MENTAL HEALTH IS EVERYBODY'S BUSINESS

SAFER CARE TOGETHER
United Against Suicide

Introduction to Mental Health, Dementia, Learning Disabilities and Autism

A compassion-focused universal guide for **health, social care and the voluntary sector.**

A universal guide to Mental Health, Learning Disabilities and Autism

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About the author

This workbook has been designed by **Terry Simpson, Mental health lead** in partnership and with much appreciation to an expert reference group within the Berkshire, Oxfordshire and Buckinghamshire footprint. It has been funded by **Health Education England (HEE), National Health Service England (NHSE)**, and on behalf of the suicide prevention national agenda.

Terry has been a mental health nurse for 22 years with extensive experience in adult mental health, crisis resolution teams and five years working in the ambulance service.

This digital workbook has been supported by wide consultation across various subgroups of the suicide prevention and intervention network (SPIN) within the Thames Valley footprint. Increasingly, all health, social care and voluntary sector services are responding to people presenting in mental health crisis.

As a multi-disciplinary partnership team, our vision is to ensure ease of access to high quality mental health care and suicide prevention wherever a person presents in crisis. Like physical health, there are a number of positive steps we can all take to maintain and improve our mental health or resilience. Resilience should be seen as our ability to bounce back from different adverse life events and burdens.

A helpful analogy could be to see resilience as the "Bounceability" of a beach ball. When the beach ball is fully inflated, it bounces back from pressures and challenges. If we are stressed and overwhelmed with a built up combination of medical health worries, relationship pressures, work pressures or financial concerns, this can all impact our Bounceability by gradually releasing air from the beach ball. Suddenly, and often without us noticing, this could impact our ability to bounce back from various life pressures. To regain our resilience, we need to re-inflate our beach ball by emotionally and objectively separating ourselves from worries and excessively going over problems in our minds through distraction techniques based on the principles of social prescribing covered later. Over time and with practice on self-compassion we can find ways to switch off and refocus our thoughts. It's important to remember that compassion starts from within ourselves and that if we are drained and deflated it is difficult to be compassionate or to give to others.

More details on maintaining our own mental health is covered later in the guide.

Your local employer or support group may well have a database of services, signposting options and mental health pathways or referral routes for support. Alternatively, search 'every mind matters' or contact 111 if urgent or 999 in a mental health emergency.

Welcome to your Workbook about Mental Health, Dementia, Learning Disability and Autism

The purpose of this resource is to give you an introduction and practical guide from a universal perspective to supporting someone in a crisis. By universal, we refer to any health, social care, voluntary sector or other people who come into contact with a person experiencing a mental health concern.

Although the guide isn't detailed, it provides a valuable introduction into common mental health conditions and how to support people from a non-specialist universal perspective. Throughout there are sections which cover basic principles of awareness, signposting and treatment. There is also a range of commonly encountered mental illnesses. This includes information such as case studies and a section which examines the connection between mental health and physical health. Principles around the legal framework on decision making, safety planning, duty of care, best interests and signposting vulnerable people at risk is also covered.

Supporting a mental health crisis can be anxiety provoking and emotionally draining. Historically there has often been gaps around working together across the system with key organisations such as primary care though GP's, voluntary sector, ambulance service, police, mental health providers, education social care and other stakeholders. Within your role or engagement you may well be dealing with people presenting with mental Illness and as part of a network of provider collaboration, we are not building a partnership process to support commissioner led system transformation. Often a mental health crisis can involve complex contributory factors which makes it difficult to be able to work out exactly what may be wrong or how you can help someone in distress. This is why its very important to take the time to listen compassionately and attentively by creating the time and space to talk. You could think that you do not have the experience or training to be able to assist someone in need, which isn't an unusual feeling for many of us. The key is to show understanding and a non-judgemental approach. By being relaxed, open-minded and inclusive you provide the best opportunity to build a good connection with the person in crisis.

Defining a crisis

A crisis can be described by a breakdown in normal coping strategies to a nature or degree that it has a significant impact on a person's mental health or day to day functioning such as sleep, concentration and mood. A crisis is often triggered or exacerbated by a range of changes in circumstance challenges which can include but is not limited to relationship problems, bereavement, finances or work pressures.

This can possibly be made worse by an individuals vulnerability to stress or mental health conditions as in the stress bucket analogy link: https://tvsuicideprevention.uk/video/?video=stress-bucket

How you engage with, approach and support a person in distress could be the difference between developing a solution focused therapeutic relationship, or potentially heighten levels of anxiety.

Recent challenges such as Covid has meant the world is changing and the pressures that people face on a day-to-day basis can make someone's life feel unbearable. We all really need to prepare for this by being kind, compassionate and listening to each other. You may be the first person who interacts with a person in crisis or the only one a vulnerable person has seen that day. Make the connections that matter to inspire hope and show them they are not alone.

Parity of esteem

Parity of esteem or equality is a notion that can apply to many healthcare situations. In mental health it has become acknowledged as a way of describing the historic inequality between medical and mental health care investment. Mental health funding previously hasn't had the same recognition as for people who present with medical problems such as diabetes or asthma.

This underinvestment has previously meant that many health, social care, voluntary staff, police and others were left filling the gaps and regularly responding to people in crisis. The government has made efforts to address this by setting out the "five year forward view for mental health". **This has evolved further into the NHS long term plan (LTP) which sets out current and future investment in mental health transformation: https://www.longtermplan.nhs.uk/areas-of-work/mental-health/**

For more information visit:
www.england.nhs.uk/publication/the-five-year-forward-view-for-mental-health

Introduction

Whilst we feel in society we have an important role to care for vulnerable people, we also know that current mental health training, support and development strategies need to be improved for everyone.

Improving how we all communicate and work together as a system around mental health is a key indicator to better person safety and experience. To evidence the joint efforts between all agencies involved in improving collaboration and pathways key agencies such as mental health Trusts, Acute hospitals, police, social care, commissioners and ambulance trusts are required to come together within Crisis Care Concordats (CCC). Many of these have developed further into integrated care systems (ICS) or sustainability and transformation partnerships (STP's) which provide the framework for system collaboration and investment.

Did you know...

*Mental health difficulties are unfortunately common and **one in 4 people** will be suffering from a mental health problem at any one time.* [1]

Crisis Care Concordats focus on 4 key principles which are related to working together on following priorities. Tackle stigma. Early intervention to prevent a crisis. Ease of access to high quality care in a crisis. To provide support, recovery, time and wellbeing to prevent possible future relapse through identifying triggers and completing with safety plans.

Did you know...

A key aspect which underpins crisis care concordats is to highlight that 'mental health is everyone's business'.

These principles recognise that previously, people in distress have been far too often passed from "pillar to post" between different agencies without anyone taking responsibility or joining up a quality caring approach. This has often confused people in crisis and carers and exacerbated levels of distress. These provider collaborative partnerships have taken the view that there should 'no wrong door' for people presenting in crisis.

> *Improving how we all communicate and work together as a system around mental health is a key indicator to better person safety and experience.*

As outlined in the NHS LTP, we are all committed to supporting and enabling everyone in ensuring that people in crisis receive ease of access to the right intervention for care and support relevant to their identified needs.

This is progressively being done with the support of key provider partnerships such as mental health telephone triage as a single point of contact for new referrals or out of hours within ambulance call centres via 111/999 and mental health triage cars. Triage cars often operate with paramedics, mental health clinicians and or police in an emergency response vehicle deployed via control rooms during operational hours.

Mental health conditions are frequently linked to or exacerbated by challenging socio-economic challenges. These can include finances, housing circumstances, community support, employment status, lifestyle factors, family, friends, drug or alcohol use. Personal resilience is also important to maintain mental health stability, recovery or relapse prevention.

In supporting this digital guide, your public health leads will be working towards further training in mental health and mental illness, identifying local operational leads in mental health interested in supporting locality care providers, and identifying local connections with partner health and social care agencies.

A mental health provider collaborative will work closely with emergency departments, as well as social care, voluntary sector and primary and secondary care providers, to ensure we improve on quality and consistency in addressing pathways around mental health. If you have any specific areas you need support or clarification on related to any complex mental health challenges that are outside of normal line management or supervision, then please liaise with your senior manager or search **'every mind matters'.**

What does mental health and mental illness mean to you?

Across health and social care, we use terminology that could have a wide variety of meanings. Mental health and mental illness are two areas where this happens quite frequently. The public perception of a mental health diagnosis and impact of functioning is often very different to what healthcare professionals mean.

We need to be ensure that any preconceived ideas or interpretations of someone's condition does not prejudice our approach, the care provided and safety plans agreed with the person and/or their family. This is why we need an inclusive and empowering approach.

Below are some questions you might wish to consider prior to reading your way through this workbook. Use the space provided to reflect on or jot down your thoughts and feelings. Think about how you provided support to people in distress in the past or what approaches you may have seen others take. You might want to discuss this with your colleague or manager in supervision.

> *We need to be ensure that any preconceived ideas or interpretations of someone's condition does not prejudice our approach, the care provided and safety plans agreed with the person and/or their family.*

Please reflect on the following questions:

- Do you have any preconceived ideas or past experience of supporting people with mental illness?
- Do you care for people with a mental illness differently from the way you might care for people with a medical illness?
- What feelings or emotions do you experience prior to or whilst supporting someone with a mental illness?
- Does society view any vulnerability around mental illness differently from those associated with a medical illness?
- Do people with a mental illness expect to be treated differently than those with a medical illness?
- If you, your family or a close friend had a mental illness, what would you want from the support that they received?

Personal reflections and Service user feedback

Activity

Personal reflections of mental health incidents

When I was admitted to hospital, perhaps the only person that really seemed to care in the first few days was the paramedic who arrived to take me to hospital. She listened, held my hand, and told me she'd help get me better... which at the time was what I needed. I still remember her...

The problem is, well, when you are physically sick, people can normally tell from the way you walk or something. But when you hear voices, nobody knows but you... It's a lonely, scary place to be in, hearing things that nobody else seems to hear...

Think about it, how would you like to get arrested for having a broken leg? That's what it felt like when the police took me away for being suicidal. My neighbours saw everything... I lost my dignity, my self respect, and my life for nearly two years.

...They [the clinicians] were obviously scared that I might attack them, or do something crazy, but all I needed was them to give me time, space and to listen. Nobody listens when you have a mental illness, they all just think you're mad...

Mental health myths and facts

Talking Stigma

Generally in society we may hear negative, disrespectful and hurtful comments related to mental health such as "nutter, weirdo, psycho, lunatic, dangerous or waste of space".

Take some time to think about the impact of stigma and the barriers to accessing help this brings. Imagine if you felt lonely, hopeless, helpless, isolated, excluded and managed as a threat. That you thought your family are better off without you. Which one of these hurtful labels above would encourage you to access help? Is it time to think again about mental health? Just because someone is struggling it doesn't mean they are failing! It isn't a weakness to talk about things that may be playing on your mind. Take some time and try to reflect on why we stigmatise mental health. Perhaps the reason why society stigmatises mental health is unlike a physical condition, mental health can be difficult to see. It can also seem too complex to resolve. Additionally we don't have diagnostic equipment such as a BP machine or ECG or easy treatment options. Perhaps because of this it scares us and we build up barriers? We know that statistically, many people who die by suicide haven't told anyone prior. We also know that over 75% of people who die by suicide are men.

Are these some of the consequences of stigma and shame related to mental health?

Myth

Mental health problems are very rare.

Fact

The number of people affected at any one time with mental health problems in the UK is consistently around 25%, although this varies depending on the type of condition.

Anxiety and depression are some of the most common conditions you are likely to see under the broad range of mental illness.

However, up to 17 people in each 100 in the UK will experience suicidal thoughts at some point during their lifetime. We will focus on suicide and at risk mental state later in this book. You should however bear in mind that suicide is often closely linked with many mental health conditions. Perhaps through improving awareness and addressing stigma we can start to tackle isolation and risk of suicide by encouraging people to talk about worries. This could help reframe how they think about themselves along with the value the place on their lives! [2]

Myth

People with mental health illnesses are usually agitated, aggressive or unpredictable.

Fact

People with a mental illness are more likely to be a victim of aggression.

Remember there are a number of socio-economic factors that can contribute to mental illness such as poverty, isolation, homelessness, domestic violence, addictions and co-existing physical health needs which leaves people vulnerable.

People with a mental illness are often isolated, and it is this vulnerability which can bear the brunt of violent incidents perpetrated against them.

The majority of people experiencing mental health problems are more likely to self-harm or direct any anger and irritability internally rather than towards others.

Myth

People with mental illness don't normally go to work.

Fact

We probably all work with someone experiencing a mental health problem.

Given that one in 4 will be suffering at any one time, its quite likely that someone you work with is struggling with a mental health condition right now.

Why do you think they may be reticent to tell their colleagues about it?

Did you know...

"... up to 17 people in each 100 in the UK *will experience suicidal thoughts at some point during their lifetime."*

(Source, Mind)

> *Anxiety and depression are some of the most common conditions you are likely to see under the broad range of mental illness.*

Myth

People who are weak, like a diagnosis for benefits, lazy, or have a flawed personality are prone to a mental illness; if they corrected this attitude they could snap out of it and get on with there lives.

Fact

Mental health conditions have nothing to do with being lazy or weak. Many factors contribute to mental health problems, including:

- Biological factors, including a genetic disposition, anatomy and physiology
- Traumatic life experiences, such as physical, sexual or emotional abuse
- A family history of mental health problems
- Difficult experiences can also contribute to mental health problems such as pressures at work, in relationships or financial worries.

Recovery and healing focuses on helping people address some or all of these factors in a here and how pragmatic way. We will look more closely in detail at some of the causes of mental illness throughout the workbook. Like many physical health problems, there are a number of factors which may contribute in a mental illness. An example is factors involved in developing cardiovascular disease. In equal measure whether mental health or physical health not all factors are within a person's control which is why its important not to lecture or judge someone in distress.

Myth

People don't recover from mental illnesses

Fact

People do recover from mental illnesses often going on to live a richer and more fulfilling life prioritising the most important things in life. Some people have a short episode of illness, get better and never experience a mental illness again. Others people may have a relapsing or changing pattern, where they have periods of being well, and other periods of being unwell. A big part of sustained recovery involves helping people recognise triggers and when they are becoming unwell (often known as relapse indicators). Early intervention and safety plans provide the best prognosis for sustained wellbeing. Have a think about how a person's previous experiences of mental illness might influence or direct your approach to supporting them.

Learn more

For more common myths and facts about mental illness, visit:

www.rethink.org

https://tvsuicideprevention.uk/video/?video=stigma

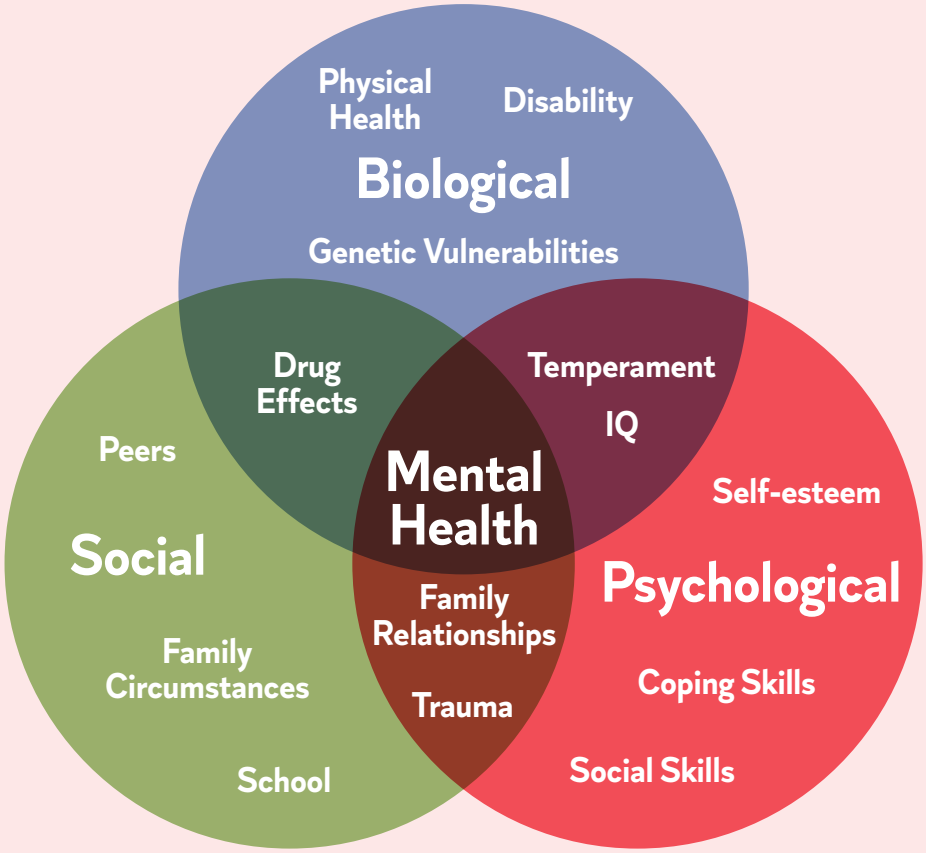
Examining the causes of mental illness

What causes mental health problems?

In health and social care, it can sometimes be difficult to think about our approach to considering why some illnesses or conditions affect one person more than others. It could be because of habits and choices, previous traumatic experience, genetics, family circumstances or a combination of these. In some circumstances it can be due to undeterminable events or hard to identify route cause. It is however, helpful for us to understand how and why a person could be impacted. This is so we can work towards mitigating or limiting a factor as part of recovery.

One way to consider how factors can influence mental health is to view it through the 'biopsychosocial' model [3]. Remember people aren't just physical biological entities! Psychologically we have individual complex emotions and thought processes as well as many social factors that can influence our wellbeing. Rather than focusing on just biological factors the biopsychosocial model explores an integrated approach to elements which could influence illness progression. This concept reflects how different elements can impact an individual's condition differently. It also demonstrates the importance of a holistic approach to health considering both physical and mental health.

> *"Remember people aren't just physical biological entities! Psychologically we have individual complex emotions and thoughts processes as well as many social factors that can influence our wellbeing."*

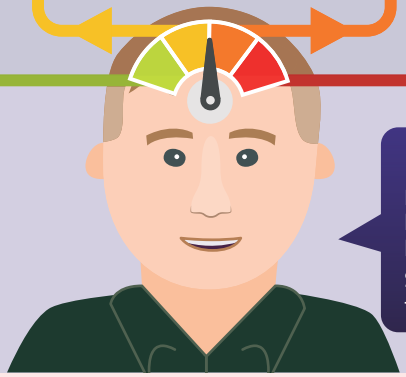


Mental Health Continuum

Like physical health, we all have mental health. Unlike physical health, mental health problems can creep up on us over time and often without us noticing. When it comes to safety planning, it's important to be aware of this, recognise triggers and access safety plans early. It's helpful to see mental health as a continuum we are all on as outlined below.

How are you **really** doing?

THRIVING	SURVIVING	STRUGGLING	IN CRISIS
• Enthusiastic • Calm • Achieving goals • Compassionate • Sleeping well • Eating normally • Normal social life	• Concerned • Restless • Irritable • Less happy • Trouble sleeping • Distracted • Isolatory	• Anxious • Often sad • Tired • Reduced performance • Restless sleep • Eating changes • Negative thinking	• Very anxious • Depressed • Absenteeism • Exhausted • Very poor sleep • Weight change • Hopeless or suicidal



Understanding the continuum

Be kind to yourself, others and always keep talking. Remember there is always hope & every life matters.

Search **every mind matters** for more information.

We all experience times when we struggle or reach crisis.
It is ok to not be ok. Your loved ones, employer and professionals can help.

Maintain your wellbeing	Promote your wellbeing	Focus on your wellbeing	Prioritise your wellbeing
▶ Connect with others ▶ Be physically active ▶ Learn new skills ▶ Give time and kindness to others ▶ Be present in the moment	▶ Actively engage in coping techniques and self-care ▶ Engage more with family, friends or support groups ▶ Be reflective. What are your support needs or safety/wellbeing plans?	▶ Connect with your family, friends, work peers, support services or contact your GP ▶ Talk about how you are feeling ▶ Consider trying a new coping technique	▶ Prioritise asking for help and self compassion. Contact your GP and any existing support. If urgent think 111 or in an emergency dial 999. We all struggle at times and remember every life matters

Activity

The competing factors behind mental illness.

Use the space below to consider and list ideas which you think might contribute to a developing mental illness in someone. An example of each has been started for context.

	Factor	Example
Biological factors	Genetic susceptibility	Long family history of depression
Psychological factors	Low self esteem	Childhood abuse
Social factors	Isolation	Single parent

... Understanding how and why a person can be affected is helpful to see in a holistic way considering all aspects of their functioning or activities of daily living. We can then work towards empowering people in adjusting for, removing or limiting risk factors as part of their recovery or signposting to appropriate professional help.

You should now be able to see there are many contributing elements which can positively or negatively influence why someone might develop a mental health condition. It may sometimes initially seem obvious which factors contribute to a condition but there are often multiple elements involved. Does this explain why some conditions are more resistant to treatment in some people?

Now think about a frequently occurring mental illness like depression. Focus more broadly about how the holistic biopsychosocial model we have described might begin to explain some of the contributing factors to how depression develops.

If you wish, try to unpick history in the case studies provided in this guide and consider how you as a compassionate person, or the GP, emergency medicine doctor or psychiatrist would begin to consider supporting the people in the case studies or reflecting on your own experience. If their problems are entirely biological, then presumably antidepressants are the key? However, if their problems are more social, then perhaps a referral to Social Services for extra assistance might be useful? Yet, if their background and current circumstances are interwoven, then is there a place for a psychologist in addition to a psychiatrist?

Case study 01 - Peer Support

Let's tackle mental health together!

Dave is a 35 married father of two children. He works as a car mechanic as part of a national chain. Dave's mum died 1 year ago after a long battle with cancer. They were very close and this has really impacted Dave. He doesn't like talking about his emotions and has bottled things up. He plays rugby and is normally quite sociable. He has become increasingly irritable, drinking more alcohol, often seems distracted and has stopped playing rugby recently.

Paul is the rugby coach and has known Dave well for many years. They have a close friendship. Paul is the rugby clubs safeguarding lead and has a keen interest in mental health awareness. He has done accredited courses on mental health awareness. He offers to meet with Dave for a coffee at a local park. He knows this will provide some confidentially and by walking together it will give Dave an opportunity to open up without distraction.

When they meet at the right time in the conversation Paul asks Dave how he is **really** doing? Dave says he has been struggling to sleep, concentrate, is often irritable and doesn't enjoy anything. He feels he is a burden on his family and everyone else. Paul listens attentively, offers support and at the right time asks Dave if has thought about suicide. Dave gets upset and says yes as he sometimes feels his family are better off without him. Paul continues to listen attentively and asks Dave if he had a plan. Dave says he doesn't have plans and he couldn't do this to his family.

His uncle died by suicide and he saw what this did to his mum. He can now see he needs help. Paul talks to Dave about what Dave feels would help and support him. Dave agrees to go talk to his wife about how he is feeling and see his GP for referral and treatment options. He also plans to talk to his manager about occupational health support as he has been struggling at work. He can see that he has been bottling things up and been drinking to block things out as a coping strategy, but this has actually made things worse.

Paul says he would like to catch up with Dave by phone or in person a couple of times in the next week. He inspires hope and tells Dave if things get worse he should call 111 or 999 in an emergency. He doesn't want Dave to feel alone, wants to check he is accessing help and is improving. Dave assures Paul if things get worse, he would tell someone he trusted.

Dave feels much better now things are more in the open and he has talked to his friend. The next day, Paul has a debrief and talks through the key themes of the situation without disclosing personal details or breaching confidence to his mental health peer support lead.

Case study questions

- Reflect on the keys themes above?
- How do you feel Paul handled this situation?
- Why was it important Paul asked Dave about suicidal thoughts?
- Would you have done anything differently?
- What key principles could you take from this in having a compassionate conversation?

In this scenario, try to reflect on how many competing factors can impact on the causes of a crisis and how these might all come together in a person with depression. The biopsychosocial model is a good framework for reflecting on family circumstances, social factors and other elements which may contribute to a mental health crisis. These principles can be applied to further scenarios in the coming chapters. This should act as a structure to frame your support for people and help underpin your signposting, safety planning and onward care referral.

Learn more

For another example of the biopsychosocial model and depression:
www.mentalhelp.net

Key conditions encountered in community care

Anxiety

Stress and anxiety

Anxiety can be seen as our instinctive physical and psychological response to a perceived or actual threat. Anxiety is a normal human response we can all experience at times and to different degrees to stressful situations such as exams or perhaps a driving test. Levels of clinical anxiety which may require support can include persistant highly emotive and responsive states often trigger by irrational fears impacting the person's daily activities or quality of life. Acute anxiety (also commonly known as a panic attack) produces chemicals such as adrenaline in our bodies which can lead to a collection of associated unpleasant physical and psychological symptoms such as nausea, shallow rapid breathing, palpitations, negative thinking and restlessness. When the levels of anxiety have a significant physical impact on our functioning or increased isolation it may be seen as unhealthy and require extra support or professional help. Other clinical referral threshold factors are if it occurs independently of an obvious stressful stimulus, persists when the stressful stimulus has ceased, or is in excess of what would typically be expected from that situation.

People with a diagnosis of anxiety could have had a traumatic experience in life possibly related to physical abuse, neglect, emotional instability, sexual abuse or bullying. Persistent excessive worry or stress can also lead to or compound anxiety. Examples of this could be sustained unrealistic pressures at work, financial instability or complex challenging family life.

People experiencing these conditions can have a lot of internal emotional conflict in their minds or conflicting views about weighing up choices, decisions or solutions. This can lead to frequent over analysis and persistent negative thinking (e.g. the glass is always half empty).

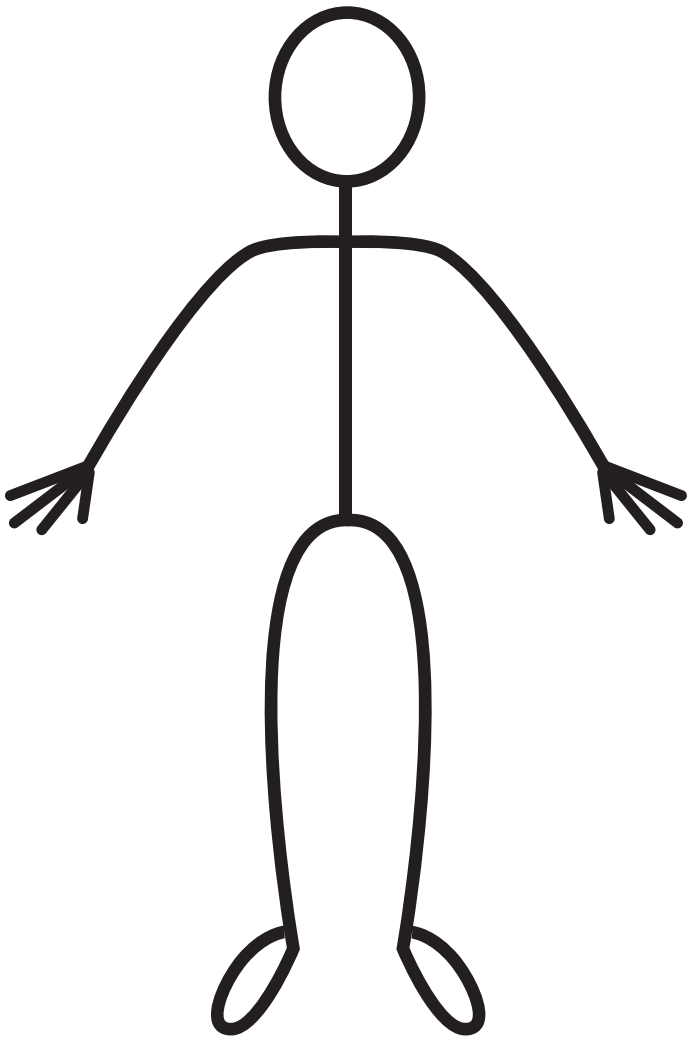
Typical symptoms of stress and anxiety include but are not limited to the following:

- Poor initial sleep
- Early morning waking
- Shortness of breath
- Palpitations
- Nausea
- Excessive ruminations (constantly overthinking a risk)
- Restlessness/ unrealistic fears
  - Heightened alertness
  - Tension in muscles
- Preoccupation
- Difficulty with memory and concentration
- Avoidance
- Irritability
- Frequently needing the toilet
- Change in behaviour
- Clammy hands, dry mouth
- "Butterflies in tummy"

Remember when the levels of anxiety have a significant physical impact on our functioning, it can be seen as clinically unhealthy and may need support or professional help. This is especially the case if it occurs independently of an obvious normal stressful event, carries on when the stressful situation has stopped, or if it is in excess of what would typically be expected from that situation.

Activity

Reflect on or, if printed, map out all the physical and psychological signs and symptoms of anxiety on the body that you are aware of to see the whole impact. For example, **physically** might be pacing around or shoulder tension. **Psychologically** it might be heightened awareness or increased emotional distress.



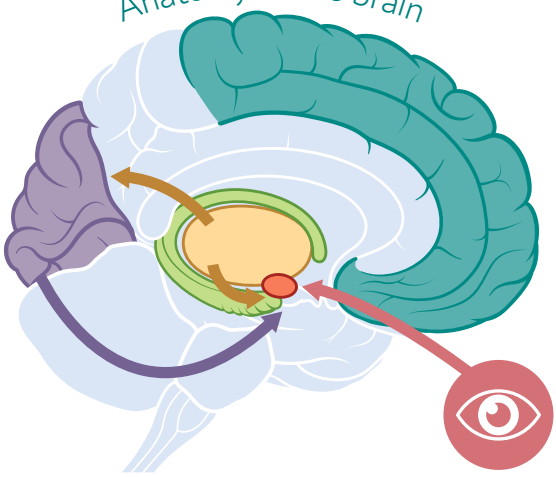
Take time to reflect on the impact anxiety can have on physical and mental health.

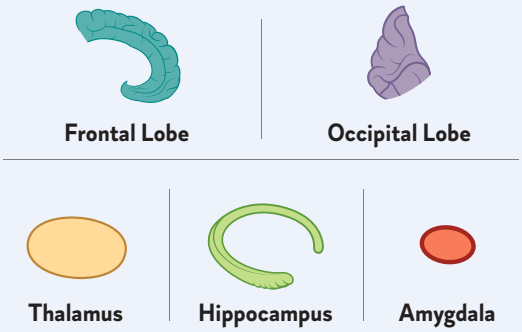
People with a diagnosis of anxiety could have had a traumatic experience in life possibly related to physical abuse, neglect, emotional instability, sexual abuse or bullying.

Amygdala Hijack (This is how our brain reacts to anxiety)

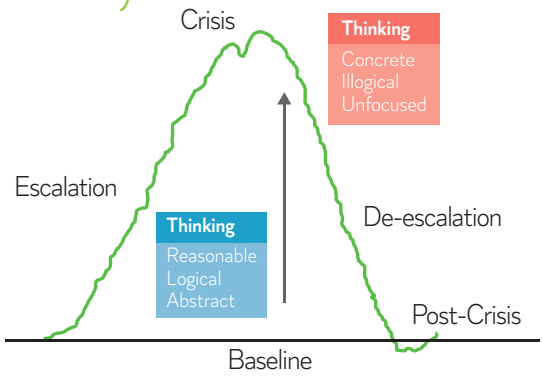
The Amygdala Hijack relates to our physiological and psychological response to a perceived or actual threat. Adrenaline rushes around our body. We experience irrational thoughts, emotions and behaviour when this "fight or flight" response in the brain is activated. We can all feel out of our comfort zone at times. Think about what might trigger this reaction for you. It might be for example presenting in public, heights or spiders. Think through what might be happening in your body. Now imagine if you had a more acute heightened persistent reaction. How debilitating would this be physically, emotionally and when it comes to day to day activities? For some people anxiety can be severe and really impact how they socialise or avoid certain phobias. The chemical reaction in our bodies described below can trigger the often irrational and unproductive fight, flight or freeze response.

Anatomy of the brain





Crisis cycle



We can all feel cross or "hangry" (combination of hungry and angry) so being aware of our individual triggers can really help reduce the frequency and intensity of this feeling. Remember, our resilience can be impacted in lots of different ways. If there is a build up of pressures or triggers there is a risk we could say or do something impulsively which we later regret. To keep a rational objective approach its important we reflect on our personal stress levels. Take notice of how stress is impacting us and how we can separate ourselves from excessive unmanageable demands to rebuild resilience and self compassion.

For more information visit:
https://youtu.be/9u3UvXqArqs

> *Talking Therapies*

The most commonly used and productive type of psychological treatment for anxiety and stress is Cognitive Behaviour Therapy (CBT) although other counselling approaches are available and may be more useful as a second line of treatment.

Quick Thought

Can you think of any conditions which may lead to or be associated with a medical call associated with heightened anxiety?

Hyperventilation Syndrome 'panic attacks' are often seen by many clinicians and volunteers. People may become uncontrollably breathless, experience chest pain, unusual sensations in their hands and face, or feel faint and weak following a real or perceived emotional stress.

The consideration of Hyperventilation Syndrome should be one of exclusion, once you are confident that there is no underlying physical reason after suitable examination or signposting and ruling out any medical cause.

Treatment

The most commonly used and productive type of psychological treatment for anxiety and stress is Cognitive Behavioural Therapy (CBT) although other counselling approaches are available and may be more useful as a second line of treatment. Another important part of recovery and resilience work can be through social support, sports, hobbies, or purposeful activities which provide distraction along with testing irrational fears in a "bite sized" way. An example of this could be avoiding leaving the house due to severe social phobia. Through a safe built-up exposure process this can be tested. It might for example be that with the right support plan even reaching the end of the gate in a front garden is a good starting point to build on. Medication can help severe anxiety but preferably on a short term basis. Some particular antidepressants can also have a positive impact on anxiety. The main two types are antidepressants from the selective serotonin reuptake inhibitors (SSRI) and serotonin-norepinephrine reuptake inhibitors (SNRI) groups. Although medication can have a positive effect on treating anxiety in some cases it is important to remember that medication often treats the symptoms but not the root problem.

This is why medication where considered clinically appropriate by the person's doctor should be seen as part of a triangulation of treatment to include counselling and social prescribing which will be covered in more detail later in this workbook.

Benzodiazepines

Benzodiazepines are types of sedating medication that can sometimes be used as a short-term treatment for severe anxiety. They can help ease the symptoms normally within 30-60 minutes of taking the medication.

Examples of these you may see prescribed are chlordiazepoxide, diazepam and lorazepam.

Although benzodiazepines can be effective short term in treating the physical symptoms of anxiety, they should not be used longer term because they can become addictive. The person should always see their GP for medication advice.

Benzodiazepines start to lose levels effectiveness after a while due to levels increased tolerance and should not be normally prescribed for more than two to four weeks. They can also lead to avoidance of root cause of anxiety if not managed carefully.

Post Traumatic Stress Disorder

Awareness of PTSD has improved over recent years. It is often triggered by exposure to traumatic

events such as a road traffic accident, violence, or warfare. Everyone is individual and many people who are exposed to a traumatic events don't go on to develop PTSD. Specific symptoms could include but are not limited to nightmares, guilt, isolation, irritability, heightened alertness, increased anxiety and flashbacks. The condition was initially recognised during World War 2, with doctors referring to "combat neurosis, combat exhaustion or battle fatigue". As well as flashbacks, people often describe an inability to fully remember some important aspects of the build up of exposure to the event. There may also be frequent symptoms of increased psychological sensitivity and a heightened sense of awareness.

Learn more

For more information regarding Post Traumatic Stress Disorder:

www.nhs.uk/conditions/post-traumatic-stress-disorder-ptsd

Treatment of PTSD should include forms of counselling or talking therapies. Preferred approaches are CBT or Eye Movement Desensitisation and Reprocessing (EMDR) in the early weeks or months after the event. There is some evidence to demonstrate the benefit of antidepressant and anxiety medication on PTSD although the National Institute for Health and Care Excellence (NICE) guidelines do not recommend medication is the first line of treatment.

> *Although medication can have a positive effect on treating anxiety in some cases it is important to remember that medication often treats the symptoms but not the root problem.*

People often can begin to recover with trusted support and having the time to process the events in a safe way. This can lead to a reduction in the frequency and intensity of the distressing symptoms. Some people may however have lasting symptoms and need to develop positive coping strategies for many years after the event.

Eating disorders

This is an overarching term for conditions such as anorexia, bulimia and binge eating. Key symptoms of eating disorders can include but are not limited to preoccupation and worrying about weight, a low body mass index (BMI), compulsion for excessive exercise to control weight and controlling what is eaten or sometimes inducing vomiting after eating. Eating disorders could affect both men and women at any age but they are most common in young women aged 13-17. There are many complex reasons why a person develops an eating disorder with self esteem and body image playing a part.

Social media and general views related to ideal weight in society can also be trigger factors. Talking therapies for eating disorders are important to empower the person to access help to reframe how they think and feel about themselves and how they believe others may perceive them. If there is a significant risk related to perceived dangerously low weight, weakness or physical health problems you should consult with the person, family, GP and any existing services around safety netting and treatment. If urgent call 111 or in an emergency call 999.

Learn more

For more information regarding eating disorders:

www.nhs.uk/conditions/Eating-disorders

Depression: Signs, symptoms and support

Typical symptoms of depression include:

- Feelings of guilt, worthlessness and hopelessness
- Lack of energy
- Lack of enjoyment of anything
- Sleep disturbance (persistently initially struggling to get to sleep or early morning waking)
- Automatic negative thinking (Pessimistic)
- Emotional and tearful
- Excessive rumination
- Ambivalence about life and possible suicidal/self harm thoughts
- Change in weight (loss or gain)
- Continuous low mood
- Irritability and intolerance
- Inability to make decisions

'I had a black dog, his name was depression'

https://youtu.be/XiCrniLQGYc

This is a helpful W.H.O. video to outline the signs and symptoms of depression, impact on functioning and solution focused approaches.

Depression

By 2030, the world health organisation project depression will become the second biggest cause of 'years lived with disability' worldwide.

In the UK, it accounts for up to 5% of GP attendances. Depression affects up to 20% of the population at some point during their lifetime.

People can have a genetic pre-disposition to depression or difficulties in early life such as bullying can contribute to self-esteem leading to depression. Depression could also be triggered or exacerbated by a recent traumatic life events such as relationship breakup, redundancy, bereavement or other factors. We all can experience grief and low mood in reaction to a loss which is a natural although uncomfortable process. It can however become more of a clinical depressive episode when it is severe and/or sustained and has a prolonged impact on sleep, mood, memory, concentration, motivation and other aspects of our normal functioning. Depression can evolve gradually over time and without noticing. Often people continue to try to cope without asking for help or even recognising they are unwell. Partners, family and friends are more likely to see changes than the individual.

There has been an increase in the diagnosis of depression over recent years. Some of the reasons for this may include changes in society, how we all connect with each other and the pressure in how we live our lives. Examples of this increased pressure may include workload, social media expectations, increased emotional awareness, financial instability, consequences of Covid, social deprivation and a reduction in local extended family contacts due to distances we live apart and changes in lifestyles.

Identifying depression

As mentioned earlier we can all feel low in mood from at times related to adjusting to difficult life events such as relationship breakdown.

> *... we can all feel low in mood from time to time related to adjusting to difficult life events such as relationship breakdown.*

For different, often complex individual reasons sometimes it is difficult to identify how some of us can really struggle to bounce back and instead descend further downwards. When the known signs and symptoms start to have a big impact on our activities of daily living (ADL's) then this may be moving towards a clinical depressive episode. Diagnosing depression can be difficult as unlike physical health we don't have a BP monitor or ECG machine to do tests.
When symptoms are mild and people are unsure whether their symptoms are simply a natural low mood they may be less likely to talk about their feelings or access help. They may also feel they are being a burden to their GP or feel embarrassed to talk about how they are feeling. Without support or treatment mild to moderate depression can become more concerning, possibly leading to suicidal thoughts and a need more enhanced professional support. A formal diagnosis of depression can only be made by a doctors assessment based on the presenting signs, symptoms and the impact on functioning.

Treatment

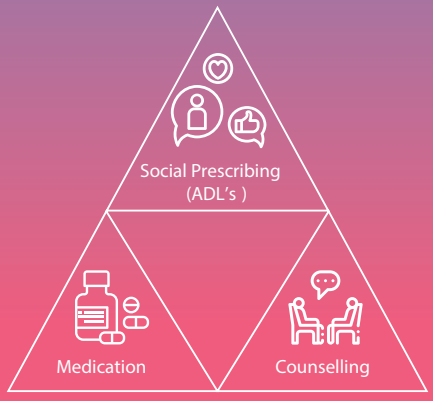
Treatment for long term or recurring depression should include psychological approaches like CBT, enhanced social support and plans to improve lifestyle/purposeful distraction activities. Suitable medication should often be part of the treatment of more severe depression. To maximise recovery it is important that the person consistently takes medication and avoids alcohol. Any gaps in treatment may have a significant impact on the effectiveness of antidepressants. Most antidepressants take 2-4 weeks to start working. The person should speak to their doctor if they don't feel a better or things have gotten worse.

Some questions you should consider when safety planning and signposting are:

1. Do you lack interest or enjoyment in doing things?
2. Have you been feeling low in mood, depressed, or hopeless in the past few weeks?
3. Have these feelings been often and intense?
4. Are there any recent events or losses which have seen a change in your mood?
5. Have you or any family/friends noticed a change in you and your outlook in life?
6. Have you been isolating yourself more lately?
7. Have you struggled with getting to sleep or wake up frequently during the night?
8. Have you noticed a lack of interest in your appearance, or have you been neglecting yourself?
9. Have you noticed a change in levels of memory, concentration, irritability or become tearful?
10. Have you thought that loved ones are better off without you or thought about suicide?

Triangulation of treatment

A combined approach to recovery and resilience that includes any or all elements



Quick Thought

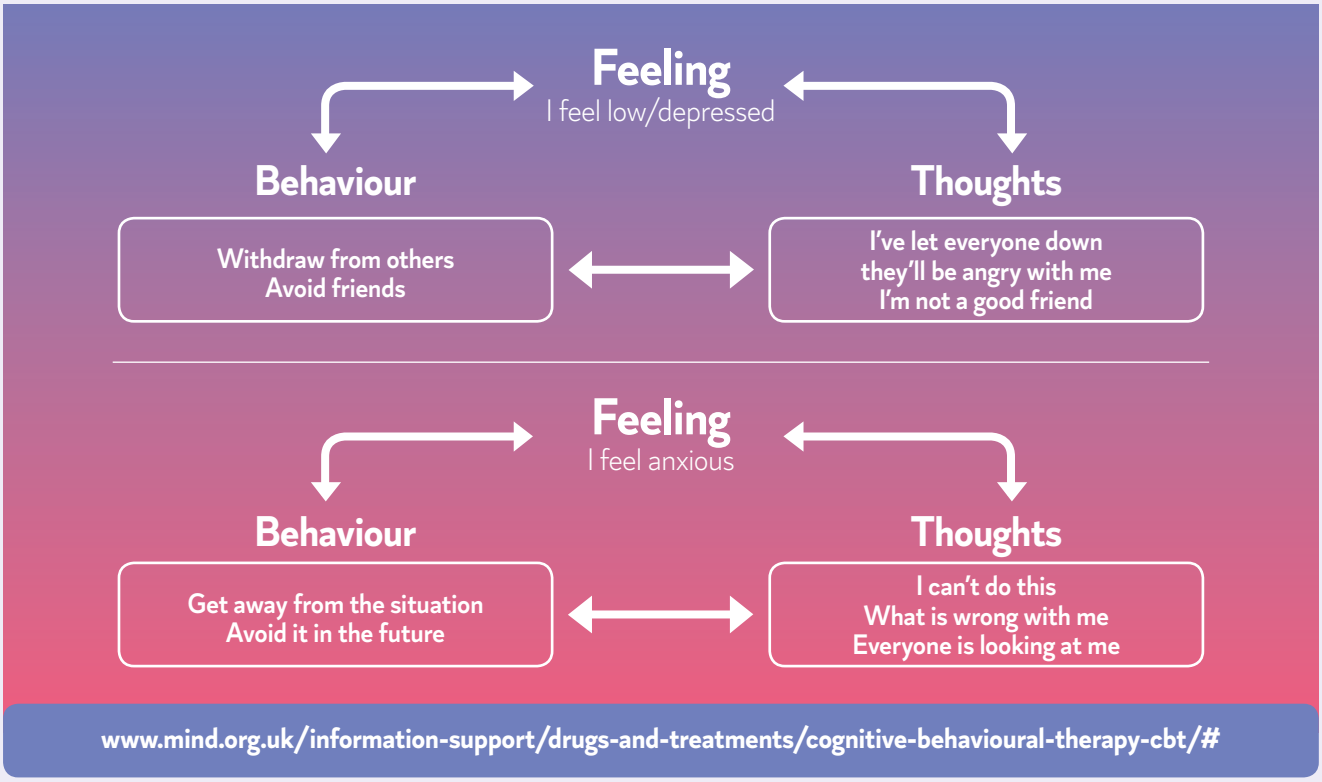
What is counselling?

It is often seen as a positive solution focused relationship where the person can be open and honest about their thoughts, feelings and behaviour. Through a structured approach counselling should be facilitated by a suitably qualified professional practitioner who is not related to, works with or emotionally connected to the person. The process should be a safe place for the person to be themselves. The counsellor should guide the person to the key thoughts that may be impacting their mood and to empower them to reframe any cyclical negative thought processes. The main preferred type of counselling in UK is Cognitive Behavioural Therapy (CBT).

What do you understand by the term CBT?

- CBT is based on the principle that thoughts and feelings directly impact our behaviour. For example in some people unhelpful thought processes can evolve to negative beliefs about themselves or others. This could then lead to adopting a pattern of behaviour that reinforces this further such as isolation and avoidance. This is summarised in the diagram below.

CBT is a talking therapy where a specially trained practitioner helps the person understand how their thoughts, feelings and behaviours interconnect to maintain the problem thinking. They work together to modify perspective of events and change behaviour leading to greater self compassion, positive solutions and acceptance.



www.mind.org.uk/information-support/drugs-and-treatments/cognitive-behavioural-therapy-cbt/#

> *Medication for depression should be consistently taken and can take up to 4 weeks to see some clinical benefits.*

Medication for depression

For more enduring or severe depression medication is effective but should very much be considered in co-production with individual choice. Empowerment on informed decision making should be progressed by their doctor. This is particularly so when exploring type of medication, suitability for the condition and balanced against any potential side effects. Medication for depression should be consistently taken and can take up to 4 weeks to see some clinical benefits. People should try to avoid alcohol and any drugs whilst on medication as these can impact efficacy. Medication should be seen as an approach to treat the symptoms of depression along with other approaches such as counselling and purposeful activities to provide distraction and build a routine. This combined approach helps understand the route causes of a depressive episode and provides the best opportunity to improve recovery.

Serotonin-specific reuptake inhibitors (SSRI'S)

These are usually preferred over other antidepressants as they cause fewer side effects. An overdose is also less likely to be serious.

Fluoxetine is probably the best known SSRI (sold under the brand name Prozac). Other SSRIs include citalopram (Cipramil), paroxetine (Seroxat) and sertraline (Lustral).

Serotonin-noradrenaline reuptake inhibitors (SNRIs)

SNRIs are similar to SSRIs. They were designed to be a more effective antidepressant than SSRIs. However, the evidence that SNRIs are more effective in treating depression is uncertain.

It seems some people respond better to SSRIs while others respond better to SNRIs.

Examples of SNRIs include duloxetine (Cymbalta and Yentreve) and venlafaxine (Efexor).

Tricyclic antidepressants (TCAs)

Tricyclic antidepressants (TCAs) are an older type of antidepressant. They are no longer usually recommended as a first-line treatment for depression because they can be more dangerous if an overdose is taken. They also cause more unpleasant side effects than SSRIs and SNRIs.

Exceptions are sometimes made in people with severe depression that fails to respond to other treatments. TCAs may also be recommended for other mental health conditions such as obsessive compulsive disorder and bipolar disorder.

Examples of TCAs include amitriptyline (Tryptizol), clomipramine (Anafranil), imipramine (Tofranil), lofepramine (Gamanil) and nortriptyline (Allegron).

Some types of TCAs, such as amitriptyline, can also be used to treat chronic nerve pain.

Monoamine oxidase inhibitors (MAOIs)

Monoamine oxidase inhibitors (MAOIs) are another older type of antidepressant with a wide range of side effects that are rarely used nowadays. They tend only to be used if other types of antidepressants are not effective and should only be taken under the supervision of a psychiatrist.

A significant drawback of MAOIs is the need to avoid certain foods and drinks, such as cheese and pickled fish, which contain a protein called tyramine. This is because consuming tyramine while taking MAOIs can cause a dangerous rise in blood pressure.

Examples of MAOIs include moclobemide (Manerix) and phenelzine (Nardil).

> *Exceptions are sometimes made in people with severe depression that fails to respond to other treatments. TCAs may also be recommended for other mental health conditions such as obsessive compulsive disorder and bipolar disorder.*

> *Individuals in a manic state can be quite vulnerable to making decisions and actions out of character that they later regret.*

Bipolar Disorder

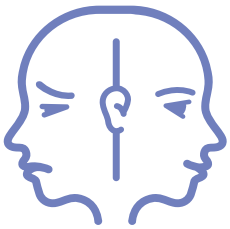
Bipolar disorder, also commonly referred to as manic depression is a condition that relates to significant fluctuations in mood. These manifest as episodes of high mood (mania) and episodes of low mood (depression). Typically people will experience an episode for several weeks. A person in a manic state can be quite vulnerable to making decisions and actions out of character that they later regret. Examples of this could include excessive spending, changing jobs or changing relationships.

> *Bipolar disorder, also commonly referred to as manic depression is a condition that relates to significant fluctuations in mood.*

Typical symptoms of each episode include:

Mania episode

- Elevated mood
- Rapid speech
- Flight of ideas (constantly changes subject)
- Delusions of grandeur (overly happy, invincible, powerful, important, 'superman')
- Excessive spending
- Not sleeping
- Irritability
- Dis-inhibition (e.g. out of character actions 'one night stands')
- No attention span
- Feeling very creative



Depressive episode

- Feelings of guilt, worthlessness and hopelessness
- Lack of energy
- Lack of enjoyment of anything
- Pessimistic
- Emotional and tearful
- Excessive rumination
- Ambivalence about life and possible suicidal/ self harm thoughts
- Change in weight (loss or gain)
- Continuous low mood
- Irritability and intolerance
- Inability to make decisions
- Irrational sleep

Treatment

The main objective in the treatment of bipolar disorder is to support mood stabilisation. This aims to balance out the highs of manic episodes and the lows of depression providing a more stable mood. Specific stabilising medication is key as part of treatment and recovery. Lithium carbonate is one of the most commonly used mood stabilising agents. It is normally well tolerated, although the side effects can be significant in some cases. These medications need close monitoring by the person's doctor and consistently taken for recovery to be sustained and effective. Some side effects include feeling faint and putting on weight. More serious side effects although rarer include lithium toxicity (severe gastrointestinal disturbance, drowsiness, co-ordination, and speech). Although less frequent this is why mood stabilising medication needs close monitoring by the person's doctor.

Other medications often used to stabilise mood in bipolar disorder are anticonvulsants, such as sodium valproate which also help to regulate mood.

If a person presents with either significant depression or profound mania they may need crisis team input or admission to a mental health hospital if considered a high risk to themselves or others. The decision to admit the person would need to be done by the existing mental health care or crisis team if known. If the person is not known to mental health services, this should be considered through a GP. If the person is deemed to be a significant risk to themselves or others and refusing support or signposting in an emergency you should call the ambulance service on 999. This could then lead to considering a mental health act assessment via a GP or Approved Mental Health professional (AMHP).

Psychosis (Schizophrenia)

Psychosis (also known as schizophrenia) is a complex mental health condition experienced by 1-2% of people. A common myth about psychosis is that is in interpreted to be a 'split personality (Eg DrJekyll and Mr Hyde) where the person possesses and responds to two alternating and competing personalities. This is a myth and over simplification. It is more of a frightening fragmentation of reality where someone can have difficulties with understanding what is real and what is not real.

Men and women are generally affected equally however men tend to develop symptoms at an earlier age, often between 19 and 27. There is clear evidence of a genetic vulnerability to psychosis. Rates are 50% in occurrence in affected children from two parents with schizophrenia. Similar increased genetic risks have been identical in twins if one develops schizophrenia. There is also an increased risk of a second sibling developing schizophrenia if one has already diagnosed.

Psychosis leads to alternate perceptions of reality. People are often described as suffering from positive and negative symptoms.

Positive symptoms include those which are there during the illness, such as delusions and hallucinations. Hallucinations are when a person hears, sees, smells or tastes something differently to others or that is not real to others. Hallucinations can be very distressing and seem very real. The most common type is auditory hallucinations where an individual's experience voices which can be very distressing and increase levels of paranoia. Imagine how it might feel if you heard voices all the time instructing you to do things that no one else could hear.

Delusions are fixed false beliefs. Typically these can be related to grandiose delusions such as "believing you are God" or "having some special powers (eg superman)" or persecutory delusions such as "being bugged, monitored or followed by security services" or that someone is out to "harm them". these symptoms can feel very real and frightening.

Negative symptoms are normal feelings or emotions which the illness takes away or can dampen down longer term. These include apathy (lack of interest), anhedonia (lack of enjoyment), social withdrawal from family and friends or cognitive delay (difficulty understanding or taking longer to respond).

Individuals who are psychotic and in crisis can (but not always) be quite agitated, impulsive, paranoid and occasionally distressed if they feel threatened or disbelieved. A psychotic episode can be triggered or worsened by an excessive use of drugs and alcohol. People with acute or intense crisis psychotic symptoms may need close careful support in the community with intensive crisis team input or inpatient admission due to impulsive risks.

Characteristics of Psychosis

- Hallucinations 'Voices'
- Paranoia
- Impulsivity
- Delusions, fixed beliefs
- Withdrawal
- Apathetic (emotionless)
- Disorganised thoughts and speech

Treatment

Medium term people experiencing psychosis are likely to have ongoing support from community based mental health teams such as early intervention services for psychosis. If the condition is longer term and more stable they may have a community psychiatric nurse (CPN) input. They are also likely to be seen at least twice a year by a consultant psychiatrist in outpatients who can medically review and adjust medications (anti-psychotics) where required. Listed below are some common medications that are used in the treatment of psychosis. It is very important that the person consistently take anti-psychotics at the correct prescribed dose as inconsistent use often results in a relapse or deterioration in the condition.

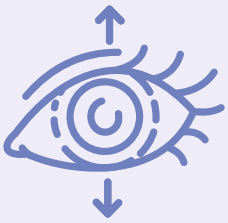
Hallucinations are when a person hears, sees, smells or tastes something differently to others or that is not real to others. Hallucinations can be very distressing and seem very real.

Modern atypical antipsychotics with less side effects:

- Amisulpride
- Aripiprazole
- Clozapine
- Olanzapine
- Quetiapine
- Risperidone
- Sulpiride

Older anti-psychotics which cause more side effects but are still used where modern ones are less effective for specific people include:

- Chlorpromazine
- Haloperidol
- Pimozide
- Trifluoperazine



Tardive Dyskinesia is a side effect caused by older less commonly used antipsychotics.

It impacts movement of the facial muscles, characterised by lip smacking, lip puckering, grimacing and excessive eye movements. It was frequently seen in the past with people who had taken high doses of older medications such as chlorpromazine for many years. It is however seen much less often now due to the development of more modern atypical antipsychotics.

Side effects

Some antipsychotic medication (mainly older less common versions) can have unfortunate side effects. These can range from mildly unpleasant through to serious or life threatening (although this is rare) such as "neutropenia". This is when you have to few white blood cells which can significantly affect fighting off infections. Milder more common side effects from modern antipsychotics include sleepiness, slower response and weight gain.

Personality Disorders

In mental health we often use terms that have a clear meaning attached to them. These can be harder to define to wider health and social care. We all know what each other mean when we talk about consciousness as an example of this. However defining what elements are necessary for consciousness to exist can become difficult to explain, unclear or confusing. Likewise is we try to define what we mean by 'personality', it can be hard to explain. We all have a unique personality, are all different and have different personality strengths and weaknesses.

In mental health, 'personality' is often described as the characteristics which influence the way in which we think, feel and behave. Although most people have established stability and emotional regulation in their norms, values and beliefs by their late teens people with a personality disorder may have established aspects in their personality which cause a high degree of emotional distress and or internal conflict. This can make it difficult for someone with a personality disorder to maintain self esteem, emotional stability and resilience to the pressures of normal life, relationships and trust. Having a personality disorder may mean people think, perceive, relate or feel differently than others do. These personality traits can lead to what others see as unusual or irrational behaviour which could be distressing or may upset people close to the person.

> *Having a personality disorder is really difficult, because, well, it's like saying that I have a defect in a part of me that I can't change. My personality is what I am, what makes me be me... How can I mend that? What the doctor is saying, is that to be 'better' then it [my personality] needs to look like what she says it should...*
> *Mental Health Service User*

Personality disorders are often but not always triggered by experiences of neglect, abuse or trauma in early developmental life.

Symptoms of personality disorder can include:

- Difficulties in forming and maintaining stable close relationships with families, friends, partners and children
- Eccentric odd or unusual behaviour
- Feelings of distress, anxiety and worthlessness
- Emotional instability and difficulties containing emotional distress
- Difficulties with trust
- History of self harm/suicidal ideation
- High expressed emotions
- Repeated self harm in adjustment to stressful situations

Try to reflect for a moment that if you experienced neglect, trauma or abuse would you find it difficult to trust people in relationships and would you understandably have unresolved anger related to the abuse? This is why its important we don't judge people and treat them with compassion, dignity and respect irrespective of how they present. Fortunately unlike many other mental health conditions, personality disorders tend to improve and people become more stable as they get older.

> *It's important to de-escalate as best as possible with a compassionate non-judgemental approach.*

Treatment

The best support you can provide for someone with a personality disorder is active listening, focusing on current solutions and encouraging hope. Formal treatment can include referral for psychological support and or psychotherapy longer term. Some medications may be helpful in reducing associated emotional distress or mood problems such as depression and anxiety in people with personality disorders.

Key reflections for your service

It can be emotionally difficult to support someone in crisis with a personality disorder.

We may often see high levels of distress and instability. People may project blame or responsibility for decision making or specific situations onto others. It's important to acknowledge distress, offer practical here and now solutions, encourage people to think differently about emotions and de-escalate as best as possible with a compassionate non-judgemental approach.

Work with the person and or any positive impacts family or friends have on what options they feel would help right now rather than longer term. Reduce or remove any audience or stimuli which are making things worse such as distressed families, friends or loud television. Ask what normally helps with distraction, reducing distress, positive options and focus on these solutions. Acknowledge the distress and provide choices and outcomes on what would help reduce levels of anguish. Empower the person to contribute to best signposting for ongoing support and encourage them to find their own solutions.

Often people with a history of self harm may have emotional difficulties with low self-esteem and self-loathing so any perception of feeling judged can be profound and trigger heightened emotional distress.

Self harm

This is an umbrella term related to deliberate self injury. Examples can include but are not limited to cutting, scratching, overdosing, hitting body parts and pulling hair. People who self harm often describe some reasons as a release for overwhelming emotional distress or a way to feel in control or a method of punishing themselves. Although referred to often in this workbook it is crucial to have a compassion, empathy and avoid perception of judgement in approach. Often people with a history of self harm may have emotional difficulties with low self-esteem and self-loathing so any perception of feeling judged can be profound and trigger heightened emotional distress. Focusing conversations on more productive coping strategies, distraction techniques, any existing safety plans, de-escalation, calmer background environments and any existing positive family or professional support can be a very positive approach. Where possible encourage people to talk openly and honestly about triggers, how they manage emotional distress and empower them to access the right help.

Medically any injury takes priority over underlying emotional factors and should be referred for treatment like any other medical condition through 111 or 999 depending on how serious the injury seems. There is sometimes a link between self harm and suicidal thoughts however this should not be assumed as each person is unique. Not all suicidal individuals have a history of self harm and self harm does not necessarily indicate suicidal intent. When considering support options and safety planning where possible and subject to consent access support from family, the persons GP and any professionals that may be involved. Consider further support and guidance through GP/111/999 for advise on decision making, confidentiality and proportionate risk management if people refuse treatment. If they are seen as a high risk they may need assessment under Mental Health Act or Mental Capacity Act. This will be depending on whether the priority of presenting risk relates to urgent medical or mental health risks. In an emergency a clinical or doctor is best placed to determine this. Urgent or emergency advise should be accessed via 111/999 depending on perceived severity of the condition.

Learn more

For more information regarding self harm:

www.nhs.uk/conditions/self-harm

Addiction and dependence: Drugs and Alcohol

Drugs

As any clinician who has worked in frontline ambulance duties will know, drug use in the UK is common, and on the increase. Up to 25% of the UK population are known to have used illicit drugs at some point in their life, and it is thought that 250,000 people use heroin on a regular basis, and 150,000 use crack cocaine. The number of people who inject drugs in the UK is falling however, at around 85,000 in latest surveys. The problem is most prevalent in urban areas, especially bigger cities such as London, Manchester and Glasgow. Many people cite drug use as a way to block out distress related to past abuse.

Alcohol

Alcohol abuse and addiction is unfortunately growing problem in the UK. The impact on health and social care systems is increasing. The wider cost to families and society is profound. Alcohol is often a contributing factor in suicides, murders, violent crimes and road traffic accidents. Rates of alcohol misuse is higher in men and in those from certain professions including health and social care settings. In society alcohol abuse is more commonly found in areas of lower social-economic backgrounds and in homeless people. In addition to the physical damage that alcohol abuse can cause, it also exacerbates the frequency and intensity of mental health symptoms such as depressive, psychosis and anxiety.

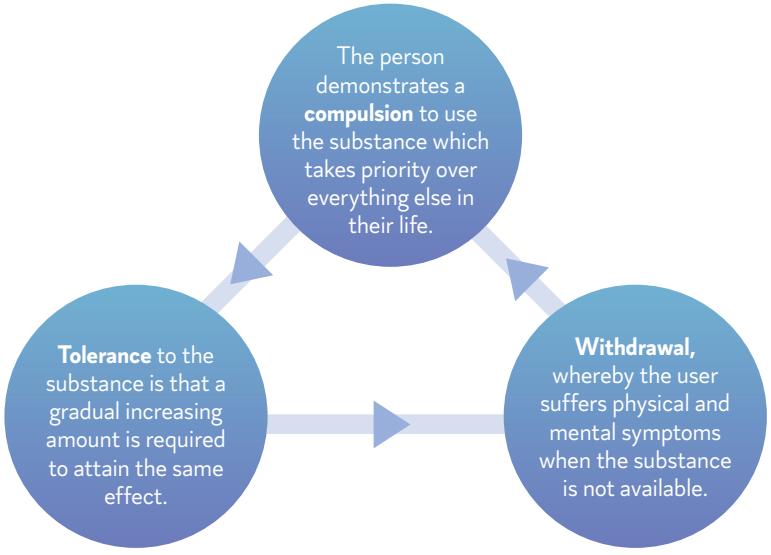
Quick Thought

Key terminology in substance misuse

Harmful use – A pattern of drug or alcohol misuse that incurs either physical or mental harm to the user. Examples include Alcoholic Liver Disease or Acute Psychosis.

Dependence syndrome

Dependence on drugs, or alcohol is characterised by a **triad of diagnostic features.**



Learn more

In 2018, there were 7,551 alcohol-related deaths in the UK. Two thirds of these deaths were amongst men.

For more information:
Statistics and discussion can be found on the Office of National Statistics Website.

Managing drug and alcohol addiction

The treatment for drug and alcohol addiction is detoxification normally through a community or inpatient plan. The person has to be ready to engage in treatment and recovery to go to rehabilitation. Consent on person engagement can be a difficult process for family and friends to accept if a person refuses treatment and is living a chaotic and or dangerous lifestyle. Prescribed medication may be available to alleviate withdrawal symptoms, manage anxiety and improve physical health but again the person needs to be motivated to engage and this needs close monitoring by healthcare professionals. Please note it can be medically very dangerous for someone who is heavily dependent on alcohol to suddenly stop all use without a detox plan. Withdrawal plans should always be done with medical advice. There are

> *... it can be medically very dangerous for someone who is heavily dependent on alcohol to suddenly stop all use without a detox plan.*

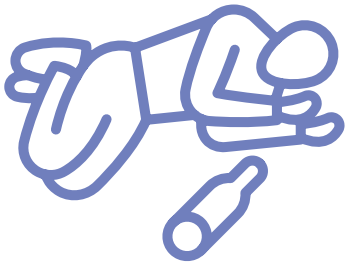
many individual and group therapy approaches to manage addiction such as alcoholics anonymous (AA) which can help service users identify the trigger for their addiction and build more suitable coping strategies for the future.

You may have generally little involvement in long term treatment of people with an addiction, and more frequently encounter people during a crisis but by demonstrating empathy and humanity in your approach you may be the conduit to that person starting a journey of recovery.

People should be referred to GP to access suitable signposting and engagement. When the person's alcohol dependence is secondary to a mental health condition and is more aligned to mental health services, it is important to establish which professionals if any are already involved in the person's care. You should encourage these to be used as a point of reference wherever possible. In some circumstances where if there is a potential high risk of harm or other medical condition it may be necessary to call 999 for clinicians to consider any medical requirements, the individual's mental capacity to consent, informed decision making and any risk management plan.

Clinical Tip: Possible alcohol misuse

> *When the person's alcohol dependence is secondary to a mental health condition and is more aligned to mental health services, it is important to establish which professionals if any are already involved in the person's care.*



It can be very hard to detect whether someone is suffering from an undiagnosed alcohol dependency, sometimes because the person may not recognise it themselves. One helpful screening tool available to ambulance clinicians is the **CAGE (Cut, Annoyed, Guilty, Eye)** mnemonic. [4]

1. Have you ever felt you should **Cut** down on your drinking?
2. Have people **Annoyed** you by criticising your drinking?
3. Have you ever felt bad or **Guilty** about your drinking?
4. Have you ever had an **Eye-opener** drink first thing in the morning to steady your nerves or get rid over a hangover?

Dementia

Dementia is an umbrella term used to describe a range of progressive conditions affecting the organ of the brain. There are over 200 subtypes of dementia, but the five most common are: Alzheimer's disease, vascular dementia, dementia with Lewy bodies, frontotemporal dementia and mixed dementia. 'Mixed dementia' is the term commonly used if a person has a combination of different types of dementia (Dementia UK, 2020).

A key step in recognising dementia is increasing public awareness that a significant decline in memory and thought process is not part of the normal process of ageing.

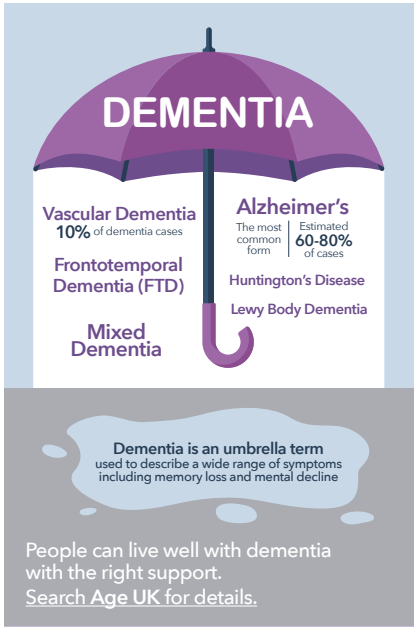
Often, the symptoms of early dementia might be considered as 'normal' in an ageing adult leading to the dementia being missed or diagnosed very late.

Diagnostic delays are often related to many factors including slow progression of condition, embarrassment about confusion at early stages and lack of public awareness (Dementia UK, 2020). Delays in diagnosis impact capacity to support and provide treatment. Dementia is irreversible so access to early support provides best prognosis.

Did you know...

... There are around 850,000 people living with dementia in the UK?

"There are over 200 subtypes of dementia..."



Dementia is an umbrella term used to describe a range of progressive conditions affecting the organ of the brain.

Reflect on the table below and where you think symptoms should fit.

Activity | Dementia or normal ageing?

Dementia	Both	Normal Ageing

Uncharacteristic agitation
Impaired judgment
Difficulty with abstract thought
Withdrawal
Isolation
Forgetting where they left the car
Forgetting some words in a sentence
Muddling words up when speaking
Mood changes

Forgetting peoples names
Forgetting where they left the car keys
Personality changes
Fluctuations in consciousness
Changes in gait and posture
Incontinence
Disinhibition
Getting confused in unfamiliar places

This activity shows how complex it is for families, people and clinicians to determine difference between normal ageing and dementia. Dementia is not inevitable or a natural part of ageing and although most common in people over 65 it also affects younger people. In excess of 42,000 people in the UK under 65 have dementia. (Alzheimers Society UK, 2020)

Often, the early symptoms of dementia are very subtle, and it may just be a feeling from the person or the family member that things are not quite right. They may describe:

+ Memory loss – especially problems with memory for recent events, such as forgetting messages, remembering routes or names
+ Asking questions repetitively
+ Increasing difficulties with tasks and activities that require organisation and planning
+ Becoming confused in unfamiliar environments
+ Difficulty finding the right words
+ Difficulty with numbers and/or handling money
+ Changes in personality and mood
+ Depression
+ Periods of being alert or drowsy, or fluctuating levels of confusion
+ Visual hallucinations
+ Becoming slower than expected in their physical movements
+ Becoming less sensitive to other people's emotions, perhaps making them seem cold and unfeeling
+ Loss of some of inhibitions, leading to behaviour that is out of character, such as making tactless or inappropriate comments

> *Remember, people can live well with dementia often in there own homes. With early diagnosis, support, treatment and care plans the progress of illness can be delayed.*

Flow chart types of dementia

Once a diagnosis is obtained, the clusters of symptoms a person may experience as their dementia progresses can often be predicted. As an example, people with frontotemporal dementia also have language problems and behavioural problems. This is because the frontal lobes part of the brain affected accounts for speech and behaviour. They may not speak clearly, in shorter sentences and may seem blunt or rude.

People with a vascular dementia may have multiple small infarcts which are caused by small blockages in blood vessels in the brain impacting. This means they can experience symptoms sometimes seen in Transient Ischaemic Attacks, such as confusion, dysphasia (difficulty understanding and expressing words) and unusual sensations. Their decline is often described as 'stepwise', as they never quite regain the function they had after each small infarct. Other people with vascular dementia may experience little bleeds in their brain caused by small vessel disease, which leads to localised damage throughout the brain.

People with Alzheimer's Disease often have lapses in short term memory, especially early in the disease, as the protein plaques characteristic of the condition attack the hippocampus initially. This can lead to difficulties in day-to-day function where short term memory is vital, such as shopping, managing administrative affairs and other

> *As dementia progresses, it's common for people to have increasing difficulty speaking and they may eventually lose the ability to speak altogether.*

tasks. As dementia progresses, memory loss and difficulties with communication often become very severe. In the later stages, the person is likely to neglect their own health and require constant care.

People with advanced dementia struggle to recognise close family and friends, or remember where they live or even know where they are. They may find it difficult to process simple pieces of information, carry out basic tasks or follow instructions.

> *Researchers all over the world are looking for ways to prevent and treat dementia. Meanwhile, the provision of person centred care can help individuals to live well with dementia.*

As dementia worsens, people often have increasing difficulty speaking and they may eventually lose the ability to speak altogether.

It's crucial to continue to communicate by any means with people with advanced dementia and to recognise and use other, non-verbal means of communication. This should include body language, gestures, facial expression and, when appropriate, touch.

Bladder incontinence in the later stages of dementia is common and some people may also experience bowel incontinence. They may be at risk of self-neglect and require increasing support with their activities of daily living.

Historically, support for dementia very much focused on helping family with managing behaviour that was seen as challenging, and providing support to the person, especially through optimising their physical health. Whilst supporting the person and their loved ones still remains important, the biggest recent advancement in dementia care has been medication research including the development of Acetylcholinesterase Inhibitors (donepezil, galantamine and rivastigmine) for mild to moderate Alzheimer's disease (and certain other types of dementia). Although these medications cannot reverse the changes associated with the diseases, they can ease symptoms and slow down the progression of the dementia for a while for some people, enabling them and their families to have a greater quality of life for a longer period.

Unfortunately there is currently no cure for dementia. Researchers all over the world are looking for ways to prevent and treat dementia. Meanwhile, the provision of person centred care can help individuals to live well with dementia.

A person with dementia may have a 'This is me' or 'Knowing me' document where you can find out more about their individual needs and preferences. These documents are the property of the person with dementia and should travel with them if they are taken to hospital or into care.

Key reflections

Unlike functional mental health problems (such as anxiety and depression) dementia is caused by traumatic injury or degeneration of the organ of the brain rather than cognitive functioning.
All types of dementia are sadly progressive and regressive, meaning that the condition gets worse over time and that people typically regress to earlier memories sometimes not recognising people close to them. Dementia can significantly impact the person and those around them.
Both the person and their loved ones may need support to live well with dementia.

From an initial first contact perspective, it is important to focus on the here and now and engage with the person in a compassionate, solution focused and pragmatic way. Unfamiliar situations can be distressing for people with dementia so using the person's preferred name, explaining who you are and what is happening, and then repeating this information as often as required, may be helpful. It is important to involve the person and their carers as much as possible to find solutions that meet their individual needs.

Case study 02

You visit Mable who is a 90 year old widow living alone.
You are aware Mable has moderate dementia and some physical health problems.

She seems confused and anxious. The house looks untidy and neglected. Mable is asking where her husband George is. You know previously from Mable's daughter that George sadly died 4 years earlier. Rather than reminding Mable of this and adding to levels of distress you redirect the conversation. You provide a warm drink, take time to listen attentively, offer help covering any opportunities to de-escalate and reduce levels of distress through distraction, focus on Mable's interests, or any known care plan. You can see Mable is vulnerable and are unsure if she has capacity to consent.
In this scenario it would be helpful to contact any family, friends, or any care coordinator where appropriate. Depending on your role and visit you should carry out any necessary tasks, tests, or clinical assessment to keep Mable safe and reduce risk of harm.
If concerned you discuss with the care coordinator, social services GP or in an emergency contact 999. If there is a care plan or safety plan or advance directive, you follow this.

Please remember that every condition and situation if different. Any care or support provided should be decision specific and scenario based. Any intervention should be proportionate to the presenting risks. This should always include any choices and preferred wishes of Mable even if confused so that Mable's rights and wishes are safeguarded balanced against any presenting risks. Think about the risks to Mable and balancing against the least restrictive options in providing care.

Below are some prompts to support decision making, inclusion and best interest.

- Is there a concern around vulnerability, any medical needs and Mable's capacity to consent?
- Do you need to consider a capacity assessment or refer to a clinician or GP who can?
- If Mable lacks capacity what would be the least restrictive option and what is in Mable's best interest?
- Are there any follow up referrals to safeguarding required, other signposting or other thoughts when reflecting on this scenario?

Remember

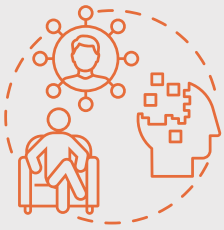
With the right care and support plans in place, people can live well in their own home or the least restrictive environment with dementia.

Further Reading

In addition to the information in this guide, you may find the link below helpful if you wish to learn more about the various types of dementia (Link to Alzheimer's Society 'Key publications about dementia').

www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=2578

Initial support of someone with a mental illness



Your approach to supporting someone with any mental health problem should not really be any different to an approach to helping someone with a medical problem.

It is effectively about developing a therapeutic compassionate relationship. Importantly having a non-judgemental approach and attentive listening can facilitate this through good communication and open-ended questions. This approach allows for an opportunity to understand all the factors and events leading up to the crisis and will help shape empowering the person on positive outcomes or ways to inspire hope.

We don't have to be experts in mental health to be able to have a compassionate conversation and connect with someone in distress. We also don't need to know all the detailed history of the persons background or detailed diagnostic history. Additionally asking this level of detail may well add to levels of distress. The key to focus on is a "here and now" approach. Think about what's happened today and what can we do to support, signpost or reduce distress. We can't change the past, but we can provide hope for accessing support and a brighter future. Understanding the current levels of challenges, concerns, any existing support, available care plans and directly asking about how safe they feel will help identify how to signpost to most suitable follow up support. As well as relevant professional support this could include areas around social prescribing, purposeful activities, distraction techniques or ways of resolving loneliness to empower the person in distress. These are discussed in detail through this workbook.

Open ended questions provide the opportunity for the person to tell their story and relieve some of their anxieties. These are questions that are less likely to be answered with "yes or no" and provide a platform for good engagement. Some examples include "how did that make you feel", "what's happened recently which has triggered your distress" or "what normally helps with upsetting thoughts"?

To build a good rapport its important to demonstrate empathy, kindness, integrity and compassion. Non verbal skills such as eye contact, seating position and facial expressions also provide the opportunity and space to build trust. Consider the environment and reduce any excessive levels of background noise. It may also be best to talk to the person alone if there are friends or relatives who are adding to the distress or the person doesn't feel they can talk openly when they are present.

This allows the best opportunity to expand areas of discussion providing the person time to explore their thoughts and emotions with confidence. Ensure that the person is involved in decision making and choices which may help with the situation and inspiring hope.

Key Reflections:

Next time you support someone, try opening the discussion with a broad open question, such as:

"Can you tell me what's happened today?"

It's really important to develop a therapeutic rapport.

Compassion, warmth, empathy and full attention can help de-escalate any distress or escalating situations. Focus on a low stimulus environment where you can discuss the situation. Where possible and appropriate with the individual, remove or distract any emotive or distressed audience or excessive stimulus/distraction such as loud music or television. Include choices and outcomes and empower where possible the person to make informed decisions around what would help right now.

“ How to De-escalate an Escalating Situation ”

It takes time, practice and effort to become confident and capable at communicating with distressed individuals, but in general, as compassionate people, we tend to be motivated to achieving this.

Managing agitation and distress in people with a mental illness

One of the most anxiety provoking scenarios for us all is an agitated and distressed person. Remember as we have already described, there is no reason to believe that this behaviour is any more likely to be encountered in people with a mental illness than from people with a physical ailment. Nonetheless, scenarios do occur where we need to try to support an agitated or distressed individual. There are many approaches that may be used. In their book ‘ABC of Mental Health’, Davies and Craig (1997) dedicate an entire chapter to this subject. We have summarised and adapted their approach in the following paragraphs, as it provides an excellent point for reference for any clinician, no matter where they typically practice.

There may be situations where the person is too agitated for safe approach. You should not place yourself at any risk of injury from any threatening or aggressive person either relating to a physical or mental health condition or co-morbidity with drug and alcohol addictions. If they require support or treatment and you deem it unsafe to approach, then request police or security assistance where necessary.

Distressing scenarios can be managed and de-escalated with an active listening, engaging and inclusive approach. Being aware of conflict resolution skills, triggers, scene safety and dynamic risk assessment helps. Non-verbal skills such as posture, facial expressions, emotions, pitch, tone, volume, paraphrasing provide the best opportunity to de-escalate. It takes time, practice and effort to become confident and capable at communicating with distressed people, but in general, as compassionate people, we tend to be motivated to achieving this.

Clinical tip:

Often reasons why people become agitated are related to fear, frustration and a sense of losing control. Most people develop coping strategies to deal with stress provoking situations. However, some people have less effective coping strategies and a low threshold for emotional distress so easily become anxious and overwhelmed. In these scenarios, the person’s behaviour can quickly become agitated. You may be able to help put themselves back in control, de-escalate, inspire hope, provide realistic solutions, positive options or reassure them that you are there to help.

Distress and De-escalation

By acknowledging the distress and engaging in a calm and compassionate way this provides positive choices and outcomes giving you the best opportunity to de-escalate an escalating situation.

Recognising distress

Most people in the health, social care or voluntary sector can quickly recognise distress. Its key to ensure we don't respond to distress in a way that could increase distress. If someone is anxious and upset they may direct this initially at you in your role. Its important to not take this personally by calmly discussing boundaries and limit setting to prevent escalation where possible.

By remaining calm, focused and engaged, you can demonstrate to the person that this is the type of behaviour that you would like to observe from them.

Reflecting distress

Acknowledging and reflecting back distress shows that you empathise with the person, and are prepared to co-operate with them to help find a solution. You should reflect back their high levels of expressed emotions in a more balanced and less emotional manner. Perhaps in response to the statement "you don't care, you don't want to help me", you might reflect back the statement "I am sorry that you feel that way" and "what can we do now to help improve the current situation".

Modelling appropriate behaviour (Behaviour Breeds Behaviour)

By showing courtesy, dignity and respect we are more likely to receive the same values back. People often begin to mirror each others terms, gestures or actions in conversations which helps develop meaningful connection and understanding. By remaining calm, focused and engaged, you can show the person that this is the type of behaviour that you would like to observe from them. Escalating your tone, or using confrontational body language can mirror the same outcomes back at you from the person in crisis.

Agreeing goals

This is best done in a co-operative and mutually agreeable way. Work together to ensure that safety plans and goals can be achieved. It might be that you feel the person needs a referral to a particular service, but you need to agree how and when they attend this meeting so that they feel empowered and included in the decisions. The severity of the illness may indicate the degree of informed agreement or their mental capacity to consent but the persons expressed wishes should always be prioritised where safe to do so.

Key reflections

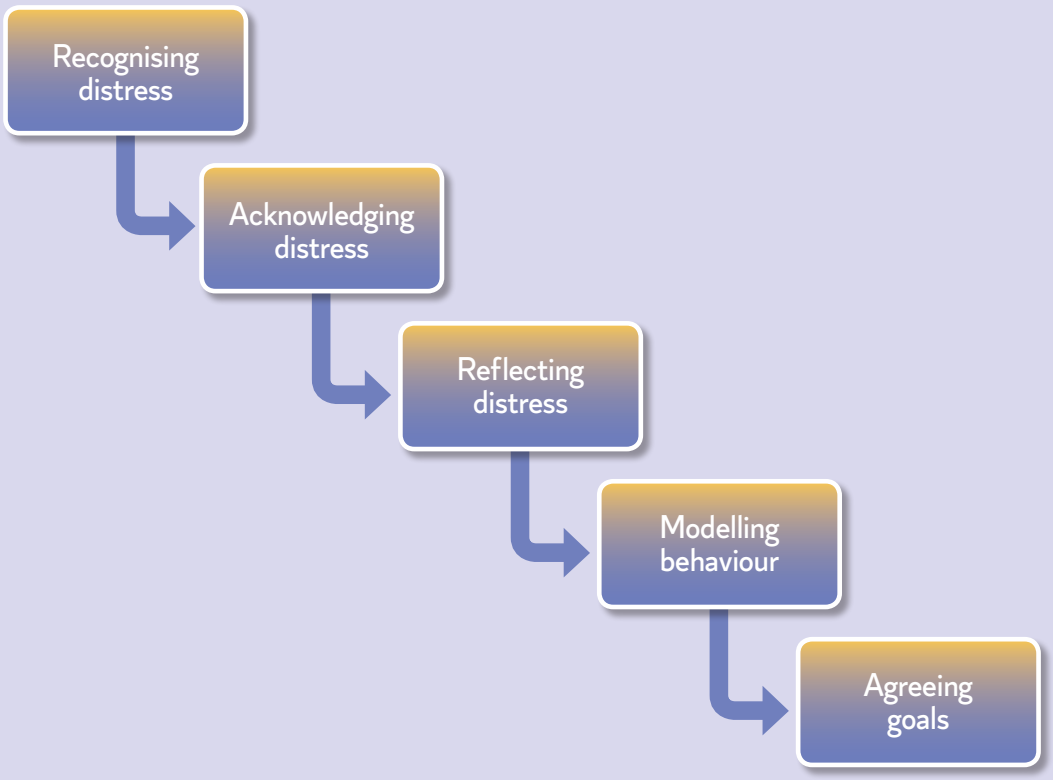
Try to imagine being in the distressed persons shoes. They may be in pain, anxious, had a long delay, had previous bad experiences be overwhelmed by many factors. They may be influenced by an audience or distressed relative, feel hopeless, helpless and feel that nobody cares. Remember distress and anger are short lived emotions. By acknowledging the distress and engaging in a calm and compassionate way this provides positive choices and outcomes. It gives you the best opportunity to de-escalate an escalating situation. Having a non-judgemental approach and listening attentively helps the person feel their concerns may be valid and justified.

Reflection

The principles in these de-escalation skills are equally applicable to mental health and other groups of people who may be agitated, challenging or distressed. This could include reasons related to specific conditions such a learning disabilities or autism. They can also apply in situations where people are in physical pain or family conflict. These skills are helpful in our personal lives too as we can all feel irritable and irrational when stressed.
A scenario where we may be tired, stressed, overwhelmed, worried might affect our objectivity. A good reflection relates to road rage which we often see where people beep horns as gestures of anger made in traffic congestion. Reflect back to the anxiety chapter and crisis cycle (see page 16-17).

Transport for London: Share the Road, M&C Saatchi London

Click link below
www.youtube.com/watch?v=ObTkJpVJgs8



Managing agitation and distress

Case study 03

As a social worker, you are called to visit Dave, a 28 year old man, by his best friend, as she has been worried about his social contacts and mental health.

When you get to the housing block, Dave's friend is at the front door and tells you that his flat is on the 9th floor, and she will show you the way. In the lift, she tells you some recent events that have concerned her.

Dave finished college with great results, took some gap years and is now studying engineering at university. He is in his second year now, and has a large group of friends that he made on the course during his first year. He has recently become very withdrawn and isolating himself. At first, everyone thought this was because his father was unwell, and he was worried about him. He has started to skip lectures, and rarely attends social events any more. On the odd occasion that he has gone out, he has left early, after appearing uncomfortable in the presence of a large group.

Over the weekend, he has spent all the time in his room. There has been some unusual shouting, but his friends thought this was an argument Dave was having over the phone with his brother.

Tonight however, Dave has been pacing the corridor outside of his room. He refuses to go back inside his room as he says it has been remotely bugged by the CIA. He is distressed and appears very distracted.

Upon entering the flat, it appears tidy and clean. Dave is sat on the floor at the end of the corridor, wearing jogging pants and a T-shirt. When you speak to him, he answers quietly and in short sentences. He appears confused, sometimes looking up to the left as if responding to something or somebody else's voice. He doesn't give much away about how he is feeling, but he does admit that he is frightened.

Activity | Planning your approach

Clearly Dave is unwell, and needs further assessment. However, there are no medical features to his condition, and therefore it is appropriate to spend some time with him, getting a better understanding of what he is experiencing, and developing an early therapeutic relationship.

1. What might you ask Dave in the next 10 minutes? Is there anything in particular that you think would be particularly important?
2. Using the reflective process below, begin to think about your impression of Dave's needs. Whilst you may not know all the information at this point, jot down what you think you might find out with more detailed conversations to ask or cross reference. Think about views of family, friends or healthcare professionals where available and appropriate to contact.
3. Think about how you might signpost for help and what information you would share to a GP, crisis team or ambulance service if deemed emergency.
4. What could you do if Dave does not want help and you feel he may be a high risk to himself or others? Would this be a point to involve emergency services and communicate concerns?

(Scenarios and decision making around duty of care and rights of people are covered later in the guide.)

Appearance

Thoughts

Speech

Perception

Mood and affect

Orientation

Case study 04

You visit your 65 year old friend Carol following a GP call at Carols husbands request. Carol is previously well known to you and you have a very close friendship. Upon arrival, the GP and a social worker are outside the house, and there are a number of police vehicles in the street which you are surprised to see.

The GP tells you that Carol appears to be experiencing a mental health crisis. You know Carol has a diagnosis of bi-polar. Given the current presentation a mental health act has been carried out and Carol has been detained under Section 2 of the mental health act. This means she will be taken to a mental health hospital for assessment and treatment due to a risk to herself and/or others. Carol's husband has made the call this evening, as he has found Carol becoming increasingly chaotic as the day has progressed and has not been sleeping for a number of days. She awoke early yesterday morning, and has hardly slept since. She is easily distracted and irritable but responds well to seeing you. She has cleaned the house from top to bottom, spent much of the evening in the garden, hoovering the grass and tending to her plants. When asked to stop Carol shouted at her husband and continued despite it being late at night.

Once Carol eventually had come inside, she has been agitated, ranting and raving at her husband in an almost incoherent manner leading to emergency service involvement. She shows you a number of recent bank statements that demonstrate very excessive spending over the last few weeks on irrational items. You suspect the total may be in the thousands of pounds.

You approach Carol in an attempt to explain yourself and gauge whether she will be safe to travel with you in the ambulance, unaccompanied by the police. Given your rapport you talk to Carol and introduce her to the ambulance crew. Although distressed and confused Carol knows she needs help and agrees to go in the ambulance if you will come
along for emotional support. You notice that she is wearing an unusual combination of clothing, including a large sun hat and bright green trousers.

En route to hospital, Carol is much less distressed with your support but continues to incoherently rant. Her train of thought appears to be very muddled, and you struggle to follow her conversation. She seems to change from distressed and offended, to laughing and jovial within a matter of minutes.

By remaining calm, focused and engaged, you can demonstrate to Carol that this is the type of response that you would like to observe from them.

Activity | Thinking about the scenario

1. Carol is demonstrating a number of signs and symptoms typical of a bi-polar episode. On the face of the information provided by all present, what are your top priorities in supporting Carol?
2. Are you aware of any medical conditions based on your role that you can think of that might lead to someone presenting like Carol?
3. If you were to plan Carol's care in the hospital for the next 7 days, what considerations would you make? (Don't worry about making a formal management plan, but think more broadly about what issues the doctors and mental health nurses might need to cover).

Think about Carol's:

- Safety
- Dignity
- Treatment
- Human rights
- Physical checks
- Mental wellbeing
- Compassionate care

Learning Disability

There are 1.5 million people with a learning disability in the UK. People with learning disabilities may be more vulnerable and should always be treated with compassion, dignity and respect by all in society. They should expect the same high quality care, support, treatment, outcomes and choices as non-disabled peers.

What Is a Learning Disability?

A learning disability is very individual and will be different for everyone. Someone with a learning disability has a reduced intellectual processing ability and due to this they have difficulty with everyday activities or expressing their needs. They may have problems managing household tasks, budgeting, socialising or managing their own health.
A learning disability is LIFELONG.

People with a learning disability might take longer to learn and need extra help and support to develop new skills. With the right support, many people with a learning disability can lead independent lives. The level of support someone needs depends on their individual needs and care plan. For example, someone with a mild learning disability may only need support with things like getting a job or managing finances. However, someone with a severe or profound learning disability may require full-time care and support with every aspect of their life – they may also have physical health problems.

There are different types of learning disability which can range from being mild, moderate or severe. Learning disabilities are lifelong. The person may have difficulties such as:

- Mobility issues and/or physical disability
- Challenges managing their own personal care
- Communication and engagement difficulties
- Managing their own personal safety
- Difficulty making own decisions/ problem solving

What causes a Learning Disability?

Several things can cause a learning disability. A learning disability occurs when the brain is still developing and can be caused by many different factors either before, during or after birth.

- Before birth things can happen to the central nervous system (the brain and spinal cord) that can cause a learning disability. A child could be born with a learning disability if the mother has an accident or illness while she is pregnant, or if the unborn baby develops specific genes. Genes are chemicals in our bodies that contain information about us, like how we look.
- A person can be born with a learning disability if he or she does not get enough oxygen during childbirth, has trauma to the head, or is born too early.
- After birth, a learning disability can be caused by early childhood illnesses, accidents and seizures up to the age of 18 years.

What gets confused for a Learning Disability?

+ **Autism** – Like a learning disability, autism is a lifelong condition. It has 3 features which might affect the way a person:
  1. Interacts with others in a social situation
  2. Is able to communicate with others
  2. Thinks about and how they deal with social situations.

  Autism is NOT a learning disability but around half of the people with autism also have a diagnosed learning disability.
+ **Asperger's** – This is a form of autism which often affects the way a person relates to others and communicates. People with Asperger's syndrome may experience anxiety, or a specific learning difficulty such as dyslexia. People with Asperger's have an average or above average intelligence therefore have no learning disability.

Specific mild learning difficulties

A learning difficulty unlike a learning disability often relates to specific areas of support required to realise potential. This tends to have less an impact on overall functioning such as:

+ **Dyslexia** – A problem with written language
+ **Dyscalculia** – A problem with numbers
+ **Dysgraphia** – Unable to write
+ **Dyspraxia** – Difficulty in co-ordinating movement

Learning Disability deaths

People with learning disabilities die at a younger age than the general population. On average, the disparity between the age at death for people with learning disabilities (age 4 years and over) and the general population (all ages) in 2019 was 22 years for males and 27 years for females. There is a reduction of one year in the disparity between the age at death of men with learning disabilities compared with men in the general population (LEDER 2019).

There have been reports by the Mencap charity such as "death by indifference" and 74 deaths and counting, that explain the reason for some deaths are due to inadequate care.

> *Every person is an individual and their needs will be different. It's important to check what works best for the person.*

In June 2015, the learning disabilities mortality review programme (LEDER) was formed. The aim of the programme is to make improvements to the lives of people with learning disabilities. It clarifies any potentially changeable factors associated with a person's death, and works to ensure that these are not repeated elsewhere.

A number of barriers can stop people with a learning disability from getting good healthcare which can lead to poor outcomes. These barriers include:

- A lack of accessible transport links
- The person not being identified as having a learning disability
- Staff having little understanding about learning disability
- Failure to recognise that a person with a learning disability is unwell
- Failure to make a correct diagnosis
- Anxiety or a lack of confidence in people with a learning disability
- Lack of joint working from different care providers
- Not enough involvement allowed from carers
- Inadequate aftercare or follow-up care

(Heslop et al. 2013; Tuffrey-Wijnes et al. 2013; Allerton and Emerson 2012).

Communication

People with learning disabilities often have challenges with communicating their needs. Every person is an individual and their needs will be different. It's important to clarify what works best for the person.

Try to imagine:

- Not being able to read this
- Not being able to tell someone else about it
- Not being able to find the words you wanted to say
- Opening your mouth and no sound coming out
- Words coming out jumbled up
- Not getting the sounds right
- Words getting stuck, someone jumping in, saying words for you
- People assuming what you want, without checking with you
- Not hearing the questions
- Not being able to see, or not being able to understand the signs and symbols around you
- Not understanding the words, phrases or expressions
- Not being able to write down your ideas
- Being unable to join a conversation
- People ignoring what you're trying to say, feeling embarrassed and moving away
- People not waiting long enough for you to respond in some way, assuming you have nothing to say and moving away.

(Mencap 2018)

> *Several things can cause a learning disability. A learning disability occurs when the brain is still developing before, during or soon after birth.*

People with a learning disability may take longer to learn and need help and support to develop new skills. With the right support people with a learning disability can lead independent lives.

Tips for good communication

- Find a good place to talk without distractions
- Ask open questions
- Check the person understands with appropriate paraphrasing. e.g. 'you felt sick, is that right?'
- If a person wants to take you to show you something go with them
- Pay attention to non-verbal communication such as body language, gestures and facial expression
- Take time and don't rush things
- Use everyday language at every opportunity
- Look for support from carer/ family who know and understand the individual communication needs

Mental Capacity Act

The Mental Capacity Act is a key legislation for people with learning disabilities. It protects an individual's right to make their own choices and gives others the duty to make decisions if the person isn't able to. The Act is discussed in more detail later in the book and in reference guides available.

What are reasonable adjustments?

Reasonable adjustments are a legal duty under the equality duty act and must be made by health services to help people with learning disabilities access services. Reasonable adjustments ensure a person with a learning disability gets as good a service as everyone else. The adjustments should be individual for the person needing the support.

Some examples of reasonable adjustments are:

- Easy-to-read information
- Allocated more time for appointments
- Using everyday communication
- Reading and acting on information given in communication passports/ Hospital traffic light assessments/care plans

Did you know...

Every person is an individual and their needs will be different, its important to check what works best for the person.

Autism

What Is autism?

Autism is a lifelong neuro-developmental condition. It is not a disability or an impairment but a difference in brain configuration resulting in a different way that information is cognitively processed.

Autism is one example of what we understand to be a hidden form of natural human variation, neurodiversity. Neurodiversity is a viewpoint that brain differences are normal and to be expected, rather than deficits. This concept can help reduce stigma around learning and thinking differences. Most people are described as neurologically typical (or neurotypical), meaning that their brains function and process information in the way 'society expects'.

Neurodivergence is a relatively new term that includes autism, attention deficit disorder, dyslexia, dyspraxia and other neurological conditions. These are 'spectrum' conditions, with a wide range of characteristics, which share some common features in terms of how people learn and process information.

This results in neurodivergent individuals having different experiences of the world around them and interacting with the world in a different way. This difference brings strengths and challenges for our neurodivergent population.

Latest research indicates a very strong genetic link

Whilst there are a lot of unsupported claims about cause, autism is not the result of MMR vaccination, diet, vitamin deficiency, pollution, or childhood upbringing.

1-2 % of the UK population are known to be autistic

NHS Digital:
digital.nhs.uk/data-and-information/publications/statistical/autism-statistics/q1-april-to-june-2020-21/data-quality-copy

This is likely to be an underestimate due to difficulties in obtaining diagnosis for autism and many autistic people successfully living with autism that will not feel the need to pursue a diagnosis.

Autism – Differences in Cognitive Processing

There are key differences in the way that an autistic brain processes information:

Sensory

Our world is full of constant sensory information being received to our brain; in non-autistic brains, most of this information is filtered out.

In autism, we see this filtering as not working in the same way. Autistic people can receive too much sensory information (hyper-sensitivity) or too little sensory information (hyposensitivity). This key difference results in very different experiences of the world and places additional demands on cognitive processing capacity. At times this can be extremely distracting for the person and can lead to periods of feeling completely overwhelmed by the amount of information being processed.

Monotropism

This term describes an information processing style in which singular parts of information are viewed and processed individually, the various pieces are then connected to form the bigger picture.

This varies greatly from a non-autistic or 'neurotypical' processing style in which all the information is processed simultaneously to instantly create the big picture (polytropism), although detail is often missed. Neither style is dysfunctional or impaired, they are just different ways of looking at the same information – one in detail, the other in broad detail.

Monotropism helps us to understand some key differences seen in autistic people:

+ **Strong attention to detail –** Autistic people have an enhanced ability to spot patterns and omissions within complex data (the Israeli army employ autistic people to review military satellite images).

+ **Literal use of social language –** Autistic people tend to interpret the exact, literal meaning of words or phrases. Our social world can be confusing for autistic people as we often say what we do not explicitly mean and frequently use idioms and metaphors which if taken at face value become confusing. (Pull your socks up is an example of a common phrase that can be interpreted differently).

+ **Executive functioning –** The cognitive processes that support us to achieve our goals and manage our complex lives. Planning, sequencing, prioritising and organising can be challenging for autistic people as multiple simultaneous cognitive processes are required in these areas.

Autism Defined as Neurodiversity

This is the positive description of autism which is becoming more widely used:

"A relatively common neurodevelopmental condition, usually associated with normal IQ range, that represents a form of natural variation bringing both strengths and challenges"

Mandy 2019

A world with neurodiversity brings additional talents that are essential for the development of humankind. Google search famous autistic people and you will see the profound contributions made.

Autism Diagnosis

These key differences in cognitive processing explain the outward presentation we see in autistic people. It is the outward differences that lead to diagnosis being made by suitably trained and qualified professionals. Differences in social communication and interaction, repetitive behaviours and strong interests in the context of developmental history provide the diagnosis of autism.

More males than females are currently diagnosed with autism. Autism in females presents differently and can be more subtle. Current assessments are based on a male autistic presentation. This explains the under diagnosis of autism in females.

Signs of autism in adults

Not all autistic people are the same, in the same way not all neurotypical or non-autistic people are the same.

Some of the common signs of autism that may be present in some autistic adults include:

+ Difficulty understanding what others are thinking or feeling
+ Becoming anxious about social situations
+ Difficulty making and maintaining friendships
+ Seeming blunt, rude or disinterested in others without meaning to, this can include not giving eye contact
+ Finding it difficult to communicate your emotions
+ Taking things very literally – for example, may not understand sarcasm or phrases like "break a leg"
+ Having the same routine every day and getting very anxious if it changes
+ Liking to plan events carefully before they happen

Learn more

Signs of autism in adults - NHS

www.nhs.uk

Challenges for autistic (and other neurodiverse) people

Autism (and neurodiveristy) is not a problem, it is another form of naturally occurring biodiversity, like ethnicity, sexuality, and left handedness. However, research tells us that autistic people have poorer health outcomes. They have been found to have an overall risk of early mortality of more than twice that of the general population for virtually every cause of death, both physical and mental health related and are nine times more likely to die by suicide. The challenge for autistic individuals is that our world is currently set up for one type of cognitive / typical functioning. It is very much like being an Apple Mac laptop in a world of Microsoft where your laptop is expected to work well on Microsoft software. The difference in functioning and needs are not accommodated.

The sensory world is a big challenge, imagine being badly affected by certain types of lighting and certain types of sounds that can cause you

> *Autism (and neurodiveristy) is not a problem, it is another form of naturally occurring biodiversity, like ethnicity, sexuality, and left handedness.*

acute distress, yet these sensory challenges are forever present as no-one else is affected by them.

Autistic people can prefer routines and predictability, knowing what is happening next is reassuring and decreases anxiety yet we live in a highly unpredictable and unstructured world.

Communication, if not clear, concise and unambiguous can become misleading and confusing.

These are challenges we have probably all faced at some point but for neurodiverse individuals, these are daily, constant challenges that become tiring and exhausting.

Supporting autistic person in crisis

When overwhelmed by the sensory and social world around them and the complex demands of everyday living, autistic people can experience extreme psychological distress leading to the person experiencing meltdown or shut down. These are extreme fight, flight or freeze responses described under the **amygdala hijack section of this workbook (pg 17).**

+ Autistic people may wear **a sunflower lanyard,** this is informing you of a hidden form of diversity.

+ Consider the sensory environment, the person may be experiencing **sensory overload.**

+ If someone is in meltdown or shut down, they will benefit from being **supported to a quiet, calm area with less noise and dull lighting.** They may benefit from being alone, or if being supported, reduce verbal communication and interaction until they are ready to receive this.

+ Be very mindful of providing physical touch to reassure an autistic person, many autistic people can find touch to be difficult. **If you do need to apply physical touch, inform the person first.**

Autism requires our understanding and acceptance and for us to do things differently to accommodate and include the needs of our autistic population.

Communication with an autistic person

+ **Be positive about autism,** use language of difference, not disability, do not describe the person as suffering with autism, be interested in their lived experience
+ **Use the persons name** to gain attention and focus
+ Do not expect eye contact, **their focus is your words,** not you
+ **Allow time for the person to process the information and respond,** our uncomfortable silence is an autistic person processing time
+ Use clear, concise language, **say what is meant.** Avoid using idioms, metaphors and humour
+ **Be predictable** – clearly outline next steps or intended actions and deliver this as expected. If several steps are required, list these in order of completion
+ **Stress and repeat key bits of information** to be remembered
+ **Avoid open ended questions,** use forced choice / closed questioning style
+ If you are a call-taker, **consider whether a clinician would be more appropriate to take the call** as they do not have to utilise the same pathways logarithm processes.

Need for Adjustments

As autism is about a diverse form of brain function there is no treatment or cure, we are not going to change the person. Autism requires our understanding and acceptance and for us to do things differently to accommodate and include the needs of our autistic population. This is a legal requirement under the Equality Act 2010 where autism (and other Neurodiversity conditions) are recognised protected characteristics, entitling the person to reasonable adjustments.

Reasonable Adjustment concept for autism

We recommend that adjustments are considered under the following headings:

Acceptance

A culture of acceptance and understanding of autism and that adjustments are needed to reduce barriers to access.

Predictability

Uncertainty and lack of predictability are anxiety provoking.

We will make our service pathways and settings as predictable as possible.

Information

Information and detail help build the big picture and the context.

We will provide information that is clear, concise and explicit.

Processing

Anxiety and sensory distractions will impact on processing.

We will use supplementary materials (text / pictures / diagrams) to support the processing of verbal information.

Sensory

Environments with challenging sensory stimuli will impact on processing and can lead to person being overwhelmed.

We will be mindful of visual stimuli (bright or flickering lights), noise (background noises and alarms), odours (perfumes, aftershaves and cleaning products) and remove these where possible.

Amazing Things Happen!
An introduction to autism

Click link below
https://youtu.be/Ezv85LMFx2E

Suicide and suicide prevention

The impact of suicide can be really profound. It is a very tragic and emotive subject to talk about. Please do reach out to someone if you had experience around suicide that is having a lasting impact on your thoughts and emotions.

Deaths by suicide are high across the world, particularly in middle aged men. In England and Wales, there were 5,691 suicides in 2019 (data from PHE) which is an increase from 5,420 in 2018. Of these, over 75% were men. Higher rates in men may be partially related to "perceived weakness" and stigma around talking about mental health. Given the challenging and unique demands related to the Covid global pandemic along social and economic impacts, the Royal college of psychiatrists anticipate an increase in mental health conditions and risk of suicide.

Recently, we have seen an increase in risks to children and autistic people in mental health crisis.

Given the covid and cost of living challenges suicide risk poses a clear public health concern. You may be likely in your role to meet people who could be at risk and understanding how to support them stay safe is key.

> *Please do seek support if you have professionally or in your personal life experienced suicide which has had a lasting impact on your thoughts or emotions.*

Evidence suggests that over 80% of people who die by suicide have had a diagnosis of a mental health condition. Many of the remaining 20% may have had difficulties with relationships, finances, addiction, loneliness, work, social circumstances or trauma.
It's critical when supporting a person in mental health or social crisis you ask directly about suicidal thoughts. There is a common misconception that asking someone about whether they have considered suicide may in some way introduce thoughts of suicide. This is entirely false, and there is no evidence to support the theory. By asking the question in a compassionate and confidential way you provide the opportunity for the person to open up to a professional if this is a risk. By directly asking you can also understand the level of risk and how to appropriately and proportionately escalate or safeguard. Think about intent, plan, access to means and protective factors or lack of (IPAP).

Always take any suicidal thoughts seriously and ensure you access further help, support or signposting. In an emergency call 999 and ask for the ambulance service.

Activity | Asking about suicide

What questions might you choose to ask the person, to give you a better understanding of their suicide risk?

It is difficult to predict who is at risk of suicide without asking. It takes a combination of empathy and confidence to be able to do this. Remember, that if you develop the right compassionate non-judgemental relationship with the person in crisis, they are very likely to feel relieved, speak freely and open up about their plans with you. Should this happen, it is important that you agree a safety plan together, signpost for support or escalate to 999 in an emergency.

Asking about suicidal ideas

+ Have you thought about suicide?
+ How often do you currently think about dying?
+ Have you felt that your life is not worth living?
+ Have you thought that family and friends would be better off without you?
+ How long does it usually take for the thoughts to go away?

If yes to above, consider asking about suicide plans:

+ Do you currently have plans on suicide?
+ Do you have specific intent about taking your own life?
+ Have you set a time or place?
+ Have you done anything or taken steps to prepare to take your own life (e.g. writing suicide note or will, arranging method, giving away possessions)?

- Are there any protective factors? (e.g. some people say they could not do this to their family, children, cite religion as a protective factor or describe plans for the future. Please don't assume family or children are a protective factor as some people get so low and hopeless that they think they are a burden and their family are better off without them).

Did you know...

You will only know the level of risk and how to manage it safely if you ***ask the questions***

In England and Wales there were 5,691 suicides in 2019 (data from PHE) which is an increase from 5,420 in 2018. Of these over 75% were men.

Risk management

Part of a mental health crisis conversation is to identify risks to the person, inspire hope and agree a safety plan together.

Once the person is considered to be at risk of suicide, it is important that the right plans are put in place for their ongoing care, welfare and safety. In most cases, this will involve a follow up assessment by a dedicated mental health professional. In an emergency, the ambulance and police services have many referral routes and access points to get clinical expert support on decision making. These include mental health nurses in control rooms via 111 or 999. Also where necessary please do escalate concerns to colleagues, managers, safeguarding or other support available. Every effort should be made to encourage the person to travel with you to engage on an informal basis if clinically indicated. However, where you consider there is a high risk to the individual or others and they are refusing referral or travel it may be necessary to consult with the GP or Duty Approved Mental Health Professional (AMHP) and possibly with the use of the Mental Health Act. These can be accessed by person's GP or via 999 ambulance service. A guide to supporting decision-making and scenarios under both the mental health act and mental capacity act is discussed in more details in this workbook.

Safety planning: Think live, love, do

Mental health protective factors often relate to **how we live, who we love and what we do.**

+ Are there any positive factors related to social support that would help?
+ Does the person live alone?
+ Can responsible compassionate relatives or friends support?
+ Is there a care team?
+ Is there a safety plan?
+ What normally helps them manage distress?
+ What structure routine or distraction skills help?
+ Is there any regular medication that can help?
+ What social support is available?
+ Are any referral routes required such as crisis team, crisis house or support workers?
+ Are there any solutions or protective factors that would help?
+ What inspires hope?

Here to support you with urgent and emergency care mental health signposting

+ Ambulance control rooms or remotely to crisis teams
+ Emergency service mental health triage vehicles with specialist mental health input
+ Universal education and support
+ Signposting services
+ Information sharing protocols around background, history and context to support professional pathways and decision making
+ Analysis of patterns around complex care, frequent callers related to mental health and social crisis so providers can improve access to care for repeat presentations

Learn more

For more information on suicide awareness and prevention:

www.mentalhealth.org.uk/blog/suicide-prevention-how-you-can-make-difference

www.zerosuicidealliance.com

www.bing.com/search?q=hub+of+hope+app&cvid=11e8267298a4406a9902c04a98d7c082&aqs=edge.0.69i59j69i57j0l7.7534j0j1&FORM=ANAB01&PC=U531

www.stayalive.app

www.4mentalhealth.com

www.ripplesuicideprevention.com

Here for you: How to support your own mental health

Given the pressures of the wider system, global uncertainties and the impact of Covid, health, social care and voluntary sector services have prioritised a mental health transformation programme. This covers the importance of close collaboration between public health and clinical mental health services in partnership with organisational wellbeing teams. A structured framework on improving mental health and psychological safety in the workplace is crucial to empower staff resilience.

This sits within 4 key principles which are Promotion, Prevention, Intervention and Recovery. These are outlined in more detail in the following pages. Please remember the importance of a non-judgemental approach, compassion, confidentiality, dignity, respect and trust around contact with colleagues experiencing a mental health or social care crisis.

A solution-focused approach and good listening skills help de-escalation, containment, managing distress, inspiring hope and regaining resilience.

Did you know...

A valuable website on mental health support and awareness is:

www.nhs.uk/oneyou/every-mind-matters

> *People are innately social beings and we should try to reduce loneliness and isolation.*

Framework for staff mental health

Like physical health we all have mental health and we can all take positive steps to manage stress and improve resilience through awareness and reflection. Unlike physical health problems it can be difficult to see or recognise a mental health problem even for the person experiencing it themselves. By taking notice we can often see a change in someone's behaviour over time. Anxiety, stress and depression are the most common forms of mental health conditions experienced by staff following Covid. Unlike physical health problems often anxiety, stress and depression can creep up over time. If unrecognised and unsupported this can have an impact on our daily routine and functioning to a point where it may become a clinical condition. Staff burnout, trauma and post traumatic stress disorder (PTSD) has been on the increase through the pandemic. A qualified doctor would need to diagnose PTSD and if PTSD is suspected a referral to occupational health or GP should be arranged.

Your organisation may already have in place Trauma Risk Management (TRiM) which is a trauma-focused peer support system. Where this exists can either be suggested following recognition of a potentially traumatic incident or self referred. TRiM is not a treatment process but a risk assessment of any requirement for treatment. Where indicated a TRiM assessment can recommend a referral to Occupational Health to be assessed by a qualified mental health practitioner for counselling and support. This could include Trauma informed Cognitive Behaviour Therapy (CBT) or Eye Movement Desensitisation and Reprocessing (EMDR) along with a range of other treatment options.

> *Anxiety, stress and depression are the most common forms of mental health conditions experienced by health, emergency services, voluntary sector and social care staff.*

Bounceability: Resilience and rational detachment

Resilience can be seen as our ability to cope with setbacks and life challenges. It is our drive and desire to succeed and bounce back from stress and adversity. All of us cope differently with pressures and stress and have different thresholds. Awareness of stress build up is important to avoid it impacting on sleep, mood and other factors. Stress activates the threat and self protection part of our brain. This means we tend to focus on things that are worries or difficult to resolve much more. We then reduce the time we spend on things we enjoy, our hopes and or ambitions when we need them the most. This can lead to irrational focus on problems often magnifying them and impacting confidence.

Bounceability

If we reflect on an analogy of a "beach ball fully inflated". When we drop it, it always bounces back. However if we were losing air slowly over time often without noticing through either work pressures, relationship pressures, financial pressures or other factors eventually the beach ball loses its "Bounceability". What if air is slowly being lost over time and often without notice through pressures such as relationships finances and work? Does this affect our "Bounceability"? Could this impact our perspective on events, outlook on life and our desire to achieve? This is why it is really important to be reflective and self-compassionate. To do this we need to rationally distance ourselves from excessive rumination on worries or negative thoughts. Social prescribing or our take 5 for mental health helps us stay connected and distracted. **Think back to the mental health continuum on page 11 for a sense check on where you are. Please take notice if you or someone you know is deflating!**

Social prescribing and Take 5 for mental health

1 Connect

How we are communicating with others. Are you isolating yourself more or reflective and engaging? Think about relationships with family, friends and work colleagues. Do you still enjoy this, have the same level of contact and support with them? Are the interactions positive and helpful? If not what would need to change?

2 Take notice

Taking time to be aware of our surroundings and being present in the moment. Avoid being distracted or multitasking. Think about ways of slowing down thoughts by trying relaxation and mindfulness. Abdominal breathing techniques and deep muscular relaxation can be a very productive way of managing stress and switching off.

3 Give

Taking time to show compassion for others and how we can create a "currency of kindness". Think about the concept of behaviour breeds behaviour. When we demonstrate courtesy, dignity and respect, are we more likely to receive this back? If we are stressed, rude or abrupt is this more likely to demonstrate defensiveness back? Think through random acts of kindness and when you intervened to brighten someone's day or when someone else provided a random act of kindness for you. How did that feel? (e.g. holding a door open for someone, allowing someone out in a traffic queue, helping an old lady in the shop get something from the top shelf). Sometimes simple acts that take little effort from us and can have a powerful impact on people's lives. People are instinctively inquisitive and social beings and we should try to support each other if we feel lonely or isolated.

4 Keep Learning

When it comes to problem solving and solution focused approaches Think about new approaches to resolving difficult problems. Seek coaching support or supervision if something is playing on your mind from a trusted colleague or friend. They could offer a fresh different perspective that helps unblock a challenge or fresh ideas. Hobbies and new interests such as team sports, reading, music, DIY, art and design, volunteering in groups and many others help with our sense of enjoyment and trying new challenges.

5 Regular exercise/ healthy living

Regular exercise really helps us both physically and mentally. Running, bike rides, team sports, swimming or brisk walks produce feel good chemicals and emotions such as endorphins and oxytocin. These are natural ways to help feel more positive and switch off. Regular exercise also provides space to problem solve and is a useful distraction from things that may be occupying our thoughts.

Social prescribing and personal pledge plan

Remember compassion starts from within. If we aren't accepting of our own strengths and challenges and emotionally in a good place it can be difficult to be compassionate to others. We are all unique and have unique abilities. We are also often our own worst critics! By reflecting on and acknowledging vulnerabilities we can reach a greater level of acceptance and understanding of our strengths and vulnerabilities. We won't all enjoy or do the same things when it comes to exercise, hobbies or interests. It can be helpful to reflect on two to three different options within each of the "take 5 for mental health" messages on the next page. This builds a sense of purpose, balance, meaning, structure and distraction in order to have the right work life balance.

> *Like physical health people who are living with or recovered from a mental health condition should have all reasonable adjustments and support plans in place to maximise potential and empowerment for a sustained recovery.*

Our universal transformation programme for staff mental health principles focuses on

Promotion

Developing awareness and normalising mental health in the workplace. This includes tackling stigma and taboos related to mental health which may prevent or delay access if staff feel judged. Your organisation may have polices and campaigns related to improving awareness and the most important thing is to "KEEPTALKING". Together we all can increase awareness, recognition and access to mental health in the workplace.

> *In response to covid and staff mental health our NHS, social care, emergency services and voluntary sector will continue to grow and develop an occupational health offer specific to mental health.*

Prevention

There are many models of staff mental health champions and peer support. Some examples include Mental Health First Aid (MHFA) and Psychological First Aid (PFA). Networks of Peer 2 Peer volunteers may be developed across your service as an initial point of contact to provide a safe place for staff to be themselves and seek initial support. The right structure, training, supervision, support and evaluation framework should be built to support all volunteers. In partnership with the health and wellbeing team, leadership and education team, any support service should continue to build the right information, workshops and awareness sessions though induction, manager awareness sessions and CPD to professional development sessions.

Did you know...

A solution-focused approach and good listening skills can help de-escalation, containment, managing distress and resilience.

Intervention

It is essential to have timely access to high quality care in a staff mental health crisis. Your service should have an occupational health offer specific to mental health. A red flag escalation process for staff at risk to themselves or others related to mental health should be in place or contact emergency services if you are concerned about a colleagues levels of risk.

Recovery

Like physical health people who are living with or recovering from a mental health condition should have all reasonable adjustments and support plans in place to maximise their individual potential for a sustained recovery. Your service should encourage personalised recovery action plans. This helps understand triggers, relapse indicators and early intervention to reduce risk of a further future episode of illness.

Forward planning updates within the Thames valley public health education and suicide prevention plans

- Mental health education lead in post since February 2022 with advisory role to work across the Thames Valley footprint as part of a provider collaborative and expert reference group.
- System approved transformation programme in place to provide consistent, evidence based best practice around mental health and pathways.
- Mental health workbook, videos, safety planning, signposting and support to be available via a website to all universal staff and volunteers.
- Mental health education plan to be added to signposting services within each area with Thames Valley.
- Focused additional training to be developed for more frequent access universal groups such as emergency departments.
- Ease of access integrated signposting to mental health services through 111/999 mental health clinicians where no existing mental health care team involved or available.

Mental health, Legal Framework and Decision Making

The Key legislation relevant to specific incidents involving people with mental health crisis includes the Mental Health Act (MHA) and the Mental Capacity Act (MCA). These encompass concepts around Best Interests decision making, least restrictive practice, compassionate care, empowerment, safety, proportionality and duty of care.

Mental Health Act

The MHA relates to compulsory admission to hospital and detention within hospital of people experiencing severe mental health problems that require assessment and/or treatment for their safety or the safety of others. Flowcharts and scenarios will be available in the reference guides on the website.

People can only be detained under the mental health act by an Approved Mental Health Professional (AMHP) and normally two appropriately qualified doctors. The main sections relevant to this guide are Section 2, Section 3, Sections 135 (1), 135 (2) & 136 (police holding powers). People already on leave whilst on a Section 2 or 3 can be compulsorily brought back to hospital if their mental state deteriorates whilst they are on leave.

Section 136 relates to the polices ability to compulsorily detain and take a person in need of immediate care or control in a public place to a 'place of safety' in order to be assessed under the Mental Health Act. Section S135 (1) is the same as 136 except for it relates to entering and detaining a person in their own home as opposed to a community setting. The police require a court magistrates warrant and AMHP to action a Section 135 (1).

People can only be detained under the MHA for assessment only where there is a high threshold of risk. These include where there is an identified or suspected mental illness, where there is evidence of a significant and current risk of harm to self or others, or where there is a risk of severe neglect or possible further significant deterioration in their illness. All reasonable efforts should be explored for alternative options to compulsory detention. This could include clinically indicated voluntary or 'informal admission'. Detained people should be transported to hospital in an ambulance.

Key reflection

Try to imagine you or one of your loved ones being "in the shoes" of a detained person. They may already feel anxiety, shame and distress about being admitted against their will. Mental health is a health based condition and a detained person hasn't committed any crime. This is why it is important to have wherever possible a least restrictive approach and health based transport solution.

Mental Capacity Act (MCA) 2005

The MCA is intended to protect those who may lack the ability to make decisions about their own care. The first principle of the MCA is that a person must be assumed to have capacity to make a decision or act for themselves unless it is established that they lack capacity in relation to those matters. It is important to note that an unwise decision does not imply a lack of capacity.

In order to assess capacity people need be able to understand all the care options open, the potential risks and feedback this information. There may for example be a number of physical health conditions such as head injury, UTI, hypoxia, hypogylycaemia, alcohol or drug intoxication or cognitive processing. Cognitive impairments can sometimes include dementia, learning disabilities and severe mental illness although this list is not exhaustive. People can also be temporarily impaired from informed decision making and examples of this include people who are severely intoxicated or under the influence of drugs.

This needs to be referred to a GP, clinician or care co-ordinator to make a best interests options based on presenting risks. It is important to note the clinicians need to demonstrate they have taken reasonable steps to negotiate on options and best interests. Any persuasion or physical intervention

(restraint) must be proportionate to the likelihood and potential severity of harm without the vital treatment. Appropriate risk assessment and management on available resources must be considered. This should be from the perspective of clinician's personal safety and the level of urgency/severity of risk to an individual's condition.

Did you know...

Further information on the mental health act, mental capacity act and common scenarios related to decision making is available on the intranet.

Mental Health Act
www.rethink.org/advice-and-information/rights-restrictions/mental-health-laws/mental-health-act-1983

Mental Capacity Act Information
www.mind.org.uk/information-support/legal-rights/mental-capacity-act-2005/overview

MHA Summary

The threshold for compulsory detention under the MHA is high

Detention under MHA is where there is a significant risk to themselves or others. If the person presents in mental health crisis with high levels of perceived risk and refuses support you should call emergency services where safety options can be considered. Remember the MHA is for mental health risks (Search Sessay VS SLAM). If the individual presents with an immediate medical serious or life threatening condition then the MCA is a more appropriate process to enable clinical urgent or life saving treatment where the person is deemed to lack capacity. A frequent example would be toxic overdose with alcohol which would require medical treatment under MCA prior to MHA assessment. Remember your service values and compassionate non-judgemental approach.

Mental Capacity Act (MCA) Summary

The MCA covers medical presentations and risks related to informed decision making. Where someone refuses treatment and you are concerned about a condition that may be impacting there ability to decide the two stage functional test must be completed and clearly documented. Examples of situations where people COULD lack capacity include but are not limited to hypoglycaemia, concussion, intoxication, head injury, mental health crisis, infection or dementia. Remember the 5 key principles which underpin the MCA 2005.

5 MCA principles

1

A person must be assumed to have capacity, unless it is established that they lack capacity. (Complete 2 stage functional test if consent refused or can't consent and risk of serious harm)

2

A person is not to be treated as unable to make a decision unless all practical steps to help them do so, have been taken without success.

3

A person is not to be treated as unable to make a decision, merely because they make an unwise decision.

4

An act or decision made for a person who lacks capacity, must be done in their best interests.

5

Before the act is done, or the decision is made, you must consider whether the outcome can be achieved in a way that is less restrictive.

Can the person 'P' **make the decision** that needs to be made?

Step 1 APPLY THE **'FUNCTIONAL TEST'**

Understand	Retain	Weigh	Communicate
information relevant to the decision in broad terms?	information long enough to make a decision?	advantages 'v' disadvantages of each viable option?	a meaningful decision by any means?

If P **cannot** do **any one** of the four elements, they lack mental capacity

If P **can** do all four elements, then P has mental capacity and can make the decision

Yes

Step 2 APPLY THE **'DIAGNOSTIC TEST'**

Does P have a **'disturbance in the functioning of the mind or brain'** — either permanent or temporary?

If **'Yes'**, progress to Causative Nexus

If **'No'**, consider how P can be supported to make a decision

Yes

Step 3 APPLY THE **'CAUSATIVE NEXUS'** PRINCIPLE

Is it the **disturbance** of the functioning of the mind or brain that is affecting P's ability to make this decision at this time?

If **'Yes'**, P lacks mental capacity - Treat under best interest principles

If **'No'**, how can P be supported to make a decision?

Yes

NB — The Causative nexus principle is the link between the disturbance in functioning of mind and brain and it's impact on capacity to make the decision, e.g. P's dementia has impaired their memory and stops them retaining information for long enough to use it.

Further information on MCA and Causative Nexus can be found on this embedded link.
https://mentalcapacitytoolkit.co.uk/3/the-causative-nexus

Please note that this process allows the person to be held for assessment and treatment, where safe to do so as a last resort if at high risk of serious harm. They can be escorted to hospital by ambulance and or police where the risks indicate for life saving or urgent assessment/ treatment where they lack capacity only and under S4B, S5,S6 of the MCA 2005. All MCA assessments are decision specific and scenario based as outlined in examples of case studies on the website. Any intervention should consider best interests around least restrictive option, as a last resort and are reasonable/proportionate to the presenting risks. Removal or intervention is in response to the risk of significant harm or death if the person is not removed. For further information, search the internet for mental capacity act code of practice.

Signposting & Notes

Database of Mental Health Pathways

Your employer or service should have a database of mental health pathways. This may be a digital application designed to facilitate access and visibility of new and existing Urgent Care Pathways for your role. This could include community crisis teams or via 111/999 as a single point of urgent and emergency care. Any pathway should provide accurate 'real-time' information to support you and the person in selecting the most appropriate response.

Further help and support

- 24/7 all age Mental health triage team in the ambulance service supporting 111/999 healthcare professional advise on incidents
- AMHP and police support via GP triage if required
- Existing mental health Trust crisis team support where available
- Police and ambulance mental health triage vehicles
- Frequent caller care plans or the person's own identified care plan or safety plan where available
- Further training and sessions on mental health crisis accessible via your service provider or online where available
- Websites and digital resources as per reference list

Emergency department case studies

Scenario 1

Elaine called 999 distressed saying they were suicidal, expressing that they were about to take an overdose of prescribed medication.

Ambulance responded and went to the home address. The person voicing suicidal ideation, however, had no evidence that the person had taken an overdose and the person denied taking an overdose. The person was taken to the nearest general hospital as the paramedics felt that the person was in mental health distress. The person referred to the psych liaison team, assessed and later discharged back to the home address with appropriate follow-up care.

Action **that could have been taken to avoid paramedics bringing the person to the Emergency Department:**

1

Telephone call by the paramedics to mental health service professional`s line to request follow up of the person. Paramedics would need assurance that the person would be followed up appropriately.

2

At point of the 999 call, it potentially could have been transferred to MH clinician via the 111 service. **The operator would have needed assurance that the person had not taken an overdose of prescribed medication.**

3

Consideration of possible crisis house referral subject to availability as more therapeutic option to support the person pathway.

Scenario 2

People brought into the emergency department by Police having been detained under S136 which was the most appropriate action given that the person needed urgent medical treatment before transfer to an appropriate place of safety.

The person was not medically fit in the initial S136 24-hour window. Police declined to ask for a further 12-hour extension of the S136. The person was left in the emergency department by the Police to receive medical treatment. Subsequently the S136 expired. Throughout the person was aggressive and violent towards medical staff hospital security staff intervened.

The person was transferred to a ward to receive further medical treatment, later the person was detained under section 5(2) of the MHA as the person was trying to leave the ward against medical advice.

Subsequently the person was detained under S2 of the MHA and transferred to an inpatient psychiatric unit upon being medically cleared.

Had the S136 been extended the person could have been detained under the MHA earlier in the process.

Scenario 3

Paramedics called out to an elderly confused individual by relative (daughter) as the person had a fall and needed emergency assistance.

This person may be unable to consent to being taken to the emergency department, however the paramedics felt she needed immediate medical intervention. Following completion of the mental capacity act 2 stage functional test the paramedics took the decision to utilise the Mental Capacity Act to take

the elderly individual to the ED, they felt the person did not have sufficient capacity to make an informed decision regarding her care. The decision was taken in the person's best interest as the lacked capacity to consent and given the suspected serious medical problem.

The paramedics took the time to inform the person's daughter of their decision.

The person needed a hip replacement and made a full recovery.

This is an example of exemplary care shown by the paramedics towards the person and the person's daughter.

Learning disabilities case studies with mental health guidance

Presentation of a mental health crisis

Crisis situations may occur due to:

- Escalation/change of behaviour with family/carers being unable to cope.
- Refusing to take usual medication.
- Trigger factors may cause a crisis (either known triggers or new).
- Family may be struggling to cope with the persons care needs and reach a crisis point.
- Change – daily routine, support needs, carers, environment etc. An example being when day services closed due to the covid outbreak. A person's daily/ weekly routine changes, they don't see their friends/ staff. This may lead to a person becoming isolated at home, staying in their room, withdrawn, not interacting with family. Depression and/ or anxiety may occur.
- Reaction to life events. Bereavement.
- Some individuals may recognise/understand when they are 'well or unwell'. 'I'm not right'.

Changes in behaviour:

- Changes/exacerbation of their 'usual' behaviour or presenting with new behaviours.
- 'Physical' behaviours might include, pulling hair (their own/others), becoming violent, swearing, stripping off, throwing things, self harm (head banging, scratching), dirty protests. Other behaviours may include withdrawal, not getting out of bed, covering themselves in blankets.
- Paranoid thinking. Becoming suspicious, thinking that people are talking about them, for example, on the phone. May believe that others (family/carers/staff), for example, are part of gang, their enemy, or are planning to harm them. May become suspicious of taking regular or new medication, thinking the medication has been changed, they are being drugged etc. Not being able to trust familiar or people they know (this could include their GP, family, carers etc).
- Interpersonal behaviour may change. Withdrawal, not speaking, no eye contact, isolating self, avoiding other people. Not wanting to go out, see or speak to friends/family. Withdrawing from regular routine/daily activities.
- The environment or changes in the environment may exacerbate, eg anxiety, due to sensory overload, banging doors, loud noises, other people, triggers.

Help/Support

- Recognising early warning signs that someone is becoming unwell.
- Supporting the person in their own/home environment.
- Supporting the family as well as the individual.
- Medication?
- Keeping the person involved/ included, in any decisions/ treatment, as much as possible. Explaining in a way they understand.
- Working in partnership with Family/cares/support staff sharing their knowledge of the person with professionals, their usual management of behaviour, what is no longer working? Why? How can things be done differently? Sharing ideas.
- Have staff had adequate training/education in managing particular/new behaviours? Do they have adequate knowledge of the person?
- Do the family/support workers have key person to contact during the crisis? Options for out of hours support?
- Referral/support of the Intensive Support Team?
- Is it appropriate for other professionals, with specialist knowledge, to provide support in the community? Psychologist, Psychiatrist, CPN etc?
- Can Day services have a role?
- Hospital admission = last resort?!
- Regular reviews.

Reasonable Adjustments

- Consistency of professionals involved. Always seeing the same GP, Psychiatrist as examples. A familiar face, develop trust and rapport, know the person when 'well and unwell'.
- Consistency of support staff.
- Seeing the person in their own environment/home. Or during quiet times for GP surgery or hospital outpatient appointments.

- Seeing the person in the same consulting room.
- Remove any known triggers from the room e.g. a ticking clock, medical equipment.
- Meet in a large room, remove items that may cause harm if particular risks/behaviours.

References

Useful video links

I had a black dog, his name was depression
(As seen in 'Key conditions encountered in prehospital care', Page 20)
https://youtu.be/XiCrniLQGYc

Transport for London: Share the Road, M&C Saatchi London
(As seen in 'Initial assessment of a person with a mental illness', Page 41)
www.youtube.com/watch?v=ObTkJpVJgs8

Mind blue light programme
https://www.youtube.com/watch?v=qnYu8uA8cIM

Drew Dudley Ted Talk on leadership through lollipop moments
https://www.bing.com/videos/search?q=ted+talks+drew+dudley+everyday+leadership&view=detail&mid=B118861DDBBE22AA44CCB118861DDBBE22AA44CC&FORM=VIRE

Websites and Apps

Headspace

Every Mind Matters
www.nhs.uk/oneyou/every-mind-matters

NHS Choices
www.nhs.uk/mental-health/advice-for-life-situations-and-events/where-to-get-urgent-help-for-mental-health

R;pple

R;pple is a digital tool, which if a user searches for harmful content online, they will first be guided through a filter of breathing exercises and then very simple, uncluttered and calmly presented strategies and forums, help lines and mental health services they can access both now and longer term: accompanied with messages of hope and encouragement to keep safe. All information about the background, context, and benefits of R;pple can be found **here.**

Kooth App
www.kooth.com

YoungMinds
www.youngminds.org.uk

Shout text service
giveusashout.org / Text number 85258

Stayalive.app app for support and safety planning
www.stayalive.app

Search for staff further internal support via your service wellbeing team portal or occupational health provider

References

1. www.mentalhealth.org.uk/statistics/mental-health-statistics-uk-and-worldwide
2. The Health & Social Care Information Centre, 2009, Adult psychiatric morbidity in England. Available at: https:// digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-in-england-2007-results-of-a-household-survey
3. Engel,G. The need for a new medical model: a challenge for biomedical science. Science, 1977; 196:126-9
4. Ewing J. Detecting Alcoholism: The CAGE questionnaire. JAMA. 1984; 252(14): 1905-1907

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Notes

Evaluation Form

Please feedback these comments to your line manager / supervisor or if printed bring this evaluation to your appraisal.

Has this guide given you an insight into mental health conditions?

☐ Yes ☐ No

Do you feel the content covered most aspects of your role in relation to mental health?

☐ Yes ☐ No

What other training methods do you feel you need to enhance your understanding of the needs of mental health people?

What methodology would you prefer to undertake to improve your knowledge of mental health, and how to respond to people with mental health needs?

☐ Training, education, workshops, accredited courses

☐ Teaching sessions facilitated and delivered by a mental health expert

Other (Please detail)

Additional comments:

Thank you for taking the time to read the workbook and complete the form.
This information will aid us to develop further education and training in mental health.

Please return this page or if digital, discuss questions with your team leader and discuss in supervision/appraisal once the workbook is completed.

MENTAL HEALTH IS EVERYBODY'S BUSINESS

SAFER CARE TOGETHER
United Against Suicide

I think it looks like an excellent resource and am interested to understand how we will be using this. I think it is easy to read but really informative and like the patient comments which I think are really thought provoking and could challenge people to reflect on how they support patients with their mental health needs. I also think there's a good mix of activities for people to undertake without that being too much.

Really good from my perspective, so a big thumbs up from the RBFT.

Jo Sandy, Head of Clinical Education & Workforce at the RBFT

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