and community involvement” (Public Health Agency of

They also indirectly affect all Canadians through illness in a family member, friend or colleague, and they are costly to the individual, their family, the health care system and the community.

It is important to realize that many mental health and substance use problems are time limited and people are able to take up their lives as before. Even when people

meaningful and satisfying lives. This may mean making some adjustments to accommodate the effects of their mental health and substance use problem.

Examples of the impact of mental health and substance use problems

- Every week at least 500,000 Canadians miss work due to mental illness. The annual economic burden of mental illness in Canada is estimated to be \$51 billion. By 2041, the cumulative cost of poor mental health to the Canadian economy is estimated to exceed \$2.5 trillion (Centre for Addiction and Mental Health, 2020).
- A 2017 survey of the Canadian workforce, found that 78% of respondents missed work due to mental health problems and illnesses and 34% of those missing work, were away from work for two or more months (Morneau Shepell, 2017).
- A 2019 report on Canadian mental health in the workplace listed on average 30% of short-term claims and 43% of long-term claims were due to mental health diagnoses (Deloitte, 2019).
- Additionally, a survey of organizations that operate in all major industry sections found depression, anxiety, and stress to be the primary cause of mental illness-related disability claims in Canada (Public Health Agency of Canada, 2015).
 - Based on the 2017 Canadian Survey on Disability, the employment rate among people with a mental health-related disability was 46%, compared with approximately 80% for people without a disability. Over half of those with a mental health-related disability believed they were disadvantaged in employment because of their condition (Statistics Canada, 2020).
- Aside from the impact on individuals, society also

bears the costs of mental health and substance use problems. Hospitalizations for mental illness are most likely to occur between the ages of 25 and 44 years (32 per cent), which has the potential to disrupt people's lives during their most productive working years (Canadian Institute for Health Information, 2015).

Mental health and substance use and specific populations

Physical illness and physical disability

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

Age/gender

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

The onset of many mental illnesses occurs during adolescence and young adulthood. For example, schizophrenia and eating disorders commonly develop from early adolescence through young adulthood. A recent Canadian study reported a high rate of hospitalizations

Page 16 of 28 | MHFA Canada: Reference Guide | Section 1
in young people connected to self-inflicted injuries, for young women these rates peaked between ages 15 to 19 years, and for young men in the 20 to 24 age range" (Skinner et al., 2016).

Men and women experience mental health and substance use disorders at different rates and seek different treatments. Women are more likely than men to use health services for a mental

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

Sexuality

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

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

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

A good interpreter will concentrate on

internalized feelings of negativity and expectations of rejection (Gilmour, 2019), as well as interpersonal violence, childhood maltreatment and personal loss (Rainbow Health Ontario, 2012).

Indigenous people

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

Cultural diversity

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

[MHFA Canada: Reference Guide | Section 1 | Page 17 of 28](#)
accurately conveying equivalent meaning as well as reporting the direct answers to questions and other responses offered. Everyone has different ways of communicating fears and needs when becoming unwell. If the opportunity is available, exploring the person's life experiences, value and belief systems, and

their reactions to illness, care and support may help establish what is realistic for the individual and what is culturally acceptable.

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

Recovery to improved mental well-being

“Recovery” in the context of mental health and substance use problems refers to the lived experiences of people as they accept and overcome the challenge of their problem or disorder. Recovery is much more than achieving the absence of symptoms and means different things to different people.

Recovery has been described as:

“...a way of living a satisfying, hopeful and contributing life even with the limitation caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness” (Anthony, 1993).

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

Page 18 of 28 | MHFA Canada: Reference Guide | Section 1
periods in between (such as depression and schizophrenia). For these reasons, it is important at all times that we consider people as individuals, rather than making assumptions based on their diagnosis.

Recovery is about much more than achieving an absence of symptoms. For some people, it can be

Recovery can progress slowly. Many different factors contribute to recovery, including:

- Having support from family and friends
 - Having a meaningful role in society through employment or education opportunities
- Getting professional help early
- Getting the best possible treatments and the person’s willingness and ability to take up the opportunities available.

Mental well-being is everyone’s business. The attitudes and beliefs that society has about mental health and substance use problems have a powerful impact on mental well-being and the recovery of individuals experiencing these problems. Recovery is about supporting each individual’s journey in using their strengths and mental well-being toward living a meaningful life—even with symptoms of mental health and/or substance use problems.

Newer, more effective treatments mean that people with mental health and substance use problems experience fewer side effects and are able to do more while in treatment or recover more quickly and completely. Therefore, a diagnosis of a mental health and/ or substance use problem does not mean the same thing for all people at all times. Individuals are encouraged to work closely with their health care providers to get the best results possible.

In addition, some mental health problems are cyclic (such as bipolar disorder), while others can occur in episodes with symptom-free

a long-term process, often described as a journey, and it may not necessarily be a linear process—there may be setbacks along the way.

It is important to recognize that mental health and substance use problems can develop over a long time, and recovery may also take time. The holistic interpretation of recovery found in

“Guidelines for a Recovery Oriented Practice,” primarily developed and promoted internationally by the Mental Health Commission of Canada (MHCC), offers guidelines to help improve understanding about recovery and to promote the application of recovery principles in practice (Mental Health Commission of Canada, 2015).

MHFA Actions

The MHFA Program provides an action plan on

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

Action: Approach the person, assess and assist with any crisis

This action is to approach the person, look out for any crises and assist the person in dealing with them. The key points for the first aider are to:

- Approach the person about their concerns
- Find a suitable time and space where both

[MHFA Canada: Reference Guide | Section 1 | Page 19 of 28](#)
people feel comfortable

- If the person does not initiate a conversation with the first aider about how they are feeling, the first aider should say something to them
- Respect the person’s privacy and confidentiality.

In a situation involving a person living with a mental health and/or substance use problem, several crises may emerge:

- The person attempts to harm themselves, e.g., by attempting suicide, by using substances to become intoxicated or by engaging in non-suicidal self-injury
- The person experiences extreme distress, e.g., a panic attack, a traumatic event or a severe psychotic state
- The person's behaviour is very disturbing to others, e.g., they become agitated or lose touch with reality.

If the first aider has concerns that the person is in crisis, the first aider needs to apply crisis first aid (see Section 3).

Action: Listen and communicate nonjudgmentally

Listening and communicating with the person is a very important skill. When listening and communicating, it is important for the first aider to set aside any judgments made about the person or their situation and avoid expressing these judgments. Most people who are experiencing distressing emotions and thoughts want to be listened to empathetically before being offered options and resources that may help them. When listening nonjudgmentally, the first aider needs to adopt certain attitudes and to use verbal and nonverbal communication skills that:

- Allow them to really hear and understand what

Page 20 of 28 | MHFA Canada: Reference Guide | Section 1 members, assistance with vocational and educational goals, and assistance with income and accommodation.

Action: Encourage other supports

The first aider can encourage the person to use self-help strategies and to seek the support of family, friends and others. Other people who have experienced mental health and/or

the person is saying, and

- Make it easier for the person to feel they can talk freely about their problems without being judged.

It is important to listen and communicate nonjudgmentally at all times when providing MHFA.

Action: Give reassurance and information

Once a person has felt listened to, it can be easier for the first aider to offer support and information. At the time of crisis, the first aider should offer emotional support such as giving the person hope for recovery, empathizing with how they feel, and offering practical help with tasks that may seem overwhelming at the moment. Also, the first aider can ask the person whether they would like some information about mental health and/or substance use problems.

Action: Encourage the person to reach out to appropriate professional help

The first aider can also tell a person about the options available to them for help and support. A person with mental health and/or substance use problems will generally have a better recovery with appropriate professional help. However, they may not know about the various options that are available to them, such as medication, counselling or psychological therapy, support for family

substance use problems can also provide valuable help in the person's recovery.

Action: Self-Care for the first aider

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

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

It can also be good to do things which improve your own mood or mental well-being. Activities which are known to be helpful for improving mood and reducing anxiety include eating well, keeping regular sleep habits, practicing relaxation techniques such as progressive muscle relaxation, being physically active, talking to supportive people, letting other people know how you are feeling, scheduling enjoyable activities (particularly those that give a sense of achievement), and doing other things you know have been helpful in the past (A. J. Morgan et al., 2012).

Applying MHFA Actions

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

- Depression
- Anxiety problems
- Psychosis

Providing MHFA to diverse cultures and populations

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

- Be aware that culture shapes each individual's understanding of health and ill health
- Learn about specific cultural beliefs that surround mental health and substance use

- Substance use problems
- Gambling problems
- Eating disorders

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

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

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

MHFA Canada: Reference Guide | Section 1 | Page 21 of 28
problems in the person's community

- Learn how these terms are described in the person's community (i.e., become familiar with the words and ideas used to talk about symptoms or behaviours related to these problems)
- Be aware of taboo concepts, behaviours or language (i.e., learn what might cause shame)

- Do not make assumptions about beliefs, practices or preferences.

This involves:

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

Providing MHFA to a 2SLGBTQ+ person

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

Spectrum of interventions for mental health and substance use problems

Society has a wide range of interventions for preventing mental health and substance use problems, and for helping people that live with them. MHFA is just one part of the spectrum of intervention. The diagram below illustrates

Page 22 of 28 | MHFA Canada: Reference Guide | Section 1
 aim to prevent problems from becoming more serious and reduce the likelihood of secondary effects such as loss of employment, school dropout, relationship breakup and drug and alcohol problems. Many people have a long delay between developing a mental illness and receiving appropriate treatment and support. The longer people delay getting help and support, the more difficult their recovery can be.

Prevention

It is important that people are supported by their

different states of mental well-being, ranging from being well to developing mental health and substance use problems, to having a mental illness and to recovery. There are different types of interventions that are appropriate at these states of mental health and substance use. For the person who is well or has some mild symptoms, prevention programs are appropriate. For the person who is moving from mild mental health and/or substance use problems to a mental illness, early intervention programs such as MHFA can be used. For a person who is very unwell, a range of treatment and support approaches are available, which will assist the person in their recovery process.

Prevention

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

Early intervention

Early intervention programs target people living with mental health and/or substance use problems and those who are just developing these problems. They

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

Where mental health
 first aid can help

Early Intervention

Treatment

Becoming Unwell
Unwell Recovering

Well

personal growth and coping skills.

Self-help books and

computerized psychological

Treatment and supports

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

Medical Treatments

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

Psychological treatments

Psychological treatments provide a supportive relationship and seek to change the way the person thinks or behaves. Usually, treatment involves talking individually, or sometimes in a group, with a mental health or addictions professional to address issues and to promote

Rehabilitation programs

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

Family and friends

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

MHFA can continue to play an important role in

treatments are also available.

Complementary treatment and lifestyle changes

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

Support groups

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

[MHFA Canada: Reference Guide | Section 1 | Page 23 of 28](#)
this period if relapses or crises occur. At such times, people need to be supported by those around them, in particular when no expert help is immediately available.

Professionals who can help

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

Family doctors

For many people developing a mental health and/or substance use problem, their family doctor will be the professional they first turn to for help. A family doctor can recognize symptoms and

provide the following types of help:

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

Psychologists

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

psychologists work for health services, while others are private practitioners.

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

Psychiatrists

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

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

Occupational therapists and social workers

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

Counsellors

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

Resources

Kids Help Phone – For young people ages 5 to 20

Not just for kids, Kids Help Phone is Canada’s leading phone and online professional counselling service for young people ages five to 20. It’s free, it’s anonymous and confidential, and it’s available 24/7, 365 days a year, in English and in French in all provinces and territories.

For immediate help:

Call the toll-free number: 1-800-668-6868

Text: 686868

Ask Online: www.kidshelpphone.ca

Young people talk to Kids Help Phone when they don’t know who to talk to.

From anxiety to depression to dealing with loss

and grief, from eating disorders to frustration to self-harm, whatever the issue they are facing, kids, teens and young adults reach out to Kids Help Phone.

Professional counsellors support the mental health and substance use and well-being of the 6.5 million young people across Canada by helping them learn the skills to effectively respond to the stresses, issues and challenges of everyday life.

Kids Help Phone counsellors support those who are dealing with significant mental or emotional distress and, if needed, link them to local resources.

Kids Help Phone also offers professional, nonjudgmental support, encouragement and

crisis intervention for young people between appointments or who are on long waiting lists for mental health and substance use services.

Committed to meeting the needs of today's technologically savvy youth, kidshelpphone.ca offers young people a safe place to go for age-appropriate direct and indirect counselling services, expert- and youth-vetted information and interactive tools.

To find local and national crisis support in your area, please go to: suicideprevention.ca/need-help/

Page 26 of 28 | MHFA Canada: Reference Guide | Section 1
AMERICAN PSYCHOLOGICAL
ASSOCIATION www.apa.org

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

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

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

CANADIAN MENTAL HEALTH
ASSOCIATION www.cmha.ca

The Canadian Mental Health Association is a nationwide charitable mental health

organization. Its website has a variety of information on mental health and mental illness.

CANADIAN PSYCHIATRIC
ASSOCIATION www.cpa-apc.org

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

CANADIAN PSYCHOLOGICAL
ASSOCIATION www.cpa.ca

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

CENTRE FOR ADDICTION AND MENTAL
HEALTH

www.camh.ca

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

CENTRE FOR INTERNATIONAL MENTAL HEALTH

www.cimh.unimelb.edu.au

<https://mbspgh.unimelb.edu.au/>

[research-groups/centre-for-mental-health](https://mbspgh.unimelb.edu.au/research-groups/centre-for-mental-health)

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

COMMUNITY ADDICTIONS PEER SUPPORT ASSOCIATION (CAPSA)

www.capsa.ca

CAPSA is a non-profit organization of people affected by addiction. Based in Ottawa, Ontario,

CAPSA strives to empower individuals impacted by addiction by providing opportunities to integrate into the broader community through peer-support initiatives and community engagement projects. We support all pathways to recovery and endeavour to collaborate with other organizations that provide services for those in need of help.

MENTAL HEALTH COMMISSION OF CANADA www.mhcc.ca

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

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

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

NATIONAL NETWORK FOR MENTAL HEALTH www.nnmh.ca

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

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

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

WORLD HEALTH ORGANIZATION

www.who.int/mental_health/en/

MHFA Canada: Reference Guide | Section 1 | Page 27 of 28

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

MENTAL HEALTH ATLAS 2017

www.who.int/gho/mental_health/reports/en/

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

ROYAL COLLEGE OF PSYCHIATRISTS www.rcpsych.ac.uk

The Royal College of Psychiatrists provides information, links and resources on a variety of

mental health topics.



2.1 Depression



Living in My Painful World

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

What is depression?

The word “depression” is used in many different ways. People feel sad or blue when bad things happen. However, everyday “blues” or sadness is not a depressive disorder. People with the “blues” may have a short-term depressed mood, but they can manage to cope and soon recover without treatment. The depression we are talking about in this chapter is major depressive disorder. Major depressive disorder lasts for

at least two weeks and affects a person’s ability to

carry out their work and usual daily activities, and to have satisfying personal relationships. This chapter also covers bipolar disorder, another illness in which depression can be a feature.

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

Signs and symptoms of major depressive disorder

A person having five or more of the following symptoms (including at least one of the first two) nearly every day for at least two weeks is categorized as having a depressive disorder:

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

weight.

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

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

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

Thinking

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

People who are depressed may say things, such as:

- “I’m a failure.”
- “I have let everyone down.”
- “It’s all my fault.”
- “Nothing good ever happens to me.”
- “I’m worthless.”
- “No one loves me.”
- “I am so alone.”

“not a team player,” having a poor work ethic or being incompetent. Unfortunately, these attitudes only serve to reinforce the depressed person’s

- “Life is not worth living.”
- “Things will always be bad.”

Feeling

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

Behaviour

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

Physical

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

How a depressed person may appear

A person who is depressed may be slow in moving and thinking, although agitation can occur. Even speech can be slow and monotonous. There can be a lack of interest and attention to personal hygiene and grooming. The person usually looks sad and depressed and is often anxious, irritable and easily moved to tears. However, in its milder forms, the person may be able to hide their depression from others, while with severe depression the person may be emotionally unresponsive and describe themselves as “beyond tears.” Sometimes when a person does not recognize depression in their friend or work colleague, they may judge them as lazy, self-centred, “not pulling their weight,”

GOLDBERG DEPRESSION

SCALE (Goldberg et al., 1988)

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

Depression Scale

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

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

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

Bipolar disorder

People living with bipolar disorder

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

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

A person is not diagnosed with bipolar disorder until they have experienced an episode of mania. It may, therefore, take

Page 32 of 102 | MHFA Canada: Reference Guide | Section 2
many years before they are diagnosed correctly and get the most appropriate treatment.

Perinatal depression

Perinatal depression refers to depression affecting some women at a time around childbirth. The depression can either occur before birth (antenatal depression) or after birth

(postnatal or postpartum depression). Feeling sad or having the “baby blues” after giving birth is common, but when these feelings last for more than two weeks, this may be a sign of depressive disorder.

The symptoms do not differ from depression at other times. However, depression at this time has an impact not only on the mother, but also on the mother-infant relationship and on the child’s cognitive and emotional development. For this reason, it is particularly important to get good treatment for postnatal depression. Treatment not only helps the mother’s depressive symptoms but can also improve the mother-child relationship and the child’s cognitive development (Poobalan et al., 2007).

Hormonal and physical changes as well as the responsibilities of caring for the baby may contribute to this form of depression. Having had a previous episode of depression increases risk for postnatal depression, and symptoms are often already present during pregnancy.

Risk factors for depressive disorders

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

The following factors increase a person’s risk of developing depression:

- A history of depression in close family members
- Being female
- Being a more sensitive, emotional and
- intoxication or withdrawal from alcohol or other drugs; and
- lack of exposure to bright light in the winter months.

These risk factors are thought to produce changes

anxious person

- Adverse experiences in childhood, such as lack of care or abuse
- Poverty, poor education and social disadvantage
- Recent adverse events in the person’s life, such as a death or serious illness in the family, having an accident, or being a victim of crime, bullying or other form of mistreatment
- Separation or divorce
- Lack of a close confiding relationship with someone
- Long-term or serious physical illness
- Having another mental illness such as anxiety disorder, psychotic disorder or substance use disorder
- Having a baby (see box on “Perinatal depression”)
- Premenstrual changes in hormone levels
- Caring full-time for a person with a long-term disability (Schulz & Sherwood, 2008).

Depression can also result from:

- the direct effects of medical conditions, for example, Parkinson’s disease, Huntington’s disease, stroke, Vitamin B12 deficiency, hypothyroidism, systemic lupus erythematosus, hepatitis, glandular fever, HIV and some cancers;
- the side effects of certain medications or drugs;

[MHFA Canada: Reference Guide | Section 2 | Page 33 of 102](#)
in the brain that lead to the symptoms of depression. People who are depressed have a loss of connections between nerve cells in some areas of the brain (the hippocampus and prefrontal cortex) that are important in mood and memory. Antidepressants are thought to work by helping the

production of new nerve cells and the formation of connections between nerve cells in these brain areas (Andrade & Rao, 2010). Other types of treatment, such as psychological therapy and exercise, possibly affect the brains of depressed people in a similar way.

Risk factors for bipolar disorder

(Tsuchiya et al., 2003)

The causes of this disorder are not fully understood. However, the following factors are known to be involved.

Having a close relative with bipolar disorder.

This is the most important risk factor known. Around 9% of people with an affected parent or sibling will also experience bipolar disorder (Smoller & Finn, 2003). While this is an increased risk, it means that over 90% of people with an affected relative will not develop the disorder.

No other risk factors are firmly established. However, there is some research supporting pregnancy and obstetric complications (which may affect the developing brain), birth in winter or spring (which may reflect the influence of maternal infections which vary by season), brain injury before the age of 10 years, and multiple sclerosis. Factors that increase the risk of an episode of bipolar disorder include recent stressful life events, including recent childbirth and social stresses.

The various risk factors for bipolar disorder are believed to lead to disruption of brain development

early in life, specifically to brain networks that control emotions. This disruption leads to instability of moods, including mania and depression (Strakowski et al., 2012).

Interventions for depressive disorders

Professionals who can help

A variety of health professionals can provide help to a person with depression. They are:

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

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

Treatments available for depressive disorders

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

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

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

A person may think their situation is hopeless and they may feel helpless. They may also have a negative view of themselves, the world and the future. Cognitive behaviour therapy helps the person recognize such unhelpful thoughts and to change them to more realistic ones. CBT also helps people to change depressive behaviours by scheduling regular

activities and engaging in pleasurable activities. It can include components such as stress management, relaxation techniques and sleep management. To get the full benefit of cognitive behaviour therapy, it is recommended that a person has 16-20 sessions of this treatment (Crome & Baillie, 2016).

- **Mindfulness-based cognitive therapy** This involves learning a type of meditation that teaches people to focus on the present moment. The person just notices what they are experiencing, whether pleasant or unpleasant, without trying to change it.
- **Interpersonal psychotherapy** Interpersonal psychotherapy helps people to resolve conflict with other people, deal with grief or changes in their relationships, and develop better relationships. To get the full benefit of interpersonal psychotherapy, it is recommended that a person has 16-20 sessions of treatment (Crome & Baillie, 2016).
- **Behaviour therapy** This is also called behavioural activation and is often part of cognitive behaviour therapy. It focuses on increasing a person's level of activity and pleasure in their life.
- **Marital therapy** This is also called couple's therapy. It can help where depression is accompanied by relationship problems. Marital therapy focuses on helping a person who is depressed by improving their relationship with their partner.
- **Problem-solving therapy**

This involves meeting with a therapist to clearly identify problems, think of different solutions for each problem, choose the best solution, develop and carry out a plan, and then see if this solves the problem.

- **Psychodynamic psychotherapy** This involves discovering how the unconscious patterns in a person's mind might play a role in their problems.
- **Reminiscence therapy** This is used with older people. It involves encouraging the person to remember and review the events in their life. The therapy might help resolve conflicts and regrets associated with past experiences and help the person to have a more positive and realistic view of themselves.
- **Self-help books** Books that are based on cognitive behaviour therapy can be effective (see Helpful resources at the end of this chapter). These are more effective when used under the guidance of a health professional, with 5-7 sessions recommended (Crome & Baillie, 2016).
- **Computerized therapy** Self-help therapy delivered over the Internet or on a computer can also be helpful. Some kinds of computerized therapy are available for free (see Helpful resources at end of this chapter). These are more effective when used under the guidance of a health professional (Cuijpers et al., 2010).

Medical treatment

The following medical treatments are known to be effective:

- Antidepressant medications have been found effective with adults who have moderate to severe depression.
- Antipsychotic medications may be used to treat people with bipolar disorder. They are also sometimes used to treat people with severe depression in combination with antidepressants, where other treatments have not worked.
- **Mood stabilizers** can help people with bipolar disorder by reducing the swings from one mood to another. They are also sometimes used in long-term depression.
- **Electroconvulsive therapy (ECT)** can be effective for people with severe depression that has not responded to other treatments. However, it has also been known to cause some negative side effects, such as memory loss.
- **Transcranial magnetic stimulation (TMS)** is sometimes used to treat severe depression or

depression that has not responded to other treatments. It involves holding a strong magnet over the scalp in order to stimulate some areas of the brain.

Complementary therapies and lifestyle changes

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

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

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

St John's wort and yoga.

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

Bipolar disorder treatments

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

- Medications. There is a range of medications that can help people with bipolar disorder. These include mood stabilizers, antipsychotics and antidepressants.
- Psychoeducation involves providing information to the person about bipolar disorder, its treatment and managing its effect on their life. Psychoeducation has been found to reduce relapses when used together with medication.

Page 36 of 102 | MHFA Canada: Reference Guide | Section 2

- Psychological therapies. Two therapies that research has found to be helpful are cognitive behaviour therapy and interpersonal and social rhythm therapy. Cognitive behaviour therapy helps people to monitor mood swings, overcome thinking patterns that affect mood, and function better. Interpersonal and social rhythm therapy covers potential problem areas in the person's life (grief, changes in roles, disputes, and interpersonal deficits), and helps them regulate social and sleep rhythms.
- Family therapy educates family members on how they can support the person with bipolar disorder and avoid negative interactions that can

trigger relapses.

Importance of early intervention for depression

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

experiences to make sure it is treated quickly and effectively.

Crises associated with depression

Two main crises that may be associated with depression are:

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

Suicidal thoughts and behaviours

Suicide is a significant risk for people with depression. A person may feel so overwhelmed and helpless that the future appears hopeless. The person may think suicide is the only way out. Sometimes a person becomes suicidal very quickly, perhaps in response to a trigger (such as a relationship breakup or arrest), and acts on

their thoughts quickly and impulsively. The risk is increased if they have also been using alcohol or other drugs. However, not every person who is depressed is at risk for suicide and nor is everyone who is at risk of suicide necessarily depressed.

Non-suicidal self-injury

(Klonsky & Muehlenkamp, 2007)

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

Action: Approach the person, assess and assist with any crisis

How to approach

If you think that someone you know may be depressed and in need of help, approach the person about your concerns. It is important to choose a suitable time when both you and the person are available to talk, as well as a space where you both feel comfortable. Let the person know that you are available to talk when they are ready; do not put pressure on the person to talk right away. It can be helpful to let the person choose the moment to open up. However, if the person does not initiate a conversation with you about how they are feeling, you can say something to them. It is important to respect the person's privacy and confidentiality unless you are concerned that the person is at risk of harming themselves or others.

How to assess and assist in a crisis

Page 38 of 102 | MHFA Canada: Reference Guide | Section 2
understood, while not being judged in any way.

This can make it easier for the person to feel comfortable to talk freely about their problems and to ask for help.

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

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

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

Action: Listen and communicate nonjudgmentally

If you believe that the person is not in a crisis that needs immediate attention, you can engage the person in conversation, such as asking the person about how they are feeling and how long they have been feeling this way. Listening and communicating nonjudgmentally is important at this stage as it can help the person to feel heard and

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

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

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

Attitudes: Acceptance, Genuineness and Empathy

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

Acceptance

Adopting an attitude of acceptance means respecting the person's feelings, personal values and experiences as valid, even if they are different from your own or you disagree with them. You should not judge, criticize or trivialize what the person says because of your own beliefs or attitudes. Sometimes, this may mean withholding any and all judgments that you have made about the person and their circumstances, e.g., listen to the person without judging them as weak—these problems are not due to weakness or laziness—and recognize that the person is trying to cope. An important way to show acceptance is to avoid communicating stigmatizing attitudes about mental illness. Be careful in applying labels to the person that they may find stigmatizing, e.g., “mentally ill” or “drug addict.” Choose your words carefully so as to avoid causing offence. Also be aware that the

person themselves may hold stigmatizing attitudes towards mental illness and that you can model acceptance, making it easier for them to accept help.

Genuineness

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

Empathy

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

Verbal skills

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

- Ask questions that show you genuinely care and want clarification about what they are saying
- Check your understanding by restating what they have said and summarizing facts and feelings
- Listen not only to what the person says but also how they say it; their tone of voice and nonverbal cues will give extra clues about how they are feeling
- Use minimal prompts such as “I see” and “Ah” when necessary to keep the conversation going

MHFA Canada: Reference Guide | Section 2 | Page 39 of 102

- Be patient, even when the person isn't communicating well, is repetitive or is speaking slower and less clearly than usual
- Do not be critical or express your frustration at the person for having such symptoms.
 - Avoid giving unhelpful advice such as “pull yourself together” or “cheer up.” If this were possible the person would do it
- Do not interrupt the person when they are speaking, especially to share your opinions or experiences
 - Avoid confrontation unless necessary to prevent harmful or dangerous acts.

Remember that pauses and silences are okay.

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

Nonverbal skills

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

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

- Pay close attention to what the person says.
- Maintain comfortable eye contact, i.e., the level of eye contact that the person seems most comfortable with. Avoid staring.
- Be aware of the person's body language as this can provide clues as to how they are feeling or how comfortable they feel talking with you. Try to

Page 40 of 102 | MHFA Canada: Reference Guide | Section 2

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

Cultural considerations for nonjudgmental communication

If you are assisting someone from a cultural background that is different from your own, you may need to adjust some of your verbal and nonverbal behaviours. For example, the

notice how much personal space the person feels comfortable with and do not intrude beyond it.

- Maintain an open body position. Don't cross your arms over your body as this may appear defensive.
 - If it is safe, sit down, even if the person is standing. This may seem less threatening.
- It is best to sit alongside the person and angled towards them, rather than directly opposite them.
- Avoid distracting gestures such as fidgeting with a pen, glancing at other things or tapping your feet or fingers as they could be interpreted as a lack of interest.

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

person may be comfortable with a level of eye contact different from what you are used to or may be used to more personal space.

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

Action: Give reassurance and information

After you have listened attentively and sensitively to the person and given them a chance to fully express and explore their issue, you can begin to discuss possible courses of

action. Spending time talking and listening means you are less likely to offer ill-considered or inappropriate advice, or to minimize or dismiss the problem based on only “half the picture.”

Treat the person with respect and dignity

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

Do not blame the person for their illness

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

Have realistic expectations for the person

and encouraging when supporting someone with depression. You should also offer the person kindness and attention, even if it is not reciprocated. Let the person know that they will not be abandoned. You should be consistent and predictable in your interactions with the person.

Give the person hope for recovery

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

Provide practical help

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

Offer information

Ask the person if they would like some information about depression. If they do want information, it is important that you give them

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

Offer consistent emotional support and understanding

It is more important for you to be genuinely caring than for you to say all the “right things.” The person genuinely needs additional care and understanding to help them through their illness so you should be empathetic, compassionate and patient. People with depression are often overwhelmed by irrational fears; you need to be gently understanding of someone in this state. It is important to be patient, persistent

[MHFA Canada: Reference Guide | Section 2 | Page 41 of 102](#) resources that are accurate and appropriate to their situation. Don’t assume that the person knows nothing about depression as they, or someone else close to them, may have experienced it before.

What isn’t supportive

- There’s no point in just telling someone with depression to get better. They cannot “snap out of it” or “get over it.”
- Do not be hostile or sarcastic when their responses are not what you usually expect of them. Rather, accept these responses as the best the person has to offer at that time.
- Do not adopt an over-involved or overprotective attitude towards someone who is depressed.
- Do not nag the person to try to get them to do what they normally would.
- Do not trivialize the person’s experiences by pressuring them to “put a smile on their face,” to “get their act together” or to “lighten up.”

- Do not belittle or dismiss the person's feelings by attempting to say something positive like, "You don't seem that bad to me."
- Avoid speaking with a patronizing tone of voice and do not use overly compassionate looks of concern.
- Resist the urge to try to cure the person's depression or to come up with answers to their problems.

Action: Encourage the person to reach out to appropriate professional help

Everybody feels down or sad at times, but it is important to be able to recognize when depression has become more than a temporary experience for someone and when to encourage that person to seek professional help. Professional help is warranted when depression

lasts for weeks and affects a person's normal ability to function in daily life. Many people with depressive disorders do not seek professional help.

Delays can affect their long-term recovery. People with mental health and substance use problems are more likely to seek help if someone close to them suggests it (Cusack et al., 2004; Vogel et al., 2007). Also, people who suspect they may have depression can help a family doctor make a quicker diagnosis by telling the doctor directly about their psychological symptoms and about their concerns that they may be suffering from depression (Herrán et al., 1999).

Discuss options for seeking professional help

Ask the person if they need help to manage how they are feeling. If they feel they do need help, discuss the options that they have for

Page 42 of 102 | MHFA Canada: Reference Guide | Section 2 seeking help and encourage them to use these options. If the person does not know where to get help, offer to help them seek assistance. It is important to encourage the person to reach out to appropriate professional help and effective treatment as early as possible. If the person would like you to support them by accompanying them to an appointment with a health professional, you must not take over completely; a person with depression needs to make their own decisions as much as possible.

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

What if the person doesn't want help?

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

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

Action: Encourage other supports

Other people who can help

Encourage the person to consider other supports available to them, such as family, friends and support groups. Some people who experience depression find it helpful to meet with other people who have had similar experiences. There is some evidence that these mutual aid groups can help with recovery from depression and anxiety (Pistrang et al., 2008). Family and friends can also be an important source of support for a person who is depressed. Recovery from symptoms is quicker for people who feel supported by those around them (Keitner et al., 1995).

Self-help strategies

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

use self-help strategies.

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

Resources

CANADIAN MENTAL HEALTH ASSOCIATION www.cmha.ca

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

CANADIAN PSYCHOLOGICAL ASSOCIATION www.cpa.ca

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

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

Canadian Psychiatric Association and Canadian Network for Mood and Anxiety

MHFA Canada: Reference Guide | Section 2 | Page 43 of 102
Treatments (CANMAT) have published Canadian guidelines on treating depression.

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

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

COGNITIVE BEHAVIOUR THERAPY ONLINE www.moodgym.com.au

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

CENTRE FOR ADDICTION AND MENTAL HEALTH www.camh.ca

The Centre for Addiction and Mental Health is a substance-related disorder and mental

health teaching hospital in Toronto. Under “Health Info/Mental Health and Addiction Index,” there are resources on mood-related disorders, concurrent disorders and substance use.

CLINICAL RESEARCH UNIT FOR ANXIETY AND DEPRESSION

www.crufad.org

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

LIVINGWORKS EDUCATION INC.

www.livingworks.net

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

MOOD DISORDERS SOCIETY OF CANADA www.mdsc.ca

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

2.2 Anxiety Problems



Lost in a Crowd

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

What are anxiety problems?

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

uneasiness through to a terrifying panic attack.

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

- more severe
 - longer lasting
 - interfere with the person's work, other
-
- Choking, dry mouth, stomach pains, nausea, vomiting and diarrhoea
 - Muscle aches and pains (especially neck, shoulders and back), restlessness, tremors and shaking.

What are anxiety disorders?

People with anxiety problems may be diagnosed with different types of anxiety disorders. These disorders differ from each other by the types of situations or things that the person feels anxious about and by the sorts of beliefs they have that

activities or relationships.

Anxiety can affect someone's thinking, feeling, behaviour and physical well-being.

Signs and symptoms of anxiety

Thinking

Mind racing or going blank, decreased concentration and memory, indecisiveness, confusion, vivid dreams.

Feeling

Unrealistic or excessive fear and worry (about past and future events), irritability, impatience, anger, feeling on edge, nervousness.

Behaviour

Avoidance of situations, obsessive or compulsive behaviour, distress in social situations, sleep disturbance, increased use of alcohol or other drugs.

Physical

- Pounding heart, chest pain, rapid heartbeat, blushing
- Rapid, shallow breathing and shortness of breath
- Dizziness, headache, sweating, tingling and numbness

[MHFA Canada: Reference Guide | Section 2 | Page 45 of 102](#) exacerbate their anxiety. The main types of disorders where anxiety is a major feature are post-traumatic stress disorder, social anxiety disorder (social phobia), agoraphobia, generalized anxiety disorder, panic disorder and obsessive-compulsive disorder. It is not unusual for a person to have more than one of these disorders.

Post-traumatic stress disorder (PTSD)

Post-traumatic stress disorder can occur after a person is exposed to actual or threatened death, serious injury or sexual violation. Examples of

traumas include involvement in war, accidents, assault (including physical or sexual assault, mugging or robbery, or family violence), and witnessing something terrible happen. Mass traumatic events include terrorist attacks, mass shootings, warfare and severe weather events.

A major symptom is re-experiencing the trauma. This may be in the form of recurrent dreams of the event, flashbacks, intrusive memories or unrest in situations that bring back memories of the original trauma. There is avoidance behaviour, such as persistent avoidance of things associated with the event, which may continue for months or years. Also, persistent symptoms of increased emotional distress occur (constant watchfulness, jumpiness, being easily startled, irritability, aggression, insomnia). The person may also overly blame themselves or others, show reduced interest in others and the outside world, and may not be able to fully remember the event.

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

[Page 46 of 102 | MHFA Canada: Reference Guide | Section 2](#)

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

[Panic disorder](#)

Some people have short periods of extreme anxiety called a panic attack. A panic attack is a sudden onset of intense apprehension, fear or terror. These attacks can begin suddenly and develop rapidly. This intense fear is inappropriate for the circumstances in which it is occurring. Other symptoms—many of which are similar to those of a

[Social anxiety disorder \(social phobia\)](#)

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

[Generalized anxiety disorder \(GAD\)](#)

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

heart attack—can include racing heart, sweating, shortness of breath, chest pain, dizziness, feeling detached from oneself and fears of losing control. Once a person has had one of these attacks, they often fear having another attack and may avoid places where attacks have occurred. The person may avoid exercise or other activities that can produce physical sensations similar to those of a panic attack.

It is important to distinguish between a panic attack and a panic disorder. Having a panic attack does not necessarily mean that a person will develop panic disorder. A person with panic disorder experiences recurring panic attacks and, for at least one month, is persistently worried about possible future panic attacks and the possible consequences of panic attacks, such as

a fear of losing control or having a heart attack. Some people may develop panic disorder after only a few panic attacks, while others may experience many panic attacks without developing a panic disorder. Some people with panic disorder also develop agoraphobia (described below), where they avoid places where they fear they may have a panic attack.

[Agoraphobia](#)

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

[Obsessive-compulsive disorder \(OCD\)](#)

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

of specific places, events or objects and often avoid these completely. The most common fears are of spiders, insects, mice, snakes and heights. Other feared objects or situations include an animal, blood, injections, storms, driving, flying or enclosed places.

[Mixed anxiety, depression and substance use problems](#)

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

People with anxiety disorders frequently use substances as a form of self-medication to help them cope. This can lead to substance use problems. Furthermore, heavy use of alcohol and

accompany feelings of anxiety.

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

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

[Specific phobias](#)

A person with a phobia avoids or restricts activities because of fear. This fear appears persistent, excessive and unreasonable. Specific phobias are common but are less disabling than other anxiety disorders. The person may have an unreasonably strong fear

[MHFA Canada: Reference Guide | Section 2 | Page 47 of 102](#)
drugs can lead to increased anxiety (Jorm et al., 2004).

[Risk factors for anxiety disorders](#)

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

- Have a more sensitive emotional nature and who tend to see the world as threatening
 - Have a history of anxiety in childhood or adolescence, including marked shyness
- Are female
- Misuse alcohol
- Experience a traumatic event.

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

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

Parental alcohol problems

- Separation and divorce

Anxiety symptoms can also result from:

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

anti-anxiety medications.

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

Interventions for anxiety disorders

Professionals who can help

A variety of health professionals can provide help to a person with an anxiety disorder:

- GPs
- Psychologists
- Mental health nurses

Page 48 of 102 | MHFA Canada: Reference Guide | Section 2

- Counsellors
- Psychiatrists
- Occupational therapists and social workers with mental health training.

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

Treatments available for anxiety disorders

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

Psychological therapies

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

- Cognitive behaviour therapy is the best treatment for anxiety disorders of all types. It involves working with a therapist to look at patterns of thinking (cognition) and acting (behaviour) that are making the person more likely to have problems with anxiety or are making their anxiety worse. Once these patterns are recognized, the person can make changes to replace these patterns with new ones that reduce anxiety and improve coping. To get the full benefit of cognitive behaviour therapy, a person needs to have a sufficient number of sessions. As a guide, it is recommended that a person has 12-15 sessions of treatment for generalized anxiety disorder, 14-16 for social anxiety disorder, 4-14 for panic disorder, 8-12 for post-traumatic stress disorder and 10 for obsessive-compulsive disorder (Crome & Baillie, 2016).
- Behaviour therapy (also known as exposure therapy) is often a component of cognitive

behaviour therapy. It involves exposing the person to the things that make them anxious. The person might be exposed to feared situations in real life or using their imagination, usually in a gradual way. This type of therapy teaches the person that their fear will diminish without the need to avoid or escape the situation, and that their fears about the situation often do not come true or are not as bad as they thought

- Self-help books which are based on cognitive behaviour therapy or behaviour therapy can be useful. These books are more effective when used under the guidance of a health professional.
- Computerized therapy is self-help treatment delivered over the Internet or on a computer. Some are available for free (see Helpful resources at the end of this chapter). These treatments are more effective when used under the guidance of a health professional (Cuijpers et al., 2010).

Medical treatments

relaxing specific groups of muscles, or by thinking of relaxing scenes or places. Relaxation training is most useful when learned under the guidance of a health professional.

Importance of early intervention for anxiety problems

It is important that anxiety problems are recognized and treated early because they can have a major impact on a person's subsequent life. Anxiety disorders often develop in childhood and adolescence and, if they are not treated, the person is more likely to have a range of adverse long-term consequences such as depression, alcohol and drug problems, suicide attempts, lowered educational achievement and early motherhood (Woodward & Fergusson, 2001).

Crises associated with anxiety problems

There are several crises that may be

Scientific evidence supports the effectiveness of a number of medications:

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

Complementary therapies and lifestyle changes

Relaxation training has good scientific evidence for effectiveness in helping people with anxiety disorders. Relaxation training involves learning to relax by tensing or

MHFA Canada: Reference Guide | Section 2 | Page 49 of 102 associated with anxiety problems:

- Experiencing an extreme level of anxiety such as a panic attack.
- Experiencing severe anxiety following a traumatic event.
- Having suicidal thoughts and behaviours.

Engaging in non-suicidal self-injury.

Panic attack

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

Traumatic event

A traumatic event is one that causes an individual or group to experience intense feelings of terror, horror, helplessness or hopelessness. The person could directly experience the event, witness it

happen to others or learn that it has happened to someone close to them. Most people who experience a traumatic event do not develop a mental illness. Others experience symptoms of severe stress and may go on to develop post-traumatic stress disorder, another anxiety disorder or depression.

Suicidal thoughts and behaviours

Extreme levels of anxiety are the most obvious crisis seen in people with anxiety disorders. However, there is also the possibility of suicidal thoughts. The risk of suicide for people with anxiety disorders is not as high as for some other mental illnesses (Arsenault-Lapierre et al., 2004). However, the risk increases if the person also has

a depressive or substance use disorder. Of people who have had an anxiety disorder in the past 12 months, approximately 2% attempt suicide (Johnston et al., 2009). Therefore, in any interaction with a person with an anxiety disorder, be alert to any warning signs of suicide.

Non-suicidal self-injury

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

MHFA Actions for Anxiety Problems

Action: Approach the person, assess and assist with any crisis

How to approach

The approach that is helpful for someone with anxiety problems is very similar to someone experiencing depression. The key points are:

- Approach the person about your concerns about their anxiety

- Find a suitable time and space where you both feel comfortable
- If the person does not initiate a conversation with you about how they are feeling, you should say something to them
- Respect the person's privacy and confidentiality.

How to assess and assist in a crisis

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

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

If you have concerns that the person may be having suicidal thoughts, find out how to assess

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

Action: Give reassurance and information

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

You can support the person in the

and assist this person in Section 3.1 *MHFA for Suicidal Thoughts and Behaviours*.

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

Action: Listen and communicate nonjudgmentally

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

- Engage the person in discussing how they are feeling and listen carefully to what they say.

[MHFA Canada: Reference Guide | Section 2 | Page 51 of 102](#)
following ways:

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

What isn't supportive

It is important for the first aider to know that recovery from anxiety problems requires facing situations which are anxiety provoking.

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

Action: Encourage the person to reach out to appropriate professional help

Many people with anxiety disorders do not realize there are treatments that can help them have a better life. Delays can cause serious consequences in the person's life, limit social and occupational opportunities, and increase the risk for depression and drug and alcohol problems.

Discuss options for seeking professional help

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

- Discuss appropriate professional help and

effective treatment options

- Encourage the person to use these options • Offer to help them seek out these options
- Encourage the person not to give up seeking appropriate professional help.

What if the person doesn't want help?

The person may not want to seek professional help. You should find out if there are specific reasons why this is the case. For example, the person might be concerned about the cost of the service or about not having a doctor they like. You may be able to help the person overcome their worries about seeking help. If the person still doesn't want help after you

Page 52 of 102 | MHFA Canada: Reference Guide | Section 2
have explored their reasons with them, let them know that they can contact you if they change their mind in the future about seeking help. You must respect the person's right not to seek help unless you believe that they are at risk of harming themselves or others.

Action: Encourage other supports

Other people who can help

Encourage the person to consider other supports available to them such as family, friends and support groups. There is some evidence that mutual support groups may be helpful for people with depression and anxiety problems (Pistrang et al., 2008).

Self-help strategies

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

People wishing to use self-help strategies should discuss them with a professional. Some self-help strategies may not be suitable for every person with an anxiety problem and people with more

severe anxiety problems may need to use self-help strategies in conjunction with medical or psychological treatments.

Resources

MACANXIETY RESEARCH CENTRE

www.macanxiety.com

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

ANXIETY CANADA

www.anxietycanada.ca

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

MINDYOURMIND.CA

www.mindyourmind.ca

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

CANADIAN MENTAL HEALTH

ASSOCIATION www.cmha.ca

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

CANADIAN PSYCHOLOGICAL ASSOCIATION

www.cpa.ca

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

COGNITIVE BEHAVIOUR THERAPY ONLINE www.moodgym.com.au

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

CENTRE FOR ADDICTION AND MENTAL HEALTH www.camh.ca

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

SELF-HELP BOOKS

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

A self-help book based on cognitive behaviour therapy.

Benson, H. (1985). *Beyond the relaxation*

2.3 Psychosis



Metamorphosis of the Kselotia

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

What is psychosis?

Psychosis is a general term to describe a mental health problem in which a person has lost some contact with reality. It is characterized by severe disturbances in thinking, emotion and behaviour. Psychosis can severely disrupt a person's life. Relationships, work, self-care and other

usual activities can be difficult to initiate or maintain.

Psychotic disorders are less common than other mental illnesses, affecting around 0.45% of adults in any one year (V. A. Morgan et al., 2012). There are numerous disorders in which a person can experience psychosis, including schizophrenia, psychotic depression, bipolar disorder (which can involve psychotic depression or psychotic mania), schizoaffective disorder and drug-induced psychosis.

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

- Premorbid (at risk phase) – the person does not experience any symptoms but has risk factors for developing psychosis.
- Prodromal (becoming unwell phase) – the person has some changes in their emotions, motivation,

thinking and perception or behaviour as described in the box below. The prodrome cannot be diagnosed and is only identifiable in retrospect. During the prodromal phase, it may be uncertain whether the person is developing a psychotic disorder or another more common mental illness.

- Acute (psychotic phase) – the person is unwell with psychotic symptoms such as delusions, hallucinations, disorganized thinking and

reduction in ability to work, study or maintain social relationships.

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

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

Signs and symptoms when psychosis is developing

(Edwards & McGorry, 2002)

Changes in emotion and motivation

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

Changes in thinking and perception

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

Changes in behaviour

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

Although these signs and symptoms may not be very dramatic on their own, when they are considered together, they may suggest that something is not quite right. It is important not to

[MHFA Canada: Reference Guide | Section 2 | Page 55 of 102](#)

ignore or dismiss such warning signs and symptoms, even if they appear gradually and are unclear. It should not be assumed that the person is just going through a phase or misusing alcohol or other drugs, or that the symptoms will go away on their own.

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

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

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

Mental illnesses where psychosis can occur

Schizophrenia

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

The major symptoms of schizophrenia include:

Page 56 of 102 | MHFA Canada: Reference Guide | Section 2

hearing voices, but can also involve seeing, feeling, tasting or smelling things. These are perceived as very real by the person but are not actually there. The hallucinations can be very frightening, especially voices making negative comments about the person. The person may hear more than one voice or experience many types of hallucinations. Because their delusions and hallucinations are so real to them, it is common for people with schizophrenia to be unaware they are ill.

- Thinking difficulties. There may be difficulties in concentration, memory and ability to plan. These make it more difficult for the person to reason, communicate and complete daily tasks.
- Loss of drive. The person lacks motivation even for self-care. It is not laziness.
- Blunted or inappropriate emotions. The person does not react to the things around them or reacts inappropriately. Examples include speaking in a monotone voice, lack of facial expressions or gestures, lack of eye contact or reacting with anger or laughter when these are not appropriate.
- Social withdrawal. The person may withdraw from contact with other people, even family and close friends. There may be a number of factors that lead to this withdrawal such as loss of drive, delusions that cause fear of interacting, difficulty concentrating on conversations and loss of social skills.

Most people experience the onset of schizophrenia between the ages of 15 to 30 years, thus coinciding with the main period of social and educational achievement in life. For people with

- Delusions. These are false beliefs, for example of persecution, guilt, having a special mission or being under outside control. Although the delusions may seem bizarre to others, they are very real to the person experiencing them.
- Hallucinations. These are false perceptions. Hallucinations most commonly involve

schizophrenia, onset of the disorder occurred before the age of 30 for 77% of people, before the age of 20 for 41%, and before the age of 10 for 4% (Häfner, 1998). The onset of the illness may be rapid, with symptoms developing over several weeks, or it may be slow and develop over months or years.

Psychotic depression

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

Bipolar disorder with psychosis

(Müller-Oerlinghausen et al., 2002)

The depression experienced by a person with bipolar disorder has some or all of the symptoms of depression listed previously in Section 2.1 *Depression*. This section also lists symptoms of mania. If in addition to these symptoms of mania a person experiences delusions and hallucinations, this is called psychotic mania. This involves grandiose beliefs about the person’s abilities or in vulnerability, e.g., the person has special powers or is an important religious figure. The person may also experience suspiciousness or paranoia, e.g., about other people doubting their powers. The person will also have a lack of insight. They may be so convinced that their manic delusions are real

that they do not realize they are ill.

Schizoaffective disorder

Sometimes it is difficult to tell the difference between schizophrenia and bipolar disorder

Drug-induced psychosis

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

Substance use and psychosis

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

Risk factors for psychotic disorders

Research suggests that psychosis is caused by a combination of factors including genetics, biochemistry and stress. Possible biological factors include genetic vulnerability, changes in the brain or a dysfunction in brain neurotransmitters. Stress or drug use may trigger psychotic symptoms in vulnerable people.

Risk factors for schizophrenia

(Tandon et al., 2008)

The most significant risk factors are:

- Having a close relative with schizophrenia. For someone with a parent or sibling with schizophrenia, the risk is around 10-15%.

because the person has symptoms of both illnesses. A person with schizoaffective disorder has symptoms of psychosis and depression but does not meet the criteria for bipolar disorder.

MHFA Canada: Reference Guide | Section 2 | Page 57 of 102

Although the risk is higher, it is important to note that 85-90% will not develop schizophrenia.

- Male sex. Biologically sexed boys and men are more likely to develop schizophrenia and tend to have an earlier age of onset.
- Urban living. People who are born and grow up in urban areas are at higher risk than people from rural areas. The reason is unknown but could be related to differences in the health of mothers during pregnancy, cannabis use or social stressors.
- Migration. People who are immigrants or the children of immigrants have increased risk. The reason is unknown, but social stress from feeling like an outsider could be a factor.
- Cannabis use. Cannabis use during adolescence increases risk, particularly in people who have other risk factors (Arseneault et al., 2004).

There are other risk factors that are far less significant and increase risk by only a very small amount. These include events during the mother's pregnancy (such as infections, severe nutritional deficiency, very stressful life events), birth complications, winter/spring birth and older age of father.

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

Risk factors for bipolar disorder

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

Page 58 of 102 | MHFA Canada: Reference Guide | Section 2
Interventions for psychotic disorders

Professionals who can help

A variety of health professionals can provide help to a person with psychosis. They are:

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

Treatments available for psychosis

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

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

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

Depression.

management strategies.

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

Schizophrenia treatments

(Tandon et al., 2008)

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

- Antipsychotic medications
These are effective for psychotic symptoms such as delusions and hallucinations. However, they may have side effects such as lack of motivation, poor memory and problems with concentration. Antipsychotic

medications can sometimes lead to weight gain and associated physical health problems such as diabetes, so a person taking this type of medication needs to have their physical health closely monitored.

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

[Bipolar disorder treatments](#)

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

[Importance of early intervention for psychosis](#)

Early intervention for people with psychosis is very important. Research has shown that the longer the delay between the onset of psychosis and the start of treatment, the less likely the person is to recover. Other consequences of delayed treatment include (Edwards & McGorry, 2002):

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

[Shared decision-making about treatment for psychotic disorders](#)

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

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

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

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

Crises associated with psychosis

Crises that may be associated with psychosis are:

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

Severe psychotic states

People who live with psychotic disorders can have periods when they become very unwell. They can have overwhelming delusions and hallucinations, very disorganized thinking and bizarre and disruptive behaviours. The person will appear very distressed or their behaviours may be disturbing to others. When a person is in this state, they can come to harm unintentionally because of their

delusional beliefs or hallucinations, e.g., the person believes they have special powers to protect themselves from danger such as driving through red lights, or the person may run through traffic to try to escape from their terrifying hallucinations.

Aggressive behaviours

A very small percentage of people experiencing psychosis may become violent (Varshney et al., 2016). People with mental health or substance use problems are often portrayed in the media as potentially violent, dangerous or unpredictable. While there is an increased risk of violence for people who experience psychosis, the use of alcohol or other drugs has a stronger association with violence than do psychotic illnesses (Arseneault et al., 2000; Noffsinger & Resnick, 1999). Many crimes are committed by people who are intoxicated with alcohol or other drugs. The risk of a person with a psychotic illness committing an act of violence is greater if they are not being adequately treated or are using alcohol or other drugs.

Suicidal thoughts and behaviours

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

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

- Depression
- Previous suicide attempt

- Poor adherence to treatment
- Fears of the impact of the illness on one's mental functions
- Recent loss

Psychosis

- Family history of suicide
- Younger age of onset
- Drug use problems

MHFA Actions for

Action: Approach the person, assess and assist with any crisis

How to approach

People developing a psychotic disorder will often not reach out for help. Someone who is experiencing profound and frightening changes such as psychotic symptoms will often try to keep them a secret. If you are concerned about someone, approach the person in a caring and nonjudgmental manner to discuss your concerns. Let the person know that you are concerned about them and want to help. The person you are trying to help might not trust you or might be afraid of

being perceived as “different,” and therefore may not be open with you.

If possible, you should approach the person privately about their experiences in a place that is free from distractions. Try to tailor your approach and interaction to the way the person is behaving (e.g., if the person is suspicious and avoiding eye contact, be sensitive to this and give them the space they need). Do not touch the person without their permission. If the person is unwilling to talk with you, do not try to force them to talk about their experiences. Rather, let them know that you will be available if they would like to talk in the future.

You should state the specific behaviours you are concerned about and should not speculate about

the person's diagnosis. It is important

Page 62 of 102 | MHFA Canada: Reference Guide | Section 2
to allow the person to talk about their experiences and beliefs if they want to. As far as possible, let the person set the pace and style of the interaction. You should recognize that they may be frightened by their thoughts and feelings.

How to assess and assist in a crisis

As you talk with the person, be on the lookout for any indications that the person may be in crisis. If you have concerns that the person is in a severe psychotic state, find out how to assess and assist this person in Section 3.5 *MHFA for Severe Psychotic States*.

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

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

Action: Listen and communicate nonjudgmentally

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

What you should try to do:

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

Things you should not do:

- Do not confront the person
- Do not criticize or blame them
 - Try not to take their delusional comments

personally

- Do not use sarcasm
- Do not use patronizing statements
- Do not state any judgments about the content of those beliefs and experiences.

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

Dealing with delusions and hallucinations

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

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

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

Dealing with communication difficulties

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

- Responding to disorganized speech by communicating in an uncomplicated and succinct manner
- Repeating things if necessary

- Being patient and allow plenty of time for the person to process the information and respond to what you have said
- Being aware that it does not mean that the person is not feeling anything, even if the person is showing a limited range of feelings.
- Not assuming the person cannot understand what you are saying, even if their response is limited.

Action: Give reassurance and information

Treat the person with respect and dignity.

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

Offer consistent emotional support and understanding

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

Give the person hope for recovery

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

Provide practical help

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

Offer information

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

Action: Encourage the person to reach out to appropriate professional help

Discuss options for seeking professional help

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

What if the person doesn't want help?

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

It is important to recognize that unless a person with psychosis meets the criteria for involuntary committal procedures, they cannot be forced into treatment. If they are not at risk of harming themselves or others, you should remain patient, as people experiencing psychosis often need time to develop insight regarding their illness. Never threaten the person with mental health legislation or hospitalization. Instead remain friendly and open to the possibility that they may want your help in the future.

Action: Encourage other supports

Other people who can help

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

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

Family and friends can help by:

- Listening to the person without judging or being critical
 - Keeping the person's life as stress free as possible to reduce the chance of relapse
- Encouraging the person to get appropriate treatment and support
- Checking if the person is feeling suicidal and taking immediate action if the person is suicidal
- Providing the same support as they would for a physically ill person—this can include sending get-well cards, flowers, phoning or visiting the person, and offering help with basic chores
- Having an understanding of psychosis

- Looking for support from a carers' support group
- Helping the person to develop an Advance Care Directive, wellness plan, relapse prevention plan or personal directive (see below).

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

What is an Advance Care Directive?

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

What is an Enduring Power of Attorney?

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

What is an Enduring Power of Guardianship?

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

Self-help strategies

People experiencing psychosis should avoid the use of alcohol, cannabis and other drugs. People sometimes take substances as a way

of coping with a developing psychotic illness, but these drugs can make the symptoms worse, initiate relapse and make the disorder difficult to diagnose (Phillips & Johnson, 2001). The use of cannabis can also slow down recovery (Linszen et al., 1994).

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

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

2.4 Substance Use Problems

What are substance use problems?

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

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

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

Substance use disorders often co-occur with depressive, bipolar, anxiety and psychotic disorders. People with a psychotic disorder are

over twice as likely to have an alcohol use disorder and six times as likely to have a drug use disorder compared to people without a psychotic disorder (V. A. Morgan et al., 2012). People with an anxiety or depressive disorder are three times as likely to have a substance use disorder (Teesson et al., 2009). One reason for this is that many people use alcohol or other drugs to relieve unpleasant emotions (Gregg et al., 2007). However, alcohol or other drugs can also cause other problems in a person's life (e.g., relationship or financial problems), and heavy use may contribute to or exacerbate a mental illness.

Alcohol use problems

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

Short-term problems caused by alcohol intoxication

(National Health and Medical Research Council, 2009)

When a person is intoxicated, they are at risk of a number of problems, such as:

- Physical injuries. People are more likely to engage in risky behaviour which can lead to injury or death. Alcohol is a big contributor to traffic accidents. Also, alcohol intoxication can in itself cause poor motor co-ordination resulting in staggering or falling and slurred speech, and even to medical emergencies such as continual vomiting or unconsciousness.
- Aggression and antisocial behaviour. People can become aggressive and are at a much higher risk of committing crimes.
- Sexual risk taking and unplanned sexual contact. People are more likely to engage in unsafe sex practices while affected by substances. People may engage in sexual activity that they wouldn't agree to while sober. Sexual risk taking may result in unwanted pregnancy or sexually transmitted infections.
- Becoming a victim of crime. While affected by alcohol and other drugs, people are at an increased risk of becoming victims of violent crime, including physical or sexual assault.

MHFA Canada: Reference Guide | Section 2 | Page 67 of 102

- Suicide and self-injury. When a person is intoxicated, they are more likely to act on suicidal thoughts or injure themselves. Alcohol increases risk in several ways. It acts as a mood amplifier, intensifying feelings of anxiety, depression or anger. It also reduces inhibitions and inhibits the use of more effective coping strategies.

Long-term problems caused by alcohol use

(National Health and Medical Research Council, 2009)

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

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

and legal problems.

- Physical health problems. In the long term, heavy use of alcohol can produce problems such as liver disease, brain damage, heart impairment, cancers, diabetes, muscle weakness, pancreatitis, ulcers and gastrointestinal bleeding, nerve damage to hands and feet, weight gain and risks to unborn babies.

How much is too much?

Many people drink alcohol and, in low doses, doing so may not lead to any damage to their

health (National Health and Medical Research Council, 2009).

For healthy men and women aged 18 years and over:

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

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

- Not drinking is the safest option.

Measuring drinks

Canada's Low-Risk Alcohol Drinking Guidelines

GUIDELINE 1

Reduce your long-term health risks by drinking no more than:

- 10 drinks a week for women, with no more than 2 drinks a day most days
- 15 drinks a week for men, with no more than 3 drinks a day most days

Plan non-drinking days every week to avoid developing a habit.

GUIDELINE 2

Reduce your risk of injury and harm by drinking no more than 3 drinks (for women) and 4 drinks (for men) on any single occasion. Plan to drink in a safe environment.

Stay within the weekly limits outlined in Guideline 1.

GUIDELINE 3

Do not drink when you are:

- driving a vehicle or using machinery and tools
- taking medicine or other drugs that interact with alcohol
- doing any kind of dangerous physical activity
- living

with mental or physical health problems

- living with alcohol use disorder

- pregnant or planning to be pregnant
- responsible for the safety of others

- making important decisions

GUIDELINE 4

If you are pregnant, planning to become pregnant, or before breastfeeding, the safest choice is to drink no alcohol at all.

GUIDELINE 5

Delay your drinking:

- Alcohol can harm the way the body and brain develop.
- Teens should speak with their parents about drinking. If they choose to drink, they should do so under parental guidance, never have more than 1-2 drinks at a time, and never drink more than 1-2 times per week.
- They should also plan ahead, follow local alcohol laws and consider the safer drinking tips listed below.
- Youth in their late teens to age 24 should never exceed the daily and weekly limits outlined in Guideline 1.

TIPS

- Set limits for yourself and abide by them. • Drink slowly. Have no more than 2 drinks in any 3 hours.
- For every drink of alcohol, have one non-alcoholic drink.

- Eat before and while you are drinking. • Always consider your age, body weight and health problems that might suggest lower limits.

While drinking may provide health benefits for certain groups of people, do not start to drink, or increase your drinking, for the sake of health benefits.

(Canadian Centre on Substance Use and Addiction, 2018)

Drug use problems

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

Cannabis (marijuana)

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

People who use cannabis are more likely to experience a range of other mental health and substance use problems, including anxiety and depression, but it is unclear which comes first. Also, cannabis use by adolescents and young adults has been found to increase the risk of developing schizophrenia, particularly in persons who are vulnerable because of a personal or family history of schizophrenia (Arseneault et al., 2004).

Opioid drugs (including heroin)

Opioid drugs include heroin, morphine, opium and codeine. Heroin is processed from morphine, which is a naturally occurring substance taken from the Asian poppy plant. Heroin produces a

MHFA Canada: Reference Guide | Section 2 | Page 69 of 102
short-term pain relief and feelings of euphoria and well-being. Most people who are dependent on heroin also have associated problems such as depression, alcohol dependence and criminal behaviour. People who use heroin are at higher risk for suicide.

Pharmaceutical drugs used for nonmedical purposes

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

Cocaine

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

Amphetamines (including methamphetamine)

Amphetamines belong to a category of stimulant drugs and have the temporary effect of

increasing energy and apparent mental alertness. However, as the effect wears off, a person may experience a range of problems including depression, irritability, agitation, increased appetite and sleepiness. Amphetamines come in many shapes and forms and are taken in many

ways. They can be in the form of powder, tablets, capsules, crystals or liquid. Methamphetamine (meth) has a chemical structure similar to that of amphetamine, but it has stronger effects on the brain. The effects of methamphetamine can last 6-8 hours. After the initial “rush,”

Page 70 of 102 | MHFA Canada: Reference Guide | Section 2
there can be a state of agitation, which can lead to violent behaviour in some individuals.

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

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

Hallucinogens

Hallucinogens are drugs that affect a person’s perceptions of reality. Some hallucinogens also produce rapid, intense emotional changes. A particular problem associated with hallucinogens is flashbacks, where the person re-experiences some of the perceptual effects of the drug when they have not been recently using it.

Ecstasy

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

It is important to note that while ecstasy refers to

the drug MDMA, the pills or powders people buying off the street may contain other substances—drugs or harmful chemicals.

Inhalants

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

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

Tobacco

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

Risk factors for substance use problems

but the risk factors for drug use disorders are likely similar.

There is no single cause of alcohol use disorders. Rather, there are many factors that increase a person's chances of developing such a disorder (Negrete & Gill, 2000). These include:

- Availability and tolerance of alcohol in society. Where alcohol is readily available and its use socially accepted, alcohol use disorders are more likely to develop. This applies not only to society as a whole, but also to particular social groups within a society.
- Alcohol use in the family. People who grow up in families where alcohol use is acceptable, where parents model use of alcohol and alcohol is readily available are more likely to develop an alcohol use disorder (Ary et al., 1993; Komro et al., 2007).
- Social factors. Certain groups are more prone to alcohol use disorders, including boys and men, people with low education and income, people who have had a relationship breakdown and certain occupations with a drinking culture.
 - Genetic predisposition. People who have a biological parent with an alcohol use disorder are more likely to develop the disorder, even if adopted into a family without a history of alcohol use disorder.
- Alcohol sensitivity. Some people are physiologically less sensitive to the effects of alcohol than others, and these people are more likely to drink heavily and develop an alcohol use disorder.
- Enjoyment from drinking. People can learn a habit of heavy drinking. This habit is maintained because alcohol has been associated with pleasant effects or a reduction of stress.

Most of our knowledge about the risk factors of substance use disorders relates to alcohol,

[MHFA Canada: Reference Guide | Section 2 | Page 71 of 102](#)

- Other mental illnesses. People who have mental health problems may use alcohol as a type of self-medication.

Interventions for substance use problems

Professionals who can help

A variety of health professionals can provide help to a person with substance use disorders. If the person is uncertain about what to do, encourage the person to consult a GP first. The GP might refer the person to a drug or alcohol service, or to a mental health professional if there are other mental health problems.

Treatments available for substance use disorders

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

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

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

- Brief intervention. If a person is drinking at a level that could damage their health or using drugs, then brief counselling by a GP can help them reduce or stop using. If they have a substance use disorder, seeing a GP can help

to motivate them to enter long-term treatment.

This type of

Page 72 of 102 | MHFA Canada: Reference Guide | Section 2

intervention generally takes four or fewer sessions, each lasting from a few minutes up to an hour. The GP looks at how much the person is using, gives information about risks to their health, advises them to cut down, discusses the advantages and disadvantages of changing and options for how to change, motivates the person to act by emphasizing personal responsibility and monitors progress. In doing these things, the GP adopts an empathic rather than a coercive approach.

- Withdrawal management. If the person is dependent on alcohol or drugs, they will have to withdraw from the substance before other treatments commence. This should be done under professional supervision. However, withdrawal is not enough and should be combined with other treatments to prevent the person from relapsing. It is only part of the recovery process and many lifestyle changes are required to change behaviours associated with drinking or drug use.
- Psychological treatments.
 - Cognitive behaviour therapy which teaches the person how to cope with craving and how to recognize and cope with situations that might trigger relapse. To get the full benefit of cognitive behaviour therapy, a person needs to have a sufficient number of sessions. As a guide, around 12 sessions are recommended (Crome & Baillie, 2016).
 - Motivational enhancement therapy which helps motivate and empower a person to change. It allows the person to consider the gains they receive from using substances, while helping to improve their awareness of the negative aspects and consequences of their use and to identify reasons to choose not to use.
 - Contingency management is used with people

who have a drug use disorder and involves offering the person incentives such as shopping vouchers or privileges for negative drug test results or for harm reduction actions such as having a hepatitis or HIV test.

- Medications. There are a number of types of medications that can assist a person to stay off substances. For people with an alcohol use disorder, these include anti-craving medications, medications that give an unpleasant effect if the person drinks or medications for the treatment of underlying anxiety and depression. For people dependent on opioid drugs, methadone maintenance therapy is available.

For a person with both a substance use disorder and other mental illness

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

Importance of early intervention

Substance use problems typically begin in adolescence and early adulthood, so this is the critical time for early intervention. There is evidence that the brains of adolescents and young adults are still developing and are more sensitive to the effects of alcohol and other drugs than the brains of older adults (Lubman et al., 2007). Substance use during this period of life can affect brain development and lead to cognitive impairments. Early intervention will also prevent many of the long-term negative effects on a person's physical health, social relationships, educational progress, financial status and job prospects. It will also reduce the possibility of serious problems with the law.

Crises associated with substance use

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

- Experiencing severe effects from alcohol use.
- Experiencing severe effects from drug use.

Showing aggressive behaviours.

- Having suicidal thoughts and behaviours.

Severe effects from alcohol use

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

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

Severe effects from drug use

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

- Drug intoxication can lead to impairment or distress, e.g., the person may have poor

judgment, engage in risky behaviours or become aggressive. The effects vary depending on the type and amount of drug and also vary from person to person. It can be difficult to make a distinction between the effects of different drugs. Illicit drugs can have unpredictable effects, as they are not manufactured in a controlled way.

- Overdose occurs when the intoxication level leads to risk of death.
- Overheating or dehydration can occur with prolonged dancing in a hot environment (such as a dance party) while on some drugs (e.g., ecstasy) without adequate water intake. This causes the person's body temperature to rise to dangerous levels.
- Sudden sniffing death may occur with inhalant use, due to heart failure. This is more likely if the person becomes agitated or engages in physical exertion, e.g., the person gets a fright and runs away.

Aggressive behaviours

There is an increased risk of aggression to others for people who experience substance use problems (Arseneault et al., 2000). Many crimes are committed by people who are intoxicated with alcohol or other drugs.

Suicidal thoughts and behaviours

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

MHFA Actions for Substance Use

Action: Approach the person, assess and assist with any crisis

How to approach

If you are concerned about someone's substance use, talk to the person about it openly and honestly. Before speaking with the person, reflect on their situation, organize your thoughts and decide what you want to say. Arrange a time to talk with the person. Talk with them in a quiet, private environment at a time when there will be no interruptions, when both of you have not been using substances and are in a calm frame of mind. Express your concerns nonjudgmentally in a supportive, nonconfrontational way. Be

assertive, but do not blame or be aggressive.

Consider the following when making your approach:

- The person's own perception of their substance use. Try to understand the person's own perception of their use of substances. Ask them about it (for example, about how much of the substance the person is using) and if they believe their substance use is a problem.
- The person's readiness to talk. Consider the person's readiness to talk about their substance use by asking about areas of their life that it may be affecting, for example, their mood, work performance and relationships. Be aware that the person may deny, or might not recognize, that they may have a substance use problem.

and that trying to force the person to admit they may have a problem may cause conflict.

- Use “I” statements. Express your point of view by using “I” statements, for example, “I am concerned about how much you’ve been drinking lately,” rather than “you” statements

drug use seems to be getting in the way of your friendships” rather than “You’re a pathetic druggie.”

- The person’s recall of events. When discussing the person’s substance use, bear in mind that the person, after using substances, might have a different recollection of events than what actually happened, or they may not remember what happened at all.
- Stick to the point. Focus on the person’s substance use and do not get drawn into arguments or discussion about other issues.

How to assess and assist in a crisis

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

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

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

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

If you have concerns that the person may be having suicidal thoughts and behaviours, find out how to assess and assist this person in Section

such as “You have been drinking too much lately.”

- Rate the act, not the person. Identify and discuss the person’s behaviour rather than criticize their character, for example, “Your

[MHFA Canada: Reference Guide | Section 2 | Page 75 of 102](#)

3.1 *MHFA for Suicidal Thoughts and Behaviours*.

Action: Listen and communicate nonjudgmentally

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

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

Action: Give reassurance and information

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

helpline and perhaps the address of a reputable website (see Helpful resources at the end of this

chapter).

Page 76 of 102 | MHFA Canada: Reference Guide | Section 2
Have realistic expectations for the person

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

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

The stages of change

(Prochaska et al., 1994)

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

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

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

Stage 2: Contemplation – the person thinks

their substance use might be a problem

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

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

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

Stage 4: Action – making the change

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

Stage 5: Maintenance – keeping up the new habits

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

A person may relapse once or several times before making long-term changes to their substance use.

Support the person who does want to change

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

be helpful for a person with a drug use problem.

Encouraging low-risk drinking

The following strategies may assist the person to

alcohol intake and that although changing drinking patterns is difficult, they should not give up trying.

- Encourage and assist the person to find information on how to reduce the harms associated with their problem drinking.
- If appropriate, inform the person that alcohol may interact with other drugs

Tips for low-risk drinking

- Know what a standard drink is and be aware of the number of standard drinks they consume.
- Know the alcohol content of their drink. • See if the number of standard drinks is listed on the beverage's packaging.
- Eat while drinking.
- Drink plenty of water while consuming alcohol to prevent dehydration.
- Drink beverages with lower alcohol content, e.g., drinking light beer instead of full-strength beer.
- Switch to non-alcoholic drinks when they start to feel the effects of alcohol.
- Do not let people top up their drink before it is finished, so as not to lose track of how much alcohol they have consumed.

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

adopt low-risk drinking:

- Help the person to realize that only they can take responsibility for reducing their

[MHFA Canada: Reference Guide | Section 2 | Page 77 of 102](#)
that the people who care (illicit, prescribed or over the counter) in an unpredictable way which may lead to a medical emergency.

- Ask the person if they would like some tips on low-risk drinking.

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

- Avoid trying to keep up with friends drink for drink.
- Avoid drinking competitions and drinking games.
- Drink slowly, for example, by taking sips instead of gulps; put your drink down between sips.
- Have one drink at a time.
- Spend time in activities that don't involve drinking.
 - Make drinking alcohol a complementary activity instead of the sole activity.
- Identify situations where drinking is likely and avoid them if practical.

about them will accept their decision not to drink or to reduce the amount they drink.

Supporting the person who does not want to change

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

able to influence their use in a positive way. Let the person know you are available to talk in the future.

You can speak with a health professional who specializes in substance

Page 78 of 102 | MHFA Canada: Reference Guide | Section 2
use disorders to determine how best to approach the person about your concerns, or you can consult with others who have dealt with such problems about effective ways to help the person. You might also discuss with the person the link between their substance use and the negative consequences they are experiencing.

What isn't supportive

If the person is unwilling to change their substance use:

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

If the person continues to have a substance use problem, you should encourage them to seek out information (e.g., reputable websites or pamphlets) about ways to reduce risks associated with alcohol or other drugs. If the person is using or planning to use alcohol or other drugs while pregnant or breastfeeding, encourage them to consult with an appropriate health professional.

Action: Encourage the person to reach out to appropriate professional help

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

Discuss options for seeking professional help

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

What if the person doesn't want professional help?

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

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

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

Action: Encourage other supports

Other people who can help

Inform the person of supports they may find useful and allow the person to decide which they prefer.

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

Role of family and friends in

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

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

(Mental Health First Aid Australia, 2020b)

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

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

Self-help strategies

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

