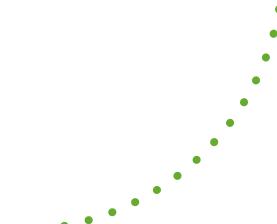




# Mental Health First Aid

## Your manual



# The Mental Health First Aid programme

## Background

In 2000, the Mental Health First Aid (MHFA) programme was created in Canberra, Australia, by Betty Kitchener, an educator with lived experience of poor mental health, in partnership with Professor Anthony Jorm, a mental health researcher. The aim in creating the programme was to extend the concept of first aid training to include mental health, so that community members were empowered to provide better initial support to people developing poor mental health, living with a mental health condition, or in a mental health crisis. The MHFA course was developed, and the original Australian version of this manual was written by Betty Kitchener and Professor Anthony Jorm, at the Centre for Mental Health Research at the Australian National University in Canberra.

The MHFA programme was first adopted outside Australia in 2003 by the Scottish government and then by England in 2006. When the programme was adopted in these countries, either a mental health government agency or a non-government mental health organisation adapted the MHFA Australia course materials in accordance with their own culture and health system. Further details of the international spread of the MHFA programme can be found at the MHFA international website:  
[www.mhfainternational.org](http://www.mhfainternational.org).

This Mental Health First Aid England manual is based on the fourth edition of the Australian MHFA manual. The manual is an in-depth reference material to

support members of the public who attend an MHFA England course.

The MHFA actions (ALGEE) recommended in this manual are in accordance with international MHFA Guidelines, which have been developed by researchers in Australia since 2005. These guidelines were developed using the consensus of expert panels with lived experience, carers, and professionals from several English-speaking countries. Further details of the guidelines and their development can be found under the 'Guidelines' and 'Research' menus of the MHFA Australia website:  
[www.mhfa.com.au](http://www.mhfa.com.au).

## Evidence based

An important factor in the MHFA programme's international spread has been the continuing attention to research and evaluation. All course content is as evidence-based as possible and many evaluation studies have been conducted. A range of studies, including randomised controlled trials, have shown that MHFA training improves knowledge, reduces stigmatising attitudes, and increases first aid actions towards people with poor mental health. Summaries of these evaluation studies can be found at the MHFA Australia website:  
[www.mhfa.com.au](http://www.mhfa.com.au).

When we consider the implementation of MHFA, as with any care service, we must be mindful of the legal frameworks within which we deliver care. Policy and legislation also provide the framework

in which support services that we may signpost people to operate, including statutory mental health services provided by the NHS.

For more information on government policy and legislation surrounding mental health in the UK, visit [www.legislation.gov.uk](http://www.legislation.gov.uk).

## Disclaimer

The information provided in this manual is for MHFA use only and is not intended to be, and should not be relied upon, as a substitute for professional mental health advice. It has been written for people who attend the Adult MHFA course and is intended as a resource during the training and as a reference after course completion. Readers should be aware that the discussions, activities, and skills covered in the Adult MHFA course are essential to MHFA. The contents of this manual alone cannot cover every aspect of the training, and it is only available to learners who attend an Adult MHFA course delivered by an approved MHFA England Instructor Member. For quality assurance purposes and to ensure that key messages are not taken out of context, it is not available to the general public. For a full disclaimer of liability see pages 170-171.



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# Foreword

We all have mental health and, just like our physical health, it needs looking after. One in four of us will experience poor mental health in any given year. But learning more about our mental health and ways to get support can empower people to thrive. That is why it is so important you have taken this step.

Having taken the course, you are becoming part of a community of half a million people in England and four million people worldwide who are trained to recognise poor mental health and help people find the support they need. It is this community which will achieve our vision of a society where mental health is accepted as a normal part of life and everyone has the skills to look after their own and other people's wellbeing.

When I did my MHFA England course in 2018, I wished I had done it 20 years earlier. The knowledge and skills I learned could have made a huge difference in both my personal and professional life.

A mentally healthy community is a productive and creative community. MHFA England training must be part of a joined-up, bigger-picture approach to mental health and wellbeing. As an MHFAider, you will be able to use your skills most effectively if you have the full support of your organisation or community, clarity about your role, and enough time to dedicate to it.

Together, we will make a positive change to conversations around mental health. But to do so, we must also look after ourselves. As Audre Lorde, the civil

rights activist and poet said, 'Caring for myself is not self-indulgence, it is self-preservation'. So please take the time and energy to look after yourself.

From me and the rest of the MHFA England team, we wish you all the best in your role. Please get in touch at [feedback@mhfaengland.org](mailto:feedback@mhfaengland.org) if you have any feedback on the course.



*Simon Blake*

**Simon Blake OBE**  
**Chief Executive**  
**Mental Health First Aid England**

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A blurred background photograph of a person with dark hair and glasses, wearing a white collared shirt. They are seated at a light-colored wooden desk, looking down at a smartphone held in their hands. A black digital wristband is visible on their left wrist. The overall atmosphere is focused and professional.

# Mental Health First Aid



# What is Mental Health First Aid?

Mental Health First Aid (MHFA) is the non-professional support offered to a person developing poor mental health, experiencing a worsening of an existing mental health condition or in a mental health crisis. This can include in a work, home, or community setting.

## The aims of MHFA are to:

1. Preserve life where a person may be at risk of harm to themselves or others
2. Provide help to prevent poor mental health from becoming more serious
3. Promote recovery from poor mental health
4. Provide comfort to a person with poor mental health

MHFA will typically be offered by someone who is not a mental health professional, but rather by someone in the person's social network (such as family, friend, or work colleague) or someone working in a public facing role (such as a teacher, police officer or employment agency worker). This person is called an MHFAider®. This stands for Mental Health First Aider and is MHFA England's official and registered trademark title for the role.

The MHFA course teaches people how to spot the early signs of poor mental health, including warning signs of common mental health crises, how to offer and provide initial help, and how to encourage a person to seek appropriate professional treatment and other sources of support.

The MHFA course does not teach people to provide a diagnosis or therapy. MHFA is the help given to someone experiencing poor mental health before professional help is obtained.

## The wider aims of MHFA are to:

1. Raise awareness of mental health in the community
2. Reduce stigma and discrimination

# Why Mental Health First Aid?

There are many reasons why people need training in MHFA.

## Poor mental health is common

Poor mental health is common, especially mental health conditions such as depression, anxiety and those associated with misuse of alcohol and other drugs. Research indicates that one in four people experiences some form of poor mental health in a year. Throughout the course of any person's life, it is highly likely that they will either develop poor mental health themselves or have close contact with someone who does. Depression is also a major cause of disability, absenteeism, presenteeism, and productivity loss among working-age adults. In addition to its direct medical and workplace costs, depression also increases health care costs and lost productivity indirectly by contributing to the severity of other costly conditions such as heart disease, diabetes, and stroke.

## There is a stigma associated with poor mental health

Stigma involves negative attitudes (prejudice) and discrimination refers to negative behaviour. Stigma may have several detrimental effects including barriers to seeking help, exclusion from employment, housing, social activities and relationships, and internalised stigma that can cause shame or low self-esteem. Better understanding of the experiences of people with poor mental health can reduce prejudice and discrimination.

## Many people are not well informed

Understanding how to recognise poor mental health and what effective

treatments are available is not widespread. There are many myths and misunderstandings about poor mental health. Common myths include the idea that people with mental health conditions are dangerous, that it is better to avoid psychiatric treatment, that people can pull themselves out of poor mental health through willpower, and that only people who are weak develop poor mental health.

Lack of knowledge may result in people avoiding or not responding to someone with poor mental health, not knowing where to seek help, or what kind of help might be useful.

## Many people with poor mental health don't receive adequate treatment or delay accessing treatment

Professional help is not always on hand, and many people may wait for years before seeking help. The longer people delay getting help and support, the more difficult their recovery may be.

People with poor mental health may be more likely to seek help if someone close to them suggests it. General practitioners (GPs), counsellors, psychologists, psychiatrists, and other mental health and social care professionals can all help people experiencing poor mental health, however, just as with accidents and other medical emergencies, such assistance is not always available straight away. When these sources of help are not available, members of the public can offer immediate first aid and assist the person in getting appropriate professional help and support.

## Why Mental Health First Aid? cont.

### People may lack the insight to realise that they need help or that help is available

Some symptoms of poor mental health cloud clear thinking and good decision making. A person experiencing such difficulties may not realise that they need help or that effective help is available, or be in such a state of distress that they are unable to think clearly about what they should do. In this situation, people close to them can facilitate appropriate help.

### Members of the public often don't know how to respond

Even in an emergency, a person wishing to give assistance at an accident may be reluctant to help for fear of doing the 'wrong thing'. In a mental health crisis, the MHFAider's actions may determine how quickly the person gets help and/or recovers.



# The MHFAider role

## Qualities and values

When supporting a person developing poor mental health or living with a mental health condition, an MHFAider should be:

- Approachable
- Impartial
- Non-judgemental
- Confidential
- Empathic
- A skilled listener
- Trustworthy
- Patient

## Practicalities and responsibilities

The main responsibility of the MHFAider is to support someone who is experiencing poor mental health or is living with a diagnosed mental health condition, upholding the values and qualities of the role. The MHFAider can also contribute to reducing stigma and promote positive mental health. The MHFAider should:

### Apply the MHFA action plan

Apply the MHFA action plan (ALGEE) to your support and use good judgement about the order and the relevance of these actions, being flexible and responsive.

- Be aware of signs and symptoms of poor mental health and mental health conditions, and understand that people move around the quadrants of the Mental Health Continuum.

- Approach a person in a considered way.
- Assist in crisis situations and, if needed, seek immediate emergency help.
- Use active listening skills throughout your support, taking into consideration your own Frame of Reference and the language you are using around mental health.
- Signpost to relevant professional resources and contacts, helping the person to prepare for mental health support where necessary. Some people may also benefit from practical help services for assistance with income, housing, or domestic abuse.
- Use the MHFAider Support App® or online national database of mental health services, [Hub of Hope](#), to signpost to appropriate contacts and resources.
- Give the person a brief outline of what they could expect from treatments, but don't recommend or advise.

### Understand self-care

Understand the importance of self-care and practise wellbeing regularly to manage the stress in your Stress Container.

After providing MHFA to a person who is in distress, you may feel worn out, frustrated, or even angry. You may also need to deal with the feelings and reactions you set aside during the conversation. MHFAiders can access Shout's mental health text support service via the MHFAider Support App. It can also be helpful to make reflective

## The MHFAider role cont.

notes on your experience in the MHFAider Support App or find someone to talk to about your experience, remembering to leave out identifying details. This is not the same as a crisis when you will need to reveal their identity. In a workplace, MHFAiders should also follow their organisation's policies and procedures.

Before an aeroplane takes off, flight attendants will talk flight passengers through the oxygen mask procedure. The procedure instructs passengers on a flight to ensure that they put on their own mask before helping others, because we can't assist others if we lose consciousness. The same principle applies to the MHFAider role. If we aren't well, we're not able to safely offer support to others.

To remain well we can practise self-care. Self-care is the practice of engaging in activities that take care of your health and actively manage poor mental health when it occurs. Self-care differs person to person and can change over time. Some things we might do daily, and some might be once a year, like enjoying a great holiday.

Examples of self-care include:

- Engaging in creativity or DIY
- Unplugging from technology
- Meditating or practising spirituality
- Learning something new or a new skill
- Doing exercise
- Dancing and singing
- Cooking and eating food that makes you feel good

- Sleeping well
- Spending time in nature
- Setting boundaries and spending time alone
- Connecting with others
- Laughing
- Watching a film or TV show
- Taking a bath or enjoying a beauty treatment
- Doing kind acts

## Maintaining boundaries

The MHFAider role is to support a person and, if appropriate, signpost them to appropriate professional help. Much like in physical first aid, it is then the job of the professional to support the person in their professional capacity. Communicating boundaries between the MHFAider and the person being supported is important. If boundaries are not maintained it risks significant impact on the wellbeing of both the MHFAider and the person being supported.

Boundaries to consider in the MHFAider role:

### Confidentiality

Confidentiality is key to the working relationship. When discussing MHFA conversations with other people (such as other MHFAiders or HR representatives), it is vital to respect the person's right to privacy. Identifiable details such as name, age, role, and appearance should be left out of conversations. Identifying someone risks stigma and unfair treatment in the

workplace or community. Confidentiality always applies unless you are concerned that the person is at risk of harming themselves or others. When entering reflective notes into the MHFAider Support App, all data is encrypted and stored securely, including names, initials, and unique identifiers.

### Inappropriate relationships

You may use natural empathy and listening skills when looking out for someone close to you; however, sometimes it may not be appropriate for you to be in the MHFAider role for a friend or family member. It is important to consider if you are the right person to support them at that time.

Pursuing a personal relationship between the MHFAider and the person being supported, where there is no existing personal relationship, is outside of the role's boundaries. It isn't possible to see a situation objectively and you risk being judgemental. A person seeking support may be vulnerable, which could compromise their mental health.

In instances where the person being supported shows signs of being dependent on your support, communicate the boundaries of the role clearly, and signpost to appropriate professional help.

### Your wellbeing

Consider and communicate your availability and time commitments to the role in relation to other work or community responsibilities and your own wellbeing.

Recognising when you are struggling is key. When you are experiencing poor mental health yourself, or are having a tough day, you will bring these emotions to the role and will find it harder to be empathic, which puts the person being supported at risk. You also put your own wellbeing at risk by adding to your Stress Container. If you can't support someone, signpost them to another MHFAider or provide the details of a mental health helpline.

A photograph of a man sitting on a bus, seen from behind. He is wearing a white polo shirt and is looking out the window. The bus interior is visible, with rows of seats and red handrails. A large teal circle is overlaid on the bottom left of the image, containing the text.

# Understanding mental health in England



# What is mental health?

## What is mental health?

The World Health Organization defines health thus:

*"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (1)."*

Mental health encompasses all types of health related to the way we think, feel, and behave. We all have mental health, just as we all have physical health. We can have good mental health or experience poor mental health, just as we can have good physical health or poor physical health.

Mental health has also been defined as:

*"A state of well-being in which every individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community (2)."*

## What is poor mental health?

Poor mental health is a state that has a negative impact on the way we think, feel, and behave.

Poor mental health can cause distress or inability in social, work, or community settings and impact daily living, including how we relate and interact with those around us. For example, you might experience a back injury due to heavy lifting, or you might experience a period of depression due to increased stress or life pressures. Just like experiencing poor physical health such as a back injury,

severity of symptoms and longevity of poor mental health varies from person to person.

Some people have only one episode of poor mental health in their lifetime, while others have multiple episodes and periods of wellness in between. Only a small minority have diagnosable long-term poor mental health (mental ill health) and even then they can still live meaningful and satisfying lives.

## What is mental ill health?

The difference between poor mental health and mental ill health is generally the degree and length of time the difficulties experienced impact a person's wellbeing and functioning. Mental ill health is when poor mental health has impacted a person to the point where it could be a diagnosable mental health condition, however, it doesn't mean there is always a diagnosis sought. Mental ill health generally has more of a significant detrimental impact on a person's life than periods of poor mental health, which may be situation specific or time limited. Just like a long-term medical condition such as diabetes, there is support and treatment available for mental ill health and mental health conditions.

## Mental health conditions

There are different types of mental health conditions, some of which are common, such as depression and anxiety disorders, and some of which are not common, such as schizophrenia and bipolar disorder. However, mental health conditions, as with

any health difficulty, can cause disability. This is not always well understood by people who have never experienced mental health conditions.

Note: Mental health conditions are different to neurological disorders, but sometimes they can display similar symptoms. Neurological disorders are described as physical malfunction of or damage to the brain and nervous system.

## Mental health on a continuum

In MHFA, mental health is seen as a continuum ranging from having good mental health to poor mental health and from having no diagnosis of a mental health condition to a diagnosis. A person will vary in their position along this continuum at different points in their life. A person with good mental health will feel in control of their emotions, and will have good cognitive functioning and positive interactions with people around them. This state allows a person to perform well at work, in their studies, and in family and other social relationships.



# The Mental Health Continuum

The Mental Health Continuum is a way of looking at how our mental health is fluid and changes over time. Initially people described the state of mental health as being a continuum, with being mentally healthy at one end and experiencing poor mental health at the other. This is less favoured now as it does not, for example, allow people who have a diagnosable mental health condition (e.g. bipolar disorder) and are coping well with the condition (good coping strategies, good medication regime, supportive friends, etc.) to have positive mental health. Now the favoured approach is to talk about two continua on different axes.

On any given day we all exist somewhere on a scale that ranges from 'maximum wellbeing' to 'minimum wellbeing', and we move up and down this scale which forms the vertical axis. The horizontal axis ranges from having no formal diagnosis of a mental health condition to having a diagnosis.

## The Mental Health Continuum quadrants

When these two ways of thinking are combined into the Mental Health Continuum, it creates four quadrants which we can move around throughout our lives.

### 1. Top-right quadrant

A person who has positive mental health and wellbeing, and no diagnosis of a mental health condition, would sit in the top-right quadrant. A person in this quadrant is thriving, coping well with life, and can adjust to day-to-day challenges

without an overwhelming impact on their quality of life.

### 2. Bottom-right quadrant

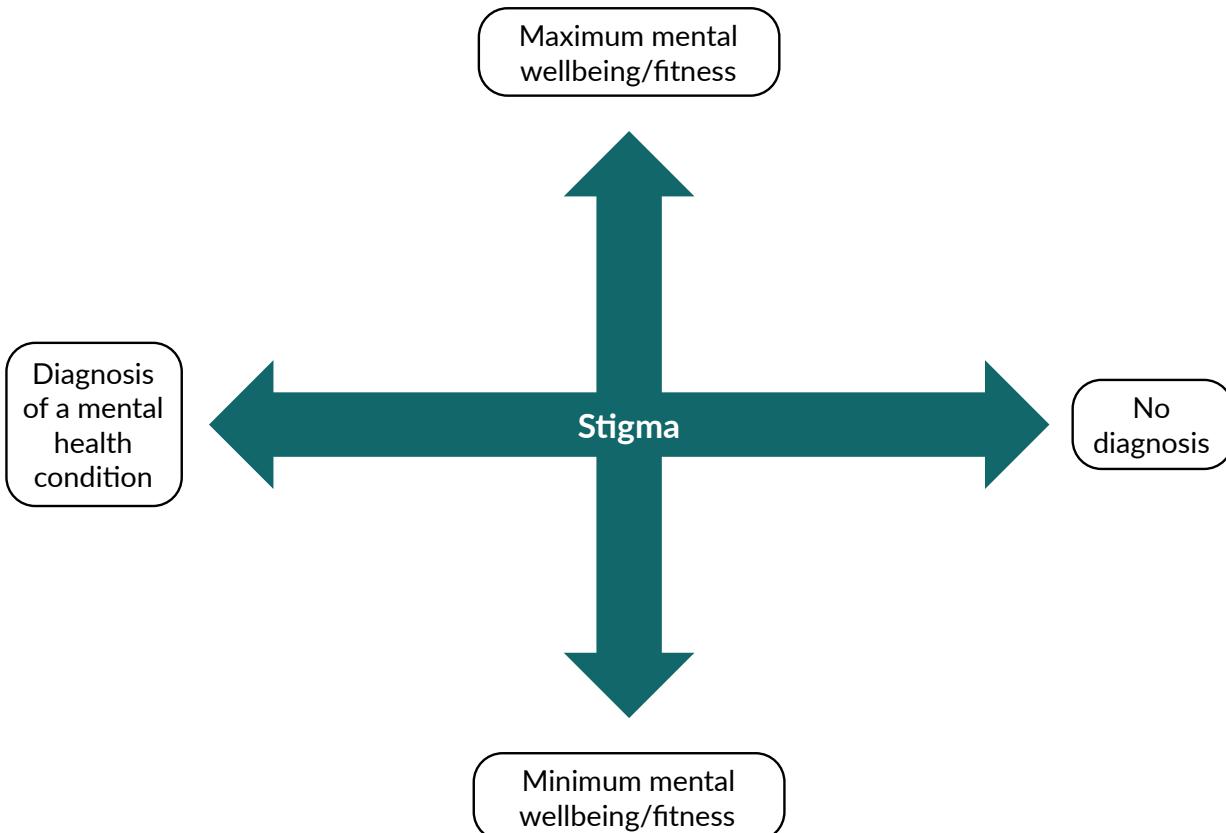
Stresses and life events can lead a person's mental health to deteriorate, which would move them into the bottom-right quadrant of the continuum. This is where a person's mental wellbeing is no longer positive, and they are struggling, but they haven't received a diagnosis yet. Maybe they don't realise they are unwell, they haven't been able to access professional help, or they don't quite meet the criteria of a formal diagnosis. People in this quadrant may be overlooked because nobody has noticed their symptoms or feelings, or that they might need help and support.

### 3. Bottom-left quadrant

A person who has received a diagnosis would sit in the bottom-left quadrant of the continuum. Here, their mental health is not yet positive, however, a diagnosis now allows them to access support and treatment to help them address their specific symptoms and difficulties.

### 4. Top-left quadrant

If this person receives appropriate support and treatment, it is possible for them to move into the top-left quadrant of the continuum, where a person can still have symptoms and a diagnosis but also ways of managing them – for example medication or coping strategies. This means that, overall, their mental health is positive. People with a diagnosis of a specific condition who are coping well and have positive mental health may no longer strictly qualify for this diagnosis



based on assessment criteria, for example if someone experienced an isolated psychotic episode as a young person. But they may feel they cannot move from the top left quadrant to the top right quadrant due to the perceptions people hold about them based on their original diagnosis. The most important thing is that the person is above the line of positive wellbeing and is coping well.

### Stigma

Stigma can be seen as a barrier to recovery due to the perceptions which people hold about mental health and poor mental health. Fear of encountering stigma or self-stigma may prevent people from seeking support and gaining a

diagnosis (and therefore from moving from the bottom right quadrant to the bottom left quadrant). This may then prevent them from receiving the treatment and support that can help them recover good mental health.

## The impact of poor mental health

The World Health Organization states that poor mental health can be a major cause of long-term disability worldwide. It is widely accepted that poor mental health ranks highly on the scale of disease burden in high-income countries, alongside cardiovascular (heart) diseases, cancers, and musculoskeletal disorders. Disease burden is the combined effect of premature death and years lived with disability caused by a mental health condition.

Poor mental health symptoms often start in adolescence or early adulthood. When poor mental health begins at this stage in life, it can affect the young person's education, movement into adult occupational roles, and forming of key social relationships including marriage.

It can also increase the likelihood of alcohol or other drug misuse or dependency. Consequently, poor mental health can cause disability across a person's lifespan and some mental health conditions can cause premature death. Therefore, it is important to detect signs early and ensure the person receives appropriate treatment and support.

Disability refers to the amount of disruption a health issue causes to a person's ability to work, look after themselves, and continue relationships with family and friends. The degree of disability that can occur during an episode of poor mental health can be comparable to that caused by physical illnesses.



# What influences mental health?

Lots of different factors influence people's mental health. Anybody can experience poor mental health or be diagnosed with a mental health condition. There is no single cause for poor mental health or diagnosable mental health conditions, and the causes can be complex.

However, we know there are risk and protective factors that can influence whether a person experiences poor mental health and how quickly they will recover.

## Risk factors

'When a society is flourishing health tends to flourish. When a society has large social and economic inequalities there are large inequalities in health. The health of the population is not just a matter of how well the health service is funded and functions, important as that is: health is closely linked to the conditions in which people are born, grow, live, work and age and inequities in power, money and resources – the social determinants of health (3).'

Poor mental health is both a cause and a consequence of inequality and as a result some groups of people are at greater risk of poorer mental health than others. This often reflects social disadvantage. Owing to inequality, those with greater risk factors may have reduced access to relevant mental health services and effective treatments. They may also find that their experiences of mental health services are substandard. Stigma and discrimination within services undermines diagnosis, treatment, and successful health outcomes, and could cause further

harm to a person's mental health. Many people have multiple intersecting risk factors. The risk factors discussed in this section should not be considered in isolation.

Although some people may be more likely to develop poor mental health, many people with these risk factors will not. People can also experience poor mental health if they do not fit into groups statistically more likely to do so.

Whilst the factors in this section carry an increased risk of developing poor mental health, many can also act as protective factors through supportive traditions, family and community networks, and positive relationships. For example, religious belief and spiritual practice may support positive mental health by helping a person to feel connected to something bigger than themselves, or encouraging strength, hope or feelings of acceptance and good self-esteem (4).

For statistics relating to inequalities and mental health see Centre for Mental Health's '[Mental health inequalities: Factsheet](#)'.

Risk factors for poor mental health include, but are not limited to:

## Age

### Why is this a risk factor?

Our age can affect our mental health at different stages throughout life. The evidence tells us that age provides a useful marker for understanding the different risks to our mental health.

## What influences mental health? cont

### What do we need to know?

16 to 24-year-olds have an increased risk of loneliness and schizophrenia is much more likely to emerge during this time than any other age. The majority of poor mental health issues appear by age 24 and some behaviours associated with poor mental health are more common in younger people, for instance, self-harm as a means of coping with feelings of distress (5).

Suicide is the biggest cause of death for men in midlife. Men in midlife now may struggle to cope with major social or life changes around this time, as are part of the so-called 'buffer' generation, caught between their older, more traditional and silent male family members and their younger, more progressive and individualistic male family members. Beyond the age of 30, men tend to have fewer supportive peer relationships. They are at a higher risk if they are from a disadvantaged background, are in a difficult relationship and/or feel societal pressures to meet traditional 'masculine' expectations (6).

The UK population is ageing rapidly, with the number of people in 'later life' growing by nearly half in the past 30 years (it is broadly defined that 'later life' starts at 50 years of age). Many people will begin to notice their fitness levels changing and experience problems with their physical health during this time. Some may struggle to cope with their changing life and social roles such as retirement, feel isolated, or find it difficult to secure employment. Older people may also face age discrimination (7).

### Disability and physical illness

#### Why is this a risk factor?

Disability or physical illness that restricts life choices or causes physical pain is likely to put a person at greater risk of poor mental health. People living with a disability are also more likely to face discrimination and exclusion.

#### What do we need to know?

Forms of physical disability or certain medical conditions can cause pain or restrict mobility, social contact, or the ability to take part in activities outside the home. For some medical conditions the risk of developing poor mental health is associated with the side effects of prescribed medications.

Learning disability is often confused with poor mental health. Evidence suggests that poor mental health may be higher in people with a learning disability than in those without. There are specific risks associated with poor mental health in people with learning disabilities, for example, genetics (both may increase vulnerability), potentially higher incidence of negative life events, access to fewer support and coping skills, stigma and discrimination (8).

### Family history

#### Why is this a risk factor?

Most people with a mental health condition do not have relatives with the same condition, but research does suggest that poor mental health can be intergenerational, which means it can affect several generations of the same family.

### What do we need to know?

Whilst poor mental health can be hereditary (passed down through genes), researchers haven't found any specific genes that definitely cause poor mental health. Poor mental health can also be intergenerational for different reasons. The ways of thinking, coping, and behaving that we may learn from our parents or carers can be a cause of poor mental health (9).

- Direct workplace discrimination in the form of a reduction of working hours or a job transfer when they choose to reveal their identity (11)
- Harassment, for example, causing someone to feel humiliated or ashamed because they are transgender or non-binary by referring to them by the wrong pronouns despite correction, or asking very personal questions about their sex life or body (11)

## LGBTQIA+

### Why is this a risk factor?

LGBTQIA+ (Lesbian, Gay, Bisexual and Trans, Queer, Intersex, Asexual, and others) people face specific discrimination that increases their risk of poor mental health.

### What do we need to know?

The evidence tells us that the following discriminatory experiences can impact the mental health of LGBTQIA+ people:

- Rejection from family members or the family home
- Homophobic, bi-phobic and transphobic bullying, hate incidents and hate crimes, for example, verbal abuse, harassment, threats of violence, damage to property (10)
- Isolation from peer groups
- Stigmatised treatment from GPs and other care professionals



## What influences mental health? cont.

### Neurodiversity

#### Why is this a risk factor?

Neurodiversity can impact mental health if a neurodivergent person faces discrimination or isn't given the correct diagnosis and/or support.

#### What do we need to know?

Neurodivergence is the term for when a person's brain processes, learns, and/or behaves differently from what is considered 'typical'. It refers to the natural differences between people's varying characteristics of neurodevelopmental conditions. Between 30% and 40% of the UK population are thought to be neurodiverse. The remaining majority are neurotypical (12).

While it is common for neurodevelopmental conditions to coexist with mental health conditions, e.g. attention deficit hyperactivity disorder (ADHD) and bipolar disorder, due to lack of awareness it is also common for neurodevelopmental conditions to be misdiagnosed as mental health conditions. It is thought that as research advances, certain mental health conditions such as some personality disorders and psychotic disorders, will show to have been diagnosed both in people who experience symptoms of poor mental health and in people who are experiencing neurodivergence (12).

### Pregnancy and parenthood

#### Why is this a risk factor?

During pregnancy and parenthood, parents can experience multiple challenges

to their mental health, including sleep deprivation, physical illness, strained relationships, isolation, financial strain, loss of self/former life, and birth trauma. Significant transformations to a person's responsibilities and routine can impact their mental health.

#### What do we need to know?

As many as one in five women experience poor mental health during pregnancy or in the first year after birth. If left untreated, poor mental health in mothers can have significant and long-lasting effects and can impact the child and the wider family (13). Suicide is a leading cause of maternal deaths in the UK within a year after childbirth, however, in almost half of the country pregnant women and new mothers have no access to specialist community perinatal mental health services (14).

It should be recognised that both mothers and fathers of young children face an increased risk of poor mental health. The following factors have been identified as commonly having an impact on the mental health of new fathers (15):

- Parental alienation
- Isolation from parenting community
- Lack of information and professional support
- Negative attitudes about young fathers (e.g. that they're absent or reckless), often fuelled by the media
- Societal pressures to not discuss their emotions or ask for help

## Race and ethnicity

### Why is this a risk factor?

The common experience of racism impacts the mental health of racialised communities in the UK. Like all forms of oppression, racism literally makes people unwell.

### What do we need to know?

Racism can range from microaggressions (subtle but offensive comments) to explicit hurtful words or physical aggression. Systemic racism (a form of racism that is embedded in the laws and regulations of a society or an organisation) and inequality of care within the mental health care system create a cumulative, negative impact on mental health.

Black people and People of Colour may be less likely to engage with health systems due to experiences of discrimination, both within and outside of health services. This could play a part in a person reaching services only at a point where symptoms have become severe enough to warrant inpatient treatment, affecting their diagnosis and/or recovery (16).

Concepts about mental health also vary across different cultures, therefore we can't assume that everyone shares the same ideas about mental health. In some communities, poor mental health is rarely recognised or spoken about, and may be seen as shameful. This can prevent people from talking about their mental health or seeking professional help (16).

## Refugee status and seeking asylum

### Why is this a risk factor?

Refugees and asylum seekers can experience prejudice and discrimination in all walks of life. They face unique and complex challenges and are often at greater risk of developing poor mental health.

### What do we need to know?

Asylum seekers and refugees are more likely to experience poor mental health than the local population, including higher rates of depression, post-traumatic stress disorder (PTSD), and other anxiety disorders. However, data show that they are less likely to receive support.

The increased vulnerability to poor mental health that refugees and asylum seekers face is linked to pre-migration experiences, such as war trauma, and post-migration conditions, such as separation from family, difficulties with asylum procedures, and poor housing (17). Strategies which disperse refugees and asylum seekers across the UK and the use of detention centres may also increase their vulnerability to poor mental health.

## Relationship status

### Why is this a risk factor?

Being in a stable relationship can support positive mental health and has been found to be associated with lower levels of stress and depression. However, single people have been found to have more positive mental health than people who are in an unhappy relationship.

## What influences mental health? cont.

### What do we need to know?

Unhealthy relationships can increase the risk of depression, anxiety, and suicide thoughts. A person's wellbeing can also have an effect on their partner (18).

There is a strong association between experiencing domestic abuse and poor mental health. Despite this, domestic abuse often goes undetected within mental health services and domestic abuse services are not always equipped to support poor mental health.

At the time of accessing specialist domestic abuse support, some people are experiencing some of the highest levels of multiple disadvantage i.e. financial problems and substance misuse, as well as poor mental health (19).

Having poor mental health is also a risk factor for experiencing abuse and therefore a significant proportion of people accessing mental health services are found to have experienced abuse (19).

### Religion or belief

#### Why is this a risk factor?

Although some religious and spiritual beliefs may be empowering and supportive, some beliefs or practices may increase the risk of poor mental health.

#### What do we need to know?

Some religious beliefs may cause a person to feel guilt for their actions, impacting how they feel about themselves and their life. Some religious groups may also believe that poor mental health is caused by demons

or spirits or is punishment for wrongdoing. As in all areas of society, there are people in spiritual or religious groups who may take advantage of vulnerable people and encourage radicalised or extremist beliefs (4), which can have a significant impact on a person's mental health.

### Sex

#### Why is this a risk factor?

The evidence tells us that although our sex does not predetermine our experience of mental health, there are some differences in men's and women's experiences of mental health, including the way they talk about or experience their symptoms, are given diagnoses, and access treatment and care.

#### What do we need to know?

Note that the NHS recognises three sexes (male, female, and intersex). Future data may change as gender identities are incorporated.

Around one in five women live with a common mental health condition such as depression and anxiety that may be caused by the following factors (20):

- Being a carer
- Living in poverty
- Physical and sexual abuse or violence
- Internalising difficult feelings
- Pregnancy and menopause

However, some factors protect women's mental health. Women tend to have better social networks than men and find it easier to confide in their loved ones. Men are more likely to act out their feelings through

disruptive or dangerous behaviour which can lead to death by suicide (20).

## Socioeconomic conditions

### Why is this a risk factor?

Low socioeconomic conditions have a significant impact on a person's mental health. Both urban and rural living come with associated risks for developing poor mental health.

### What do we need to know?

People who experience disrupted education, inadequate housing, or poverty are more likely to develop poor mental health. In addition, community violence and time spent in prison can also have a negative impact on a person's mental health.

The risk of developing depression, psychosis or an anxiety disorder has been found to be higher in urban dwellers than those who live outside the city. Studies have identified a large number of factors related to the built environment, such as reduced access to green spaces and high levels of noise and air pollution. Other factors pertain to the social environment, such as loneliness, perceived and actual crime, and social inequalities (21).

On the other hand, living in rural and remote areas often means people can feel socially isolated, which in some people can lead to anxiety and depression. Funding for mental health tends to be focused on 'according to need' i.e. where there are higher percentages of those registered with serious mental health

conditions, which tends to be in urban areas. This can mean people living in rural and remote areas have to travel longer distances to mental health services and can be further impacted by little or no regular public transport (22).

## Traumatic events

### Why is this a risk factor?

When a person experiences trauma, their body's defences take effect and create a normal temporary stress response. When this does not resolve, there is a risk of developing more long-term poor mental health.

### What do we need to know?

It is common for a person to experience shock, denial, sadness, or guilt following a traumatic event. If these feelings persist for longer than a month they can lead to more serious mental health problems such as PTSD and depression (23).

Recent adverse and traumatic life events, such as being a victim of crime, experiencing serious illness or death in the family, having an accident, experiencing bullying or victimisation, going through separation or divorce are all risk factors for developing poor mental health.

People who have had adverse childhood experiences (e.g. physical abuse, sexual abuse, neglect, conflict in the home, overstrictness) are also more likely to develop poor mental health.

## What influences mental health? cont.

### Working environments

#### Why is this a risk factor?

Work can give a person purpose and financial stability, promote independence, help to develop social contacts, improve self-esteem, and be an important step to recovery.

It is also a factor in preventing poor mental health. However, stresses at work can increase the risk of developing poor mental health and aggravate existing poor mental health.

#### What do we need to know?

Job stressors (e.g. high job demands, low job control, lack of social support in the workplace), as well as unemployment and poor living conditions caused by low income or unemployment, increase the risk of a person developing poor mental health. Work-related stress can also aggravate existing poor mental health, making it more difficult to manage.

To enhance employee wellbeing, employers can implement the following core standards (24):

- Produce and communicate a 'positive mental health at work' plan
- Develop mental health awareness among employees
- Encourage open conversations about mental health and the support available
- Provide employees with good working conditions and ensure they have a healthy work-life balance and opportunities for development

- Promote effective people management to ensure all employees have a regular conversation about their health and wellbeing
- Routinely monitor employee mental health and wellbeing

### Protective factors

The more protective factors a person has, the less likely it is that they will develop poor mental health. Risk and protective factors can be current or influenced by past experiences. While we cannot change past events, by focusing on which protective factors can be strengthened or newly developed, we can support our own, and others', wellbeing and recovery.

Examples of protective factors include:

#### Life skills

- Self-belief and values
- Problem solving and coping skills
- Communication and conflict resolution
- Respectful relations and emotional literacy

#### Community engagement/physical health

- Meaningful activity
- Positive social network
- Stable home and positive parenting
- Physical activity, rest and reflection
- Nutrition

# Stigma and discrimination

## What are stigma and discrimination?

Stigma involves negative attitudes (prejudice). Discrimination refers to negative behaviour. This includes negative attitudes and behaviour from individuals or wider inequalities such as low levels of support, understanding and acceptance of poor mental health present in society.

Society's attitudes and support for people with poor mental health should be fundamentally the same as for physical illnesses. People experiencing poor mental health need the respect and assistance of friends, family members, and the broader community.

The World Health Organization's Diagnostic and Management Guidelines for Mental Disorders in Primary Care, ICD-10 Chapter V, stress that the approach to poor mental health should be fundamentally the same as that to physical ill health.

## The effects of stigma and discrimination

Stigma can have several detrimental effects. It may lead people to hide their difficulties from others. People are often ashamed to discuss poor mental health with family, friends, teachers and/or work colleagues. It may also hinder people from seeking help. They may be reluctant to seek treatment and support for poor mental health because of their concerns about what others will think of them.

Stigma can lead to the exclusion of people with poor mental health from employment, housing, social activities, and having relationships. Although many people with poor mental health say they would like to work and are capable of work, studies consistently show that people with a long-term mental health condition in England have the lowest employment rates for any group of people with disabilities.

Stigma and discrimination can also include ruling out the possibility that a person with long-term poor mental health may be able to work, volunteer, or contribute to their community in a meaningful way, regardless of their personal circumstances, strengths, or skills. While it may be true that some people can be so affected, it is crucial to consider the person as a unique individual rather than making sweeping judgements based on their diagnosis.

## Language

The language we use daily can make a real difference to the way we contribute to or reduce stigma and discrimination. This includes words, phrases, and the context of the language we use.

Unhelpful language can reinforce stereotypes and contribute to stigma. Helpful language can have a positive effect on people's attitudes towards mental health.

## Stigma and discrimination cont.

The effects of language on a person can include:

- Unhelpful language can act as a barrier to accessing professional help by creating shame or 'othering' (when individuals or groups are defined and labelled as not fitting in within the norms of a social group) (25).
- Unhelpful language can cause a person to internalise stigma and feel shame.
- Helpful language can normalise conversation around mental health and remove shame. By practising using empowering language we can contribute towards a person accessing help or talking about their personal experience.
- Poor mental health is not always visible to others and so people with poor mental health may be incorrectly perceived as weak, lazy, selfish, uncooperative, attention seeking or exaggerating symptoms. People with poor mental health can internalise these words and begin to believe the negative things that others say about them.

The nuances of language mean that different terms may be chosen by people with lived experience of poor mental health to self-describe. These may be unique to the person and terms can be empowering or stigmatising depending on the person.

### Stigma associated with specific mental health conditions and behaviours

Symptoms of psychotic conditions involve unusual experiences which can be difficult for most people to relate to, meaning that

the conditions carry significant stigma, especially where the person may be given a diagnosis of schizophrenia. Such stigma is maintained by a widespread lack of understanding of psychosis and mistaken beliefs and language. For example, slang terms like 'psycho' may conflate the diagnosis of psychosis with the concept of psychopathy (another term for severe antisocial personality disorder, which by its definition includes a lack of remorse and capacity to care for other people and is associated with increased criminality). It is important to remember that people who experience psychosis are in fact far more likely to be the victims of violent crime than the perpetrators. They are also far more likely to harm themselves than others. Unfortunately, the media tends to publicise the few people with poor mental health who become violent, rather than the large numbers who don't, which skews public perception around this topic.

For many years the diagnosis of personality disorder was used as a way of excluding people from the mental health system altogether. The perception was that it was 'untreatable', effective treatment for personality disorders did not exist, and that the very real distress of someone in crisis was 'acting out' or 'attention seeking behaviour'. Even though much good work has been done to dismantle the derogatory views held by many professionals and improve treatment and care pathways for people with personality disorder, in many parts of the country systems are still not in place to deal with people who, in an acute crisis, are likely to communicate their distress through behaviour that can be very challenging, anxiety provoking, and hard to understand.

While many mental health conditions may be invisible, people who carry out self-harm behaviour often have scars or other visible signs that mark them noticeably. The attention these receive adds to stigma and discrimination. Many people hide their scars obsessively to prevent the negative consequences of them being seen. A number of people report discriminatory treatment, for example, no pain relief being provided when wounds are stitched up, or being faced with stigmatising attitudes that dismiss their symptoms, such as the person 'having brought it on themselves'.

The effects of these judgements and public 'disgust' promote the cycle of shame that leads to self-harm. They can lead to people not staying to complete treatment in emergency departments or deter them from seeking treatment in future. It may also make them less likely to ask for help for any underlying poor mental health.



# The Frame of Reference

## What is the Frame of Reference?

The Frame of Reference model shows that the way we all make sense of the world, of other people and ourselves, including our feelings, beliefs, and behaviours, is unique to each one of us, and shaped by our life experiences. We all see things slightly differently, and so we treat ourselves and other people differently too. Our individual Frame of Reference is influenced by a range of factors such as our family situation, education, culture, and life experiences. Our ‘window on the world’ shows us being surrounded by factors that have moulded our feelings, beliefs, and behaviours.

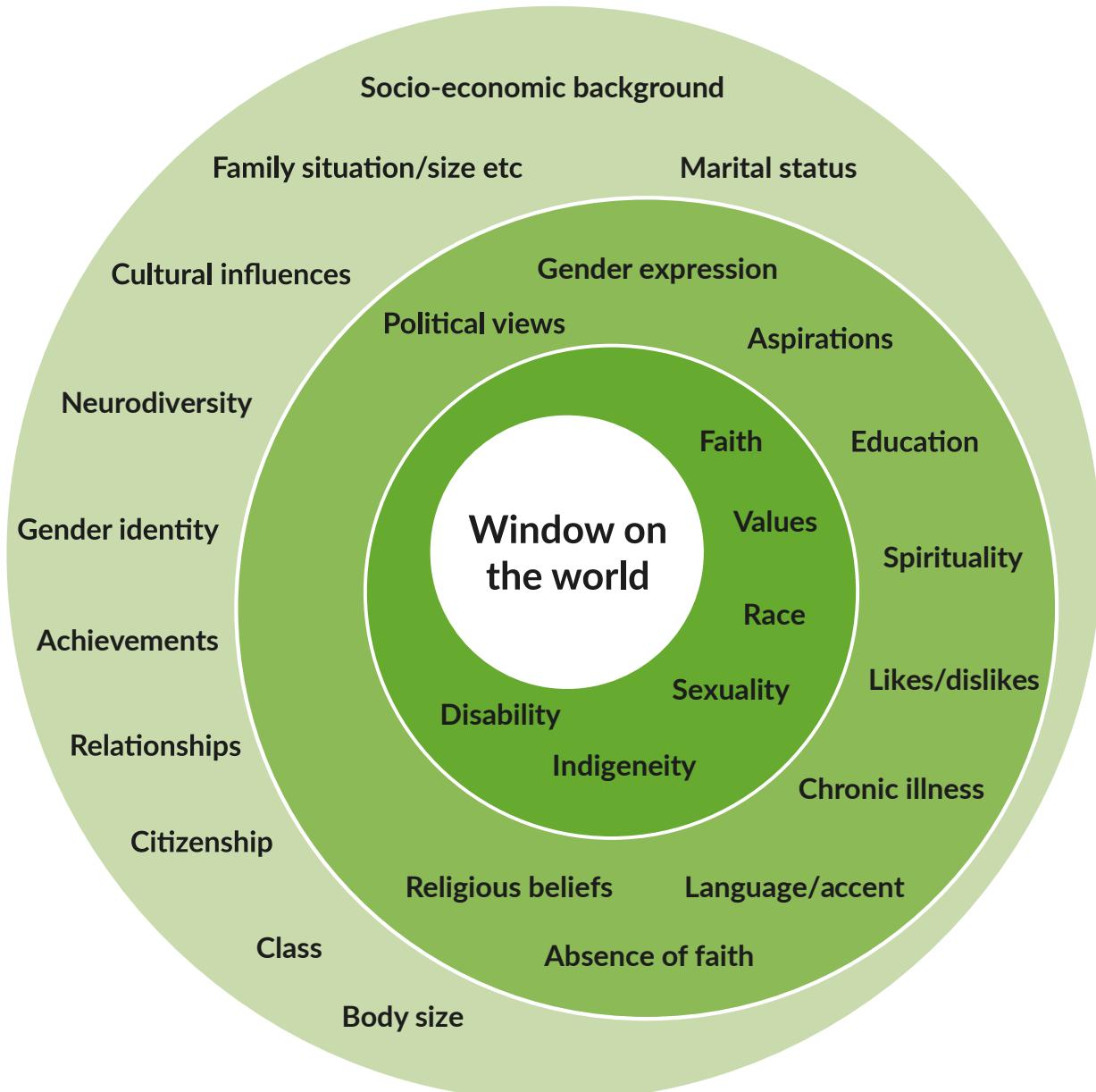
Because we all see things differently, it is best not to make assumptions when giving MHFA. To fully understand how someone else sees the world, we need to ask them about their point of view and put ours to one side during an MHFA conversation.

## Frame of Reference and Mental Health First Aid

It is useful to consider our own Frame of Reference when providing MHFA to someone. Sometimes, our window on the world can lead us to make judgements about a person’s situation and so hinder us from truly listening non-judgementally to the person we are helping. By noticing and understanding where these judgements may come from, we can more easily set them aside to help the person in front of us.

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### Example Frame of Reference



# Stress and vulnerability models

There are many different models to explain what may contribute to the development of poor mental health. Two key models are the Stress Vulnerability Model and the Stress Container. Both show how external stressors and individual vulnerabilities can combine to lead to the development of poor mental health.

## Sources of stress

It is useful to consider what we mean by the term 'stress'. Stress can come in many different forms. Some examples include:

### Physical stress

Late nights, binge drinking, drug misuse, lack of routine, poor diet, poor physical health or health conditions

### Environmental stress

Poor housing, social isolation, unemployment, new environments to adjust to such as moving house or holidays

### Emotional stress

Relationship problems, peer pressure, highly expressed emotion within the family home, conflicting cultural values and beliefs, leaving home, marriage

### Acute life events

Bereavements, physical accidents, rape, assault, arrest/imprisonment, fights, pregnancy and childbirth.

### Chronic stress

Accommodation problems, debts, prolonged use of drugs/alcohol

## The Stress Vulnerability Model

The Stress Vulnerability Model was proposed by Zubin and Spring in 1977. The idea behind it is that people become unwell when the stress they face becomes more than they can cope with. People's ability to deal with stress – their vulnerability – varies, so issues which one person may deal with easily might be enough to cause another person to develop poor mental health.

Possible causes of vulnerability levels include:

### Genetics

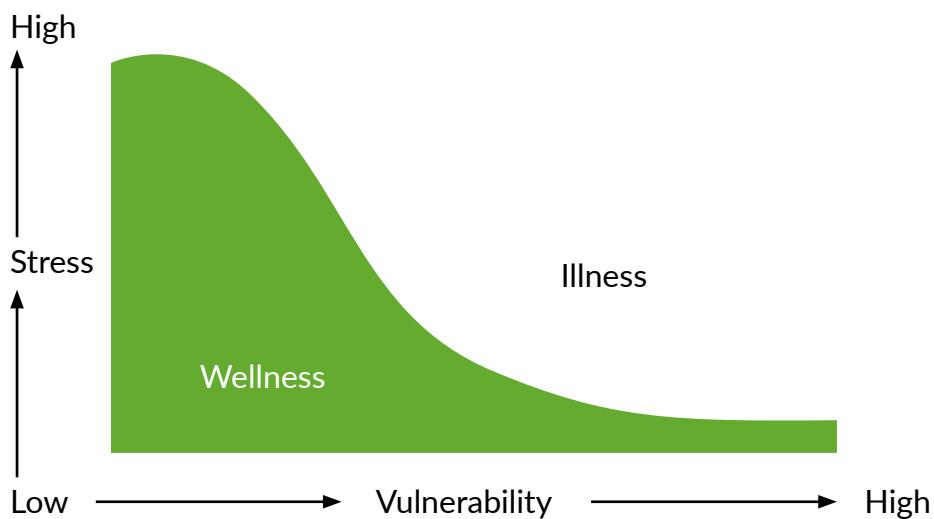
Evidence from family studies, particularly studies involving twins, seem to show a strong genetic element. It seems that one aspect of a person's vulnerability is related to their genetic make-up.

### Coping style

Certain methods of coping with life's difficulties seem to be more effective than others. People who use effective coping skills seem to deal with stress better than those who don't.

### Thinking style

How people think about themselves or the world around them seems to make a major difference to their level of vulnerability to stress. There are positive thinking methods which help some people to cope better than others.



### The Stress Vulnerability Model

#### Environment

The way a person deals with stress and the options they have are often related to their environment. Anything from the state of a person's home to the neighbourhood they live in can make a difference.

can be developed just as other skills can and it is sometimes possible to change a person's environment for the better.

#### Social skills

The better a person's social skills the easier it is for them to get other people to help them when things get too tough for them to handle alone. People with lots of supportive friends tend to do better in times of crisis than people with fewer or perhaps no other people to turn to.

The key to decreasing levels of vulnerability may lie in helping people to examine the factors outside of genetics which make them vulnerable and looking for positive ways to change them. For example, it is possible to adopt different styles of coping and thinking. Social skills

## Stress and vulnerability models cont.

### The Stress Container

#### What is the Stress Container?

In the Stress Container model, the level of vulnerability a person carries is represented by the size of a container into which everyday stresses flow. Those who have low vulnerability are less likely to experience mental health issues. They have large containers. The size of the container can be due to a lot of factors from someone's background, e.g. being bullied or abused as a child. The more of these negative factors there are, the smaller the container, so it will overflow quicker than for someone who has a large container/low vulnerability and is able to cope with stress more efficiently.

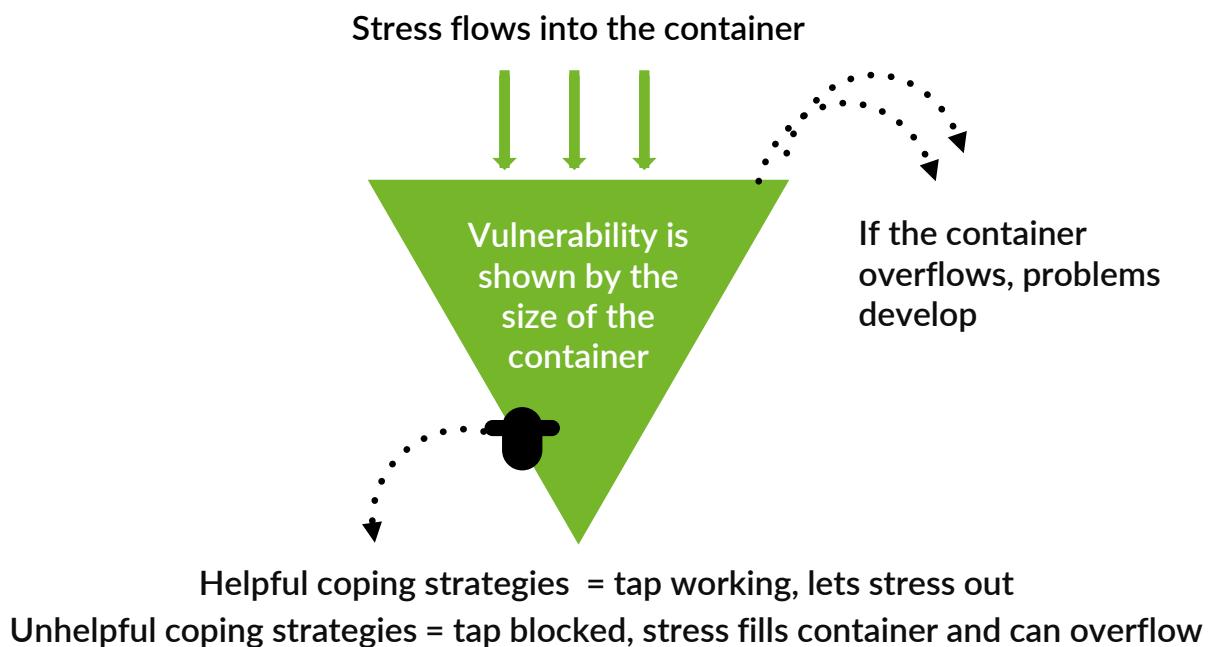
When the container overflows, the person is overwhelmed. This needs attention because mental and physical illness can arise if someone is constantly overwhelmed. This is sometimes called our 'stress signature'. Awareness of what overwhelmed looks and feels like is very important for maintaining health.

There is a tap on the Stress Container to release stress before it overflows. There is a gap at the bottom of the container below the tap where stresses in life can become trapped. This is normal and sometimes certain stressors can't be dealt with at that time. Our Stress Containers are never completely empty. It is about actively managing what is in there.

#### Coping strategies

Stresses need to be dealt with to create capacity in the container and stay healthy. Learning ways of coping with stress is another way of stopping the container overflowing, for example talking through worries with someone or getting a good night's sleep. These allow stressors to be released by the tap.

Some coping strategies are not helpful and may actually make things worse and increase overflowing or block the tap, e.g. drinking alcohol, taking drugs, or not talking through worries. It is important to know that we all use unhelpful coping strategies sometimes and some unhelpful coping strategies can come about as a result of other vulnerabilities or life experiences, including trauma. They may have been helpful to the person in small doses or under different circumstances before becoming problematic. As with any skill in life, it is possible to develop new coping strategies. Many interventions and supports for poor mental health will take this approach.

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# Recovery

## What is recovery?

Recovery refers to the lived experience of people as they accept and overcome the challenge of their poor mental health. Recovery is much more than achieving the absence of symptoms and means different things to different people.

People can, and do, recover from mental health conditions with severe symptoms. A wide variety of factors can influence recovery. These include having supportive social networks (family and/or friends) and playing a meaningful role in society, for example through education and employment opportunities. Recovery may also be impacted by the quality and availability of treatments and the person's willingness and ability to take up the opportunities available to them.

For some people recovery can be a long-term process and may not be linear – there may be setbacks on the way. Poor mental health affects people differently and so recovery will be different for each person. This holistic interpretation of recovery, primarily developed and promoted internationally by the mental health service user movement, was perhaps best described by W. A. Anthony in 1993:

*“... (Recovery) is a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of poor mental health (26).”*

Recovery provides an empowering message of hope, which says that, regardless of symptoms, people with poor mental health should have every opportunity to lead fulfilling and satisfying lives. What brings meaning to a person's life may be different for everyone, and recovery is about the person discovering this for themselves as well as discovering – or re-discovering – a sense of personal identity which goes beyond that provided by a diagnosis. Instead of focusing on illness and condition, recovery involves moving towards personal strengths, greater resilience, and wellbeing.

Hope is central to recovery, and for many people, it flourishes as they gain opportunities to be actively in control of their lives. This may include retaining choice over treatment and finding ways of helping themselves in a way that suits them. Therefore, focusing mental health services on recovery means moving away from traditional models of medical treatment, where professionals are the experts, and towards a more evenly balanced relationship, where professionals become partners and coaches to the person's recovery, one of many resources to support the person's growth.

Recovery is a deeply personal process, but people don't recover in isolation – social inclusion and involvement in local communities is a cornerstone of recovery. This means that mental health is everyone's business. The attitudes and beliefs that society holds about mental health have a powerful impact on someone's experience and their recovery.

## Spectrum of interventions for poor mental health

There are a wide range of interventions for preventing and helping people with poor mental health. MHFA is just one part of the spectrum of intervention where different types of interventions are appropriate for different states of mental health. For a person who is well or with some mild symptoms, prevention programmes are appropriate. For a person who is experiencing mild to moderate symptoms, early intervention approaches such as MHFA can be used. For a person who experiences severe symptoms with or without a diagnosis of a mental health condition, a range of treatment and support approaches are available to assist them in their recovery process.

### Prevention

Prevention programmes range from parenting skills training, drug education and resilience training programmes in schools, to promotion of physical exercise to improve mood, to stress management courses and policies to reduce stress in the workplace.

MHFA is also a useful tool to raise mental health literacy in the population.

### Early intervention

Early intervention programmes target people who are just developing poor mental health. They aim to prevent difficulties from becoming more serious and reduce the likelihood of knock-on

effects such as loss of employment, school dropout, relationship break-up and drug and alcohol misuse. Many people have a long delay between developing poor mental health and receiving appropriate treatment and support. The longer people delay getting help and support, the more difficult their recovery can be. It is important that people are supported by their family, friends, and work colleagues during this time. People are more likely to seek help if someone close to them suggests it. It is during this early intervention phase that giving MHFA can play an important role.

### Treatment, therapies, and professional support

There are many different types of treatment, therapies and professional support that can help people with poor mental health with their recovery. Once the person has decided to seek help, they can choose from several sources of help, treatment approaches, and service settings. For further information on specific treatments and therapies, see each condition section of the manual.

A photograph of a young woman with dark hair, wearing a light brown hijab and a grey scarf, smiling broadly. She is sitting on a bench in a park-like setting with yellow autumn leaves in the background. A large teal circular graphic overlaps the bottom left of the image, containing the text.

# The Mental Health First Aid action plan



## The five actions: ALGEE

Before providing MHFA, MHFAiders need some basic knowledge about mental health so that they can recognise developing poor mental health. Having an action plan can help to support a person more effectively.

In a physical first aid course, participants learn an action plan and acronym for the best way to help someone who is injured or unwell. The physical first aider will not always need to use all actions, as it will depend on the condition of the injured person.

Similarly, the MHFA course provides an action plan on how to help a person in a mental health crisis or developing poor mental health. Its acronym is ALGEE, and it is made up of five actions.

- Approach the person, assess and assist with any crisis
- Listen and communicate non-judgementally
- Give support and information
- Encourage the person to get appropriate professional help
- Encourage other supports

Although the action of assisting with a crisis is the highest priority, the other actions in the MHFA action plan may need to happen first. MHFAiders should use good judgement about the order and the relevance of these actions, and need to be flexible and responsive, depending on the individual and situation they are supporting. Listening and communicating

non-judgementally is an action that occurs throughout the practice of MHFA.

At the centre of the ALGEE graphic is a person. This is because the action plan is person-centred.



# Action 1: Approach the person, assess and assist with any crisis

The first action is to approach the person, look out for any crises and assist the person in dealing with them.

## Approach

If you think that someone you know is showing signs of poor mental health and in need of help, approach them about your concerns. If you know the person, the main thing to notice is change in their behaviour. The approach is to ensure as far as possible that the person will feel safe and comfortable talking to you. The key points are to:

### Try to find a suitable time and space

Find a place where you both feel comfortable if the situation permits.

### Let the person choose the moment to open up

However, you should initiate a conversation with the person about how they are feeling, if they do not do so themselves.

### Let the person know what you may have noticed

Let the person know what has caused you to be concerned for them.

### Let the person know that you are available to talk when they are ready

Avoid putting pressure on the person to talk right away.

### Respect the person's privacy and confidentiality

Unless you are concerned that the person is at risk of harming themselves or others.

## Assess

Assess for any risk of crisis (a situation where immediate help is required):

- The person may harm themselves by attempting suicide or by self-harming
- The person experiences distress e.g. a psychotic state, a traumatic event, or a panic attack
- The person's behaviour is very worrying to others (e.g. they become aggressive or lose touch with reality)

Be aware of crisis indications whilst talking with the person and asking questions about what they are experiencing. Always be aware that risk to life or health can be present for the person and the MHFAider, and you need to respond accordingly.

If the MHFAider has no concerns that the person is in crisis, they can ask the person about how they are feeling and how long they have been feeling that way and move on to Action 2.

## Assist

If the person is in a crisis, assist them based on what they have told you, and seek immediate professional help if required.

For details on how to apply first aid to crisis situations, see pages 128-160.

## Action 2: Listen and communicate non-judgementally

### It is important to always listen and communicate non-judgementally throughout MHFA.

Our brains are designed to evaluate a situation and judge people immediately. We all spend a great deal of time listening to what people are saying, and most of the time the words we hear trigger a reaction in our own minds. This means that we are often switched off to what the person is really saying and instead are following our own train of thought.

Listening and communicating non-judgementally means setting judgements aside about the person and their situation and ensuring the person doesn't feel judged. Most people who are experiencing distressing emotions and thoughts want to be listened to before being offered options and resources. When listening non-judgementally, the MHFAider needs to practise active listening and use helpful listening and communication skills that:

- Allow the listener to really hear and understand what is being said to them, and
- Make it easier for the other person to feel that they can talk freely about their worries without being judged.

### Active listening

It is more important for an MHFAider to be genuinely caring than to say the 'right things'. Active listening is key to communicating non-judgementally and is built on three core conditions: acceptance, genuineness, and empathy. All are necessary

to create a safe, comfortable environment to enable someone to talk openly.

#### Acceptance

Acceptance is respecting a person's feelings, experiences, and values, even though they may be different from yours.

#### Genuineness

Genuineness is showing the person that you accept them and their values by being open and authentic during interactions through helpful verbal and non-verbal actions.

MHFAiders need to acknowledge what the person has said and show acceptance and validation through their responses. This will enable the person to feel connected and supported and helps to explore any concerns which may prevent them from getting support.

#### Empathy

Empathy is a state where you can truly hear and understand another person's feelings and have motivations to improve the situation, as well as being able to demonstrate it. For example, you may approach a person sleeping on the street and ask them how they are, and if there's anything you can do to help.

By increasing your level of engagement in a conversation through listening to the person and striving to understand them, you can increase your level of understanding. High levels of engagement and understanding result in showing

empathy. Showing sympathy has lower levels of engagement and understanding, and pity has the lowest.

To understand empathy, it may be helpful to also understand pity and sympathy.

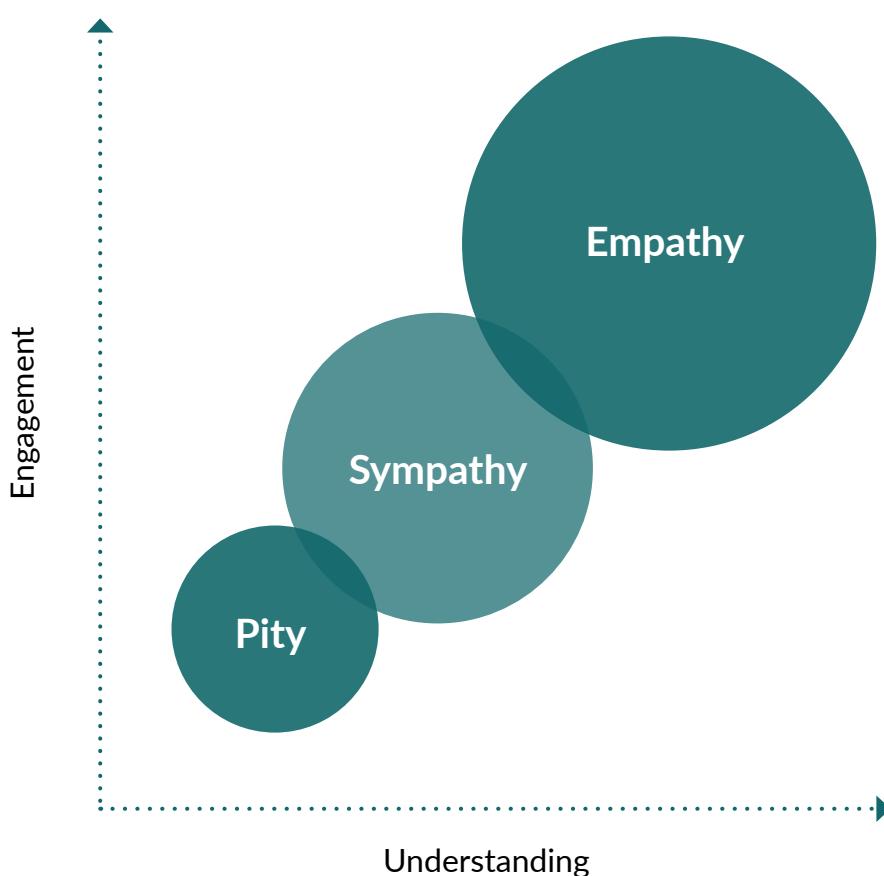
### Sympathy

Sympathy is a common reaction to a difficult situation of another person. There is an element of emotional investment, however, there's a feeling of distance between you and the other person. For example, you may decide to give the

person sleeping on the pavement some money and hope they spend it on a warm dinner or hostel and have a slightly more comfortable night.

### Pity

Pity is a state of feeling sorry for someone but there is further emotional detachment and an element of superiority. For example, you may see the person who is homeless and sleeping on the pavement and think about how unfortunate their situation is. You're glad you have a home to go to.



## Action 2: Listen and communicate non-judgementally cont.

### Helpful listening actions

Although you are asked to focus your attention on the feelings of the other person, it is important to be aware of your own feelings and thoughts. Supporting a person who may be distressed may evoke a number of responses in you, e.g. fear, irritation, sadness, a sense of being overwhelmed. These are normal responses to a difficult situation.

However, it is important that the listener continues to be open to listening respectfully and attempts to avoid reacting to what is being shared. That means focusing on the distressed person and understanding how it feels to be in their place. At times this may seem difficult, depending on the relationship between listener and the distressed person. Remember that in this moment you are offering the distressed person a place of safety based on respect, acceptance and understanding. In being an effective listener, it is important to be aware of your own Frame of Reference.

The way you respond to what a person is saying can impact the other person. Helpful listening actions can help to develop trust, feelings of validation, and hope for recovery. Unhelpful listening actions can create barriers to professional help or support, internalised stigma or shame and increased isolation.

The helpful actions below can be used by MHFAiders as part of their conversation to support a person experiencing poor mental health.

#### Helpful verbal listening actions

- Listen without interrupting
- Pay attention
- Ask appropriate questions to make sure both you and the other person are clear on what is being said
- Listen not only to the person's words but also to their tone of voice and look at their body language – all will give clues to how they are feeling
- Check your understanding of what is being said by restating what the person has said
- Summarise facts and feelings
- Minimal prompts such as 'Mmm', 'Ah' or 'I see' may be all that is necessary to keep the conversation going
- It is okay to have long pauses in the conversation. The person may simply be thinking or be lost for words. If you say something to fill what you see as an embarrassing silence, you may break the person's train of thought or the rapport between you
- Sitting quietly, but attentively, through a period of silence will demonstrate that you value being with the other person more than what you may say

#### Helpful non-verbal listening actions (body language)

- Be attentive
- Keep eye contact comfortable (avoid staring or avoiding eye contact)
- Keep an open body position (e.g. try not to cross your arms across your body)

- Sit down even when the other person is standing – it will make you seem less threatening
- Try not to sit directly opposite and facing the other person, as this can make it seem as though you are invading their space

Combining these skills and attitudes so that you can take part in a supportive conversation is not difficult, but it does take practice. Professional mental health workers and counsellors are trained to take this approach. This course does not give you that length or depth of training. However, as an MHFAider, you need to be aware of this approach and increase your skills in this area through practice. Using these techniques will enable you to be more confident in providing MHFA.

## Following a difficult conversation

After a difficult conversation you may feel unsettled, shocked, confused, angry, etc. You may also need to deal with the feelings and reactions you set aside during the conversation.

MHFAiders can access Shout's mental health text support service via the MHFAider Support App. It can also be helpful to make reflective notes on your experience in the MHFAider Support App or find someone to talk to about your experience, remembering to leave out identifying details. This is not the same as a crisis when you will need to reveal their identity.

# Action 3: Give support and information

Once a person with poor mental health has felt listened to, it can be easier for the MHFAider to offer support and information.

## Support

### Continue to provide emotional support

Recognise and accept how the person feels. This type of support is integrated across all actions of ALGEE and at this stage helps to give them hope for recovery.

### Support with practical help

Supporting with tasks which may seem overwhelming can help a person manage any external stressors they may be facing. For example, in a workplace setting you may be able to speak to a manager about reducing the person's workload. In a family or community setting, you may be able to offer to help with dog walking or grocery shopping.

### Be mindful not to take over or problem-fix

This can make it harder for the person to feel empowered and like they can make changes to improve their own situation.

### Encourage employers to support employees' mental health by:

- Holding mental health promotion events and getting involved with anti-stigma campaigns
- Placing confidential self-rating sheets in cafeterias, break rooms, or bulletin boards to assess levels of staff wellbeing
- Considering mental health routinely as part of policies and procedures, e.g. those relating to managing sickness absence,

supporting return to work or reasonable adjustments

- Ensuring workers' access to mental health services through health insurance benefits and benefit structures
- Taking a whole organisation approach to mental health. Staff awareness, line manager training, organisational policies/procedures and available support systems all need to work together.

## Information

### Ask

Ask the person if they would like information at the time of the conversation, especially if they seem overwhelmed by distressing emotions.

### Provide information from trusted sources

Helping the person understand that poor mental health is common and mental health conditions are real medical conditions will help reduce internalised stigma or barriers. MHFAiders should avoid using search engines as they may find unreliable results. Trusted and updated information can be found on the MHFAider Support App, in the MHFA England manual and through trusted sources such as [Mind](#), a national mental health charity.

It is important that you provide resources that are accurate and appropriate to their situation. Try not to assume that the person knows nothing about their signs and symptoms, as they, or someone else close to them, may have previously experienced a mental health condition.

# Action 4: Encourage the person to get appropriate professional help

For information on professional supports specific to conditions or behaviours, see the professionals and treatments sections under Developing mental health conditions. For specific helpful resources and contacts sign in to your MHFAider Support App or go to the [Hub of Hope website](#).

Seeking professional help for mental health issues is a difficult step for many people. Recovery outcomes are much better with early intervention.

## Ask

Start by asking if the person has received professional help before and whether they'd be open to accessing it now. By asking, you start a conversation centred around the person's hopes for recovery, and whether they know about sources of support. Discuss which services they think are most appropriate and then discuss the best way/s to access them.

## Appropriate contacts

A person with poor mental health will generally recover more quickly with appropriate professional help. However, they may not know about the various options that are available to them, such as medication, counselling or psychological therapy, support for family members, assistance with employment and educational goals, and assistance with income and accommodation.

Talk about which services they might think are most appropriate and then

discuss the best way to access them. Provide leaflets, websites, or phone numbers where possible. Some services include:

- Medical treatments include various types of prescribed medications and other treatments given by a doctor.
- Psychological therapies involve providing a supportive relationship and changing the way the person thinks or behaves. Usually, these therapies are delivered by talking one-to-one with a mental health professional, either face-to-face or online, or sometimes in a group, to address issues and to promote personal growth and coping skills. Self-help books and computerised psychological treatments and apps are also available.
- Complementary therapies and lifestyle changes involve using natural or alternative therapies to make positive changes in daily life. These can be used under the guidance of a health professional or as self-help.
- Support groups bring people with common difficulties together, allowing them to share experiences and help each other. Participation in self-help groups can help reduce feelings of isolation, increase knowledge, enhance coping skills, and improve self-esteem.
- Rehabilitation programmes help people regain skills and confidence to live and work in their community.

## Action 4: Encourage the person to get appropriate professional help cont.

### Explore concerns around professional help

Exploring professional and treatment options may also help to identify any concerns and/or reluctance the person may experience about accessing treatment, e.g. due to fear of stigma or mistaken beliefs about treatment.

### Once the person has chosen to contact professional help

If the person you are supporting is particularly nervous about taking the first step, you can offer some support if appropriate.

### Practise for a conversation with a professional

Alternatively, you can write down notes of their next steps and key information they'd like to let the professional know.

### Getting a diagnosis

Let the person know that they can help a GP make a quicker diagnosis by telling the doctor directly about their psychological symptoms and that they may be experiencing poor mental health. Remind the person you are supporting that it may take time to get a diagnosis and find a healthcare provider the person is able to establish a trusting relationship with.

### Check-in

Make time to check in with the person to see how their appointment went and how they felt about it.

### What if the person doesn't want professional help?

#### Explore reasons why

The person may not want to seek professional help. You should try to find out if there are specific reasons why this is the case. For example, the person might be concerned about having to wait for treatment or about not having a doctor they like, or they might be worried they will be sent to hospital. These reasons may be based on mistaken beliefs, and you may be able to help the person overcome their worry about seeking help.

Remember that stigma and fear of stigma can also be major barriers to seeking help, and that treating the person's poor mental health in a non-judgemental manner may help create room for them to overcome such fears.

#### Respect the person's decision

If the person still doesn't want professional help after you have explored their reasons with them, let them know that if they change their mind in the future, they can contact you. You could also encourage other supports such as self-help strategies. You must respect the person's right not to seek help unless you believe that they are at risk of harming themselves or others.

# Action 5: Encourage other supports

Other supports can be useful in situations where a person isn't ready to seek professional help or would benefit from both kinds of help.

The following supports can be encouraged during MHFA:

## Family and friends

Family and friends are a very important source of support for a person who is experiencing poor mental health. People who feel supported by those around them recover faster. Family and friends can help by:

- Listening to the person without judging or being critical
- Encouraging the person to get appropriate professional help
- Checking if the person is experiencing suicide thoughts or behaviour, and if so, taking immediate action
- Providing the same support as for a physically unwell person (e.g. sending get well cards or flowers, telephoning or visiting, helping when the person cannot manage)

People with poor mental health who are hospitalised are sometimes less likely to receive flowers, getwell cards, other gifts, phone calls and visits, which can lead them to have feelings of rejection. It is important that family and friends give the same sort of support to a person with poor mental health as they would to a person with a physical illness.

## Support groups

Some people who experience poor mental health find it helpful to meet

with other people who have had similar experiences. There is some evidence that such peer support groups can help with recovery. Hearing or reading about other people's experiences can validate the person's own experiences, help them make sense of them, and make them feel less isolated and alone. Peer support can also allow the person to learn from others' experiences of navigating health systems, managing side effects of medications and the range of treatments that may be on offer.

## Community and voluntary sector organisations

In addition to offering professional support such as access to talking therapies, community and voluntary sector organisations can also offer a range of other support services. These may include:

- Organising self-help and support groups (including online/virtual communities)
- Informal befriending or visiting services, where a person has become socially isolated
- Offering a range of complementary therapies (see also self-help strategies below)

Similar support may also be on offer to friends and families.

## Self-help strategies

Not all help can or should be provided by specialists in mental health or by primary care staff like GPs. Many people experiencing poor mental health can

## Action 5: Encourage other supports cont.

help themselves and are keen to do so. As well as being directly helpful, self-help strategies can also enable people to feel that they are regaining control of their lives and doing something positive for themselves.

It is important to note that the person's ability and desire to use self-help strategies will depend on their interests and the severity of their symptoms. You should not be forceful when trying to encourage the person. Self-help strategies may be useful alongside other treatments. What works well for one person may not work for another. Not all self-help strategies are suitable for all people, because of side effects or interactions with other medical illnesses or treatments.

Often what people need is support to access a range of good-quality materials. Self-help materials can come in many different forms, including books/leaflets (also referred to as bibliotherapy), self-help groups, or computerised packages (like computerised cognitive behavioural therapy, CBT) or apps.

It can also be helpful for a person to create an individual plan that makes note of all the self-help strategies they may find beneficial. See Appendix A for information on WRAP® (Wellness and Recovery Action Plan).

### Complementary therapies

As part of self-help, some people may also choose to use complementary therapies. These are not covered by NICE guidelines but may be helpful to some people.

They include:

- Light therapy – This involves bright light exposure, often in the morning. They are also known as SAD lights and may be helpful for people whose depression is associated with lack of light in winter
- Acupuncture
- Mindfulness – A form of meditative practice that teaches the individual to focus on living non-judgementally in the present moment. Mindfulness also forms part of some newer psychological therapy approaches
- Massage therapy
- Yoga, relaxation therapy
- Creativity or expressing themselves e.g. writing, engaging with music or art

### Wellbeing approaches

There are also some key lifestyle choices which people can make to improve or maintain their mental health. These were first summed up in 2008 by the New Economics Foundation as part of a project which aimed to draw on global, evidence-based research to create a set of actions people could use to improve their own wellbeing through life. They are known as the Five Ways to Wellbeing.

#### The Five Ways to Wellbeing

##### Connect...

Connect with the people around you. With family, friends, colleagues, and neighbours. At home, work, school or in your local community. Think of these as the cornerstones of your life and invest time in developing them. Building these

connections will support and enrich you every day.

### **Be active...**

Go for a walk or run. Step outside. Cycle. Play a game. Garden. Dance. Exercising makes you feel good. Most importantly, discover a physical activity you enjoy and one that suits your level of mobility and fitness.

### **Take notice...**

Be curious. Catch sight of the beautiful. Remark on the unusual. Notice the changing seasons. Savour the moment, whether you are walking to work, eating lunch, or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters to you.

### **Keep learning...**

Try something new. Rediscover an old interest. Sign up for that course. Take on a different responsibility at work. Fix a bike. Learn to play an instrument or how to cook your favourite food. Set a challenge you will enjoy achieving. Learning new things will make you more confident as well as being fun.

### **Give...**

Do something nice for a friend, or a stranger. Thank someone. Smile. Volunteer your time. Join a community group. Look out, as well as in. Seeing yourself, and your happiness, linked to the wider community can be incredibly rewarding and creates connections with the people around you (27).

## Action 5: Encourage other supports cont.

### The 10 Keys to Happier Living

In 2011, global not-for-profit Action for Happiness, which describes itself as 'a movement of people taking action for a happier and kinder world', launched, with the aim of reducing poor mental health.

As part of the launch, positive psychology expert Vanessa King led the development of the evidence-based 10 Keys to Happier Living, the acronym for which is GREAT DREAM. These are the areas in which scientific research suggests we can take practical action to boost our wellbeing and to help prevent depression and anxiety. They incorporate the Five Ways to Wellbeing and additionally include a further five, more 'internal', areas that King's research suggested were important and where we can also take action in improving wellbeing.

#### The ten keys are:

Giving – Do kind things for others

Relating – Connect with people

Exercising – Take care of your body

Awareness – Live life mindfully

Trying out – Keep learning new things

Direction – Have goals to look forward to

Resilience – Find ways to bounce back

Emotions – Look for what's good

Acceptance – Be comfortable with who you are

Meaning – Be part of something bigger

Within each of the Keys, King and Action for Happiness have brought together many different ideas for acting and encouraging people to experiment with them. King says:

*"Different things work for different people at different times, so we need a menu rather than a prescription of actions (28)."*

# Relating

The people around you offer a valuable pool of support so it's important to put time into strengthening those connections.

## Give it a go:

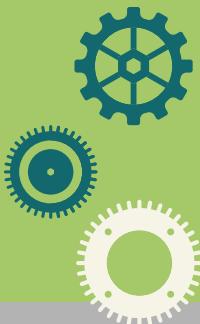
- Meet up with someone you haven't seen in a while
- Turn off distractions to chat with friends or family about your day

# Giving

Holding out a helping hand makes other people happy and will make you feel happier too.

## Give it a go:

- Share your skills or offer support
- Ask friends, family or colleagues how they are and listen without judgement



# Direction

Working towards positive, realistic goals can provide motivation and structure.

## Give it a go:

- Choose a goal that is meaningful to you, not what someone else expects of you
- Remember to celebrate progress along the way



# Resilience

Although we can't always choose what happens to us, we can often choose our own response to what happens.

## Give it a go:

- Find an outlet such as talking to friends or writing it down
- Take action to improve your resilience skills



# Exercising

Regular activity will provide an endorphin boost and increase confidence.

## Give it a go:

- Find an activity that suits you and your schedule
- Swap the car on short journeys and cycle or walk to work



# 10 KEYS TO HAPPIER LIVING

## ACTION FOR HAPPINESS

Find out more about the 10 Keys to Happier Living at [actionforhappiness.org](http://actionforhappiness.org)



MHFA England

Visit [mhfaengland.org](http://mhfaengland.org) to learn about Mental Health First Aid and how you can support a friend, family member, colleague or student with their mental health

# Emotions

Positive emotions can build up a buffer against stress and even lead to lasting changes in the brain to help maintain wellbeing.

## Give it a go:

- Take time to notice what you're grateful for and focus on the good aspects of any situation
- Set aside time to have fun

# Awareness

Taking time to switch off autopilot and 'be in the moment' is a great tool to combat stress.

## Give it a go:

- Pay attention to your senses — what can you see, hear or feel around you?
- Choose a regular point in the day to reflect



# Trying out

Learning new things is stimulating and can help to lift your mood.

## Give it a go:

- Take on a new role at work or school
- Try out a new hobby, club or activity that interests you



# Meaning

People who have meaning in their lives experience less stress, anxiety and depression.

## Give it a go:

- Prioritise the activities, people and beliefs that bring you the strongest sense of purpose
- Volunteer for a cause, be part of a team, notice how your actions make a difference for others



# Acceptance

No one is perfect. Longing to be someone different gets in the way of making the most of our own happiness.

## Give it a go:

- Be kind to yourself when things go wrong
- Shift the focus away from what you don't have and can't do, to what you have and can do

# Providing Mental Health First Aid to someone from a different cultural background

## Being culturally competent and safe

When providing MHFA to a person not from your own cultural background, always be culturally competent and practise cultural safety.

### Cultural competence

Being culturally competent when providing MHFA includes:

- Being aware that a person's culture will shape how they understand health and poor health
- Being aware that specific cultural beliefs that surround poor mental health in the person's community may differ from what you are used to
- Learning how poor mental health is described in the person's community (knowing what words and ideas are used to talk about the symptoms or behaviours)
- Being aware of what concepts, behaviours or language are taboo (knowing what might cause shame)
- Asking questions about their experience with empathy, compassion, and patience

Some forms of verbal and non-verbal communication are appropriate in certain cultures and others are not appropriate. For instance, some individuals may regard prolonged eye contact as rude. Some cultures encourage the use of silence whereas others are embarrassed or made

to feel awkward by it. In some Islamic cultures, silence may include concern for privacy. In French and Spanish cultures, silence is a sign of agreement.

### Cultural safety

Practising cultural safety means:

- Respecting the culture of the community by using appropriate language and behaviour
- Not doing anything that causes the person to feel ashamed or embarrassed
- Supporting the person's right to make decisions about seeking cultural based care

## Working with an interpreter or a bilingual worker

When a person does not speak English, has limited English, or chooses to communicate their distress in their mother tongue, the best solution may be to use a professional interpreter. The choice to use a trained interpreter or a family member must be made by the person who is experiencing poor mental health. Being able to do so will help the person to feel that they are in control of the situation.

Language holds and creates the person's reality, experience, culture, and worldview. A good interpreter will concentrate on accurately conveying equivalent meaning as well as reporting the direct answers to your questions and other responses

offered. You should also be aware that the interpreter may bring their own biases to the situation.

Once you have listened to the person and given them the chance to express the difficulties they are experiencing, you can begin to discuss options that may be available to help them. Having listened to them will allow you to have a better understanding of what support or information could be helpful to them.



A blurred background photograph of a person in a suit jacket sitting at a table in a restaurant. A teal circle containing the text is overlaid on the left side of the image.

# Developing mental health conditions



# What is depression?

The word depression is used in different ways. Everyone can feel sad when bad things happen. However, sadness is not depression. The type of depression this section addresses is ongoing poor mental health and a diagnosable mental health condition. Depression is a common but serious condition and can be recurrent (people recover but develop another episode later).

Depression has no single cause and often involves the interaction of many diverse biological, psychological, and social factors. People may become depressed when something very distressing has happened to them, and they cannot do anything to control the situation. However, while some people will develop depression in a distressing situation, others in the same situation will not.



# Signs and symptoms

## General symptoms of depression

Depression affects emotions, thinking, behaviour and physical wellbeing. A person who experiences diagnosable clinical depression will have at least two of the following symptoms for at least two weeks, however, not everyone who experiences depression has all these symptoms:

- An unusually sad mood that does not go away
- Loss of enjoyment and interest in activities that used to be enjoyable
- Lack of energy and tiredness

People living with depression can also experience other symptoms such as:

### Effects on emotion

Sadness, anxiety, guilt, anger, mood swings, lack of emotional responsiveness, helplessness, hopelessness

### Effects on thinking

Frequent self-criticism, loss of confidence or self-esteem, self-blame, worry, pessimism, impaired memory and concentration, indecisiveness and confusion, tendency to believe others see you in a negative light, thoughts of death and suicide

### Effects on behaviour

Crying spells, withdrawal from others, neglect of responsibilities, loss of interest in personal appearance, loss of motivation

### Physical effects

Chronic fatigue, moving slowly or being unable to relax, lack of energy, sleeping too much or too little, overeating or loss of appetite, constipation, weight loss or gain, irregular menstrual cycle, loss of sexual desire, unexplained aches and pains

### Cross-cultural variation

People from different cultural backgrounds may express the signs and symptoms of depression through the expression of feelings of isolation, shame and/or guilt, or in physical terms

## General signs of depression

There are some warning signs of depression that MHFAiders can look out for in those around us.

### Physical appearance

A person who is depressed may, though not always:

- Look sad and/or worried
- Be slow in moving and thinking
- Speak in a slow and monotonous way
- Look unkempt
- Show a lack of attention to physical appearance and personal hygiene

A person experiencing depression may be able to hide their symptoms well whilst others may appear emotionally blunted and 'beyond tears'. People also sometimes refer to 'smiling depression', or cases where a person may have developed a coping strategy of presenting as outwardly happy, with their internal experience not matching this.

## Signs and symptoms cont.

### Attitudes and thinking

A person experiencing depression commonly has a negative view of themselves, the world, and the future. Their thoughts often follow themes of hopelessness and helplessness. They may say things such as:

- "I'm a failure."
- "I have let everyone down."
- "It's all my fault."
- "Nothing good ever happens to me."
- "I'm worthless."
- "No-one loves me."
- "I am so alone."
- "Life is not worth living."
- "There is nothing good out there."
- "Things will always be bad."

### Signs and symptoms of depression in the workplace or community

It is important to consider the ways in which depression and other poor mental health may present in a workplace or community environment.

Signs and symptoms may also include:

- Decreased productivity
- Decreased morale
- Decreased cooperation
- Absenteeism
- Presenteeism
- Alcohol and/or other drug misuse

### Bipolar disorder

Many people with depression will experience more than one episode of depression during their life. However, there are some people who experience depression on some occasions and mania on others.

A person experiencing mania may:

- Be overconfident and full of energy
- Be very talkative
- Find it difficult to stick to one subject in conversation
- Be full of ideas
- Have less need for sleep
- Take risks they normally wouldn't

Although some of these symptoms may sound beneficial (e.g. increased energy and full of ideas), mania often creates difficult situations (e.g. they could spend too much money and get into debt, they can become angry and aggressive, or get into legal trouble). These consequences may play havoc with work, study, and personal relationships. The person can have grandiose ideas and may lose touch with reality (psychotic episodes).

A person is not diagnosed with bipolar disorder until they have experienced an episode of mania. It may take many years before they are diagnosed correctly and get the most appropriate treatment. Because bipolar disorder impacts strongly on a person's mood, it is often mentioned alongside depression under the umbrella term of 'mood disorders'. However, treatment approaches between depression and bipolar disorder may differ.

Bipolar disorder is less common than depression and requires medical treatment.

**For further information about bipolar disorder see page 94 in the Psychosis section.**

## Perinatal depression

Perinatal depression refers to depression that occurs in a woman at a time around childbirth. The depression can either occur before birth (antenatal depression) or after birth (postnatal or postpartum depression). Feeling sad or having the 'baby blues' after giving birth is common, but when these feelings last for more than two weeks, this may be a sign of a depressive condition.

Perinatal depression has an impact not only on the mother, but also on the mother-child relationship and on the child's cognitive and emotional development. For this reason, it is particularly important to receive good treatment for postpartum depression.

Factors that may contribute to perinatal depression are hormonal and physical changes resulting from pregnancy and childbirth, and the responsibilities of caring for the baby. Having had a previous episode of depression increases risk for postpartum depression and symptoms are often already present during pregnancy.

# Crises associated with depression

The main crises that may be associated with depression are:

The person is experiencing suicide thoughts and/or behaviour.

**For crisis first aid for suicide thoughts and behaviour see pages 140-149.**

The person has self-harmed.

**For crisis first aid for self-harm see pages 133-139.**



# First aid best practice for signs of depression

**Remember to revisit the ALGEE action plan in full on pages 42-57.**

## **Have realistic expectations for the person**

Depression is not laziness, but depression can make it hard for people to feel motivated. You should accept the person as they are and have realistic expectations for them. Everyday activities like cleaning the house, paying bills, or feeding the dog may seem overwhelming to the person. You should let them know that they are not weak or a failure because they have depression, and that you don't think less of them as a person. You should acknowledge that the person is not 'faking', 'lazy', 'weak' or 'selfish'.

## **Offer consistent emotional support and understanding**

People with depression are often overwhelmed by irrational fears; you need to be gently understanding of someone in this state and acknowledge that these fears may be very real to them. It is important to be patient, persistent and encouraging when supporting someone with depression. You should also offer the person kindness and attention, even if it is not reciprocated. Let the person know that they will not be abandoned. You should be consistent and predictable in your interactions with the person.

## **Reassure them that diagnosis takes time**

Depression is not always recognised by health professionals, so bear in mind that

it may take some time to get a diagnosis and find a healthcare professional with whom the person is able to establish a good relationship. You should encourage the person not to give up seeking appropriate professional help, including asking for a second opinion if this is necessary.

## **Avoid feeling or showing blame**

Depression is a real health issue, and the person cannot help being affected by depression. It is important to remind them that they have a health issue and that they are not to blame for feeling 'down'.

## **Avoid trivialising, belittling, or patronising**

Try not to pressure them to "put a smile on their face", to "get their act together", to "lighten up", or dismiss the person's feelings by attempting to say something positive like, "You don't seem that bad to me." Avoid speaking with a patronising tone of voice and don't use patronising mannerisms or facial expressions.

## **Be mindful not to take over or problem-fix**

Resist the urge to try to cure the person's depression or to come up with answers to their worries. This can make it harder for them to feel empowered and like they can make changes to improve their own situation.

# Professionals and treatments that can help with depression

**For specific helpful resources and contacts sign in to your MHFAider Support App or go to the [Hub of Hope website](#).**

Most people with depression remain at home and receive care in the community. Most will not need to see a psychiatrist but receive treatment from their GP. Community care may also involve specialist outpatient treatment, however (where people attend hospital appointments without being admitted to a ward). It is often provided by a range of professionals including GPs, psychiatrists, social workers, counsellors, psychologists, community psychiatric nurses (CPNs) and members of voluntary sector organisations.

Only in the most severe cases of depression, or where there is a danger that a person might be at risk of harm to themselves or others, is a person with depression admitted to hospital. Most people with depression are treated successfully in the community.

## GPs

Many people who experience depression will turn to a GP first for professional help. A GP can provide different types of help:

- Look for a possible physical cause of the depression (e.g. medication side-effects or physical health conditions)
- Explain depression and how the person can best be helped
- Refer the person to specialist mental health services, including psychological therapies and psychiatrists if necessary

- Signpost the person to a range of self-help material e.g. books, exercise on prescription, computer-based therapies such as cognitive behavioural therapy
- Prescribe antidepressant medication if needed and monitor treatment with antidepressants

GPs can make a quicker diagnosis if the person tells them directly that they believe that they are depressed. Some GPs are more comfortable dealing with depression than others. However, a GP should take the time to listen to the person and take account of the person's treatment preferences. If a person is not happy with a GP, they should not hesitate to seek help from another.

## Counsellors, psychotherapists, and clinical psychologists

Counsellors, psychotherapists, and clinical psychologists specialise in the psychological treatment of poor mental health. They are not medically qualified and so they cannot prescribe antidepressants or other medications. Counsellors, psychotherapists, and psychologists vary a lot in their level of training, their approach to treatment and in their experience of helping people with depression.

A counsellor, psychotherapist or clinical psychologist can help by providing:

- Opportunities for the person to talk about their feelings
- Opportunities to be listened to in an emotionally supportive and non-judgemental way

- Specific methods for overcoming depression and preventing its recurrence

A good counsellor, psychotherapist or clinical psychologist will use methods to promote coping, such as cognitive behavioural therapy or interpersonal psychotherapy. They will be registered with accrediting organisations such as the [British Association for Counselling and Psychotherapy \(BACP\)](#), which has a framework for good practice.

If a person wants help from a counsellor, psychotherapist, or clinical psychologist they can either contact one directly or get a recommendation from a GP. Several organisations have nationwide lists of therapists. GPs may also refer to psychological therapy services provided by the NHS, and some of these services allow people to refer themselves.

### Psychiatrists

Psychiatrists are doctors who specialise in treating mental health conditions. Psychiatrists generally only treat people who have severe or long-lasting difficulties. They are experts on medication. They can help people who are having side-effects from their medication or interactions with their other medications. Psychiatrists can also be helpful to people who have depression combined with other medical issues. A GP might refer a person to a psychiatrist if they are very ill or not improving.

### Antidepressants

The brain functions by passing electrical impulses between the neurons (nerve cells). These impulses carry several different messages and functions, for example:

- Sensory messages (sights, sounds)
- Motor messages (the impulse to move passes through the motor neurons through the nervous system to the limbs)
- Cognitive functions (perception, language, thinking, attention, memory)
- Regulation of mood, appetite, energy, body temperature, etc

Impulses are carried between different neurons by certain types of chemical messengers, known as neurotransmitters. Neurotransmitters flow from one neuron to another at junctions called synapses (where the neurons meet) to transmit these impulses.

Serotonin is a neurotransmitter involved in the regulation of mood. It is thought that too little serotonin can cause low mood and low energy. When a transmitter flows between neurons it does so for a minuscule amount of time and then returns to the synapse it came from – thus the expression ‘reuptake’.

Selective serotonin reuptake inhibitors (SSRIs, known as antidepressants) work by limiting the reuptake of the serotonin at the synapse, thus making

## First aid best practice for signs of depression cont.

it more available. The effect should be an improvement in mood. SSRIs take between two and five weeks to work so it is important that a person should be encouraged to keep taking them, even if they don't see any improvement at first.

Sometimes people report a worsening of symptoms in the first week or two. It is not clear whether this is a short-term side effect or the depression itself. However, most people report a definite improvement in three to four weeks.

Different types of antidepressants will act in slightly different ways, although most have some effect on serotonin messages in the brain.

### Cognitive behavioural therapy (CBT)

CBT is based on the idea that how we think affects the way we feel, but also how we behave. When people experience depression, they tend to think negatively about most things and develop unhelpful thinking patterns which can lead to them feeling more depressed. These thoughts and feelings may in turn cause them to act in certain ways which support these unhelpful thinking patterns. For example, feeling hopeless about friendships and believing nobody cares about them may cause a person to withdraw from social contact and so not notice attempts by friends to reach out.

Cognitive behavioural therapists will teach the person to recognise such unhelpful thoughts (also referred to as 'thinking distortions' or 'negative automatic thoughts') and change them to more

realistic ones. They may also use other techniques which focus on changing behaviour, e.g. getting the person with depression to do more of the things which give them pleasure, helping them to solve problems in their life, and learning better social skills.

The idea is that by learning to change thoughts and behaviour, the person can develop new strategies which in the long run will change their mood for the better. CBT is not suitable for some people with depression who are too unwell to develop new thinking skills. However, once people have begun to recover with medical treatment, CBT may be helpful.

# Other supports for depression

## Community and voluntary sector organisations

The role the voluntary sector plays in providing mental health care in the community is often underestimated, yet it plays an integral part alongside statutory services provided by the NHS and private practice. Voluntary sector organisations can provide support and assistance in several different ways:

- Counselling or other talking therapies, including bereavement support (often at low costs or on sliding scales for people on low incomes)
- Help with daily living
- Advice and information
- Help with finding employment or keeping employment

## Helplines

Opportunities to talk are always available over the telephone. Some organisations also offer email helplines, online chat, or text support.

Other helps include support groups, community and voluntary sector organisations, family and friends, and self-help strategies.

Revisit the ALGEE action plan in full on pages 42-57 for further information on other supports general to all mental health conditions.

# What is anxiety?

Most people experience anxiety at some time. Anxiety is a natural response that is useful in helping us to avoid dangerous situations and in motivating us to solve everyday problems. Anxiety can vary from mild uneasiness through to a terrifying panic attack. It can vary in how long it lasts, from a few moments to episodes over

many years. An anxiety disorder differs from normal anxiety in the following ways:

- It is more severe
- It is long-lasting
- It interferes with the person's work or relationships



# Signs and symptoms

## General signs and symptoms of anxiety disorders

Anxiety can manifest itself in a variety of ways:

### Physical effects

- Palpitations, chest pain, rapid heartbeat, flushing (cardiovascular)
- Hyperventilation, shortness of breath (respiratory)
- Dizziness, headache, sweating, tingling and numbness (neurological)
- Choking, dry mouth, nausea, vomiting, urinary frequency, diarrhoea (gastrointestinal)
- Muscle aches and pains (especially neck, shoulders, and lower back), restlessness, tremor and shaking (musculoskeletal)

### Psychological effects

- Unrealistic and/or excessive fear and worry (about past or future events)
- Mind racing or going blank
- Decreased concentration and memory
- Difficulty making decisions
- Irritability, impatience, anger
- Confusion
- Restlessness or feeling on edge, nervousness
- Tiredness, sleep disturbances, vivid dreams
- Unwanted, unpleasant, repetitive thoughts (also known as intrusive thoughts)

### Behavioural effects

- Avoidance of situations
- Repetitive compulsive behaviour, e.g. excessive checking, continual seeking of reassurance
- Distress in social situations
- Urges to escape situations that cause discomfort (phobic behaviour)

There are many different types of anxiety disorders. The main ones are generalised anxiety disorder, panic disorder, phobic disorders, post-traumatic stress disorder, acute stress disorder and obsessive-compulsive disorder.

## Generalised anxiety disorder (GAD)

The main symptom of generalised anxiety disorder (GAD) is overwhelming anxiety and worry. Worries are commonly about things that may go wrong or one's inability to cope, for example with money, health, family, and work, even when there are no signs of trouble. People with GAD experience physical and psychological symptoms of anxiety or tension more days than not and these continue for at least six months. This type of anxiety disorder is difficult to control.

Symptoms can include the following:

### Physical

Physical symptoms of GAD will reflect general physical symptoms of anxiety. Typically, a person with GAD might experience:

- A fast-beating or pounding heart
- Headaches

## Signs and symptoms cont.

- Stomach pains
- Tremors
- Muscle tension
- Inability to relax
- Dizziness
- Sweating
- Dry mouth

### Psychological

- Excessive worry
- Irritability
- Restlessness
- Feeling on edge
- Difficulty concentrating or mind going blank
- Sleep disturbances

Generalised anxiety disorder can make it difficult for people to concentrate at work, function at home and generally get on with their lives.

### Behavioural

- Inability or difficulty in making decisions that would normally be easy
- Continually seeking reassurance around everyday matters

## Panic disorder

A person with a panic disorder has panic attacks and is afraid that a panic attack might occur.

A panic attack is a sudden onset of intense apprehension, fear, or terror. These attacks can begin suddenly and develop rapidly. This intense fear appears inappropriate for the circumstances in which it is occurring.

The person experiencing a panic attack often has a sense of impending doom or death. Many of the symptoms are physical ones and can appear like those of a heart attack or asthma attack.

### Symptoms of a panic attack

A person having a panic attack could experience several of the following symptoms at the same time:

- Palpitations or increased awareness of heartbeat
- Sweating
- Trembling or shaking
- Feeling of choking, shortness of breath or smothering
- Chest pain or discomfort
- Nausea or abdominal distress
- Feeling of unreality or detachment from oneself or from one's surroundings
- Feeling dizzy, unsteady, light-headed, or faint
- Fear of losing control
- Fear of dying
- Numbness, tingling or pins and needles
- Chills or hot flushes

For crisis first aid for panic attacks  
see pages 130-132.

## Phobias

A person experiencing a phobia avoids or restricts activities because they have a specific fear. This fear appears persistent, excessive, and unreasonable.

### Agoraphobia

Agoraphobia involves avoidance of situations because of the fear of having a panic attack. Some people avoid leaving their home for fear of a panic attack occurring. Other people avoid certain situations (for example, shops, driving a car) in which a panic attack has happened before. It is not a fear of open spaces, although open and public spaces may often be avoided if this is where a person has had panic attacks before.

### Social phobia or social anxiety disorder

Social phobia or social anxiety disorder is the fear of any situation in which public scrutiny may be possible. Usually, this is combined with the fear of behaving in a way that is embarrassing or humiliating. Social phobia often develops in shy children as they move into adolescence. A person experiencing social phobia would typically avoid meetings at work or social gatherings.

### Specific phobias

People may have phobias about specific things, for example, fear of spiders or fear of heights. The person with a specific phobia will avoid whatever they are fearful of. These phobias are often less disabling than agoraphobia and social phobia because they involve specific situations.

Animal phobias or phobias relating to the natural environment (e.g. heights) are common.

## Obsessive-compulsive disorder (OCD)

This form of anxiety disorder is the least common, but it is a very disabling condition. Obsessional thoughts and compulsive behaviours accompany the feelings of anxiety.

### Obsessional (or intrusive) thoughts

Obsessional (or intrusive) thoughts are recurrent thoughts, impulses, or images that the person cannot dispel. These thoughts are unwanted and inappropriate and cause marked anxiety in the person. Obsessive thoughts are often about fear of contamination or harm. For example, a person may have repeated thoughts about a loved one dying suddenly, or about causing someone direct harm, even when this is not in the person's nature.

### Compulsive behaviours

Compulsive behaviours are repetitive behaviours or mental activity. Mental activity can include counting silently or repeating certain words or phrases internally. It may not be obvious that someone is engaging in compulsive behaviour just by appearance. The person feels driven to behave in this way to reduce anxiety about an obsession. They may feel that if they don't engage in the compulsive behaviour, the obsessive fear may become true, e.g. if they don't count

## **Signs and symptoms cont.**

to ten, their loved one will come to harm – even when they understand this fear to be irrational. Common repetitive behaviours include the need to wash, check and count. Obsessive-compulsive disorder usually begins in adolescence.

## **Mixed anxiety and depression**

Many people with anxiety don't fit neatly into a particular type of anxiety disorder. It is common for people to have some features of several anxiety disorders. A high level of anxiety over a long period will often lead to depression and long periods of depression can also bring about symptoms of anxiety. Many people have a mixture of anxiety and depression as a result.

# Crises associated with anxiety

The main crises that may be associated with anxiety disorders are:

The person has suicide thoughts or behaviour. People with anxiety disorders are at increased risk of suicide, particularly if depression is also present.

[For crisis first aid for suicide thoughts and behaviour see pages 140-149.](#)

The person experiences a panic attack. The person may have an exaggerated belief that they are at risk of harm, which can spiral into a panic attack.

[For crisis first aid for panic attacks see pages 130-132.](#)

The person has experienced a traumatic event. This may be either recently or have happened some time ago.

[For crisis first aid for traumatic events see pages 150-154.](#)

The person has self-harmed.

[For crisis first aid for self-harm see pages 133-139.](#)

# First aid best practice for signs of anxiety

**Remember to revisit the ALGEE action plan in full on pages 42-57.**

## **Create a calming space**

Try to talk to the person in a calming and private environment away from distractions, loud noises, and bright lights.

## **Highlight that anxiety can be unpleasant but it is rarely harmful**

Let the person know that effective help is available – skills can be learned to reduce the effects of stress and anxiety.

## **Be aware that recovery means facing anxiety-provoking situations**

As MHFAiders, it is important to be aware that avoiding such situations can slow recovery and in the long run worsen anxiety. Facilitating a person's avoidance of anxiety-provoking situations may therefore not be supportive to the person in the long run.

## **Allow a person to take it at their own pace**

It is equally important not to dismiss their fears as trivial and force them into situations which cause great distress. Supporting a person to confront their fears in small, gradual steps, with the person retaining control and choice over their actions, is likely to be the most helpful in the long term.

## **Avoid concentrating on physical symptoms**

Anxiety also often produces frightening physical sensations, frightening thoughts, and/or mental effects such as poor

concentration and memory. Focusing on these is likely to only increase the fear and anxiety. It is therefore important that the underlying anxiety is addressed. Physical symptoms will pass when the anxiety improves.

## **Encourage self-care specific to anxiety**

Encourage the person to identify and challenge exaggerated worries and pessimistic thoughts. Suggest they reduce their caffeine intake to 300mg or less per day or avoid it altogether.

# Professionals and treatments that can help with anxiety

For specific helpful resources and contacts sign in to your MHFAider Support App or go to the [Hub of Hope website](#).

As with depression, treatment for anxiety disorders will in most cases be offered in primary health care services, by professionals like GPs and counsellors/psychotherapists. Only people with persistent or severe difficulties are likely to be referred to specialist mental health services and receive treatment by psychiatrists.

People can also contact a counsellor, psychotherapist, or clinical psychologist directly or get a referral from a GP.

## Medications

Antidepressants (usually SSRIs) which are effective in treating depression have also been shown to be of help for anxiety disorders. It is likely that similar chemical messengers involved in depression, in particular serotonin, also play a role in symptoms of anxiety. Antidepressants may be particularly helpful in treating anxiety where the person also experiences symptoms of depression, which is often the case.

There are also other medications which can, in the short term, relieve symptoms of anxiety, including benzodiazepines (including diazepam, also known as Valium). These are not recommended for treating anxiety because they carry notable side effects like sedation, and

because there is a significant risk of dependence and addiction. Although they may help relieve anxiety in the short term, in the long term they can cause 'rebound anxiety' when treatment is stopped, and over time people need increasing doses to gain the same effect, which increases the risk of serious side effects. Treatment with such medications is therefore likely to be short-term, and the risks and benefits need to be carefully weighed by a medical professional.

## Psychological therapy

The two main types of psychological therapy recommended for anxiety are cognitive behavioural therapy (CBT) and applied relaxation.

## CBT

CBT is based on the idea that how we think affects the way we feel but also how we behave. People with anxiety are likely to develop unhelpful thinking patterns which can lead to them feeling more anxious and cause them to act in ways which then further the anxiety. For example, a person afraid of public speaking may anticipate the worst possible outcome and predict that they will embarrass themselves during an upcoming presentation. Their fear may then cause them to avoid the presentation altogether, which means they continue to believe they are 'useless' at giving presentations, even though this may not be the case.

## Professionals and treatments that can help with anxiety cont.

CBT focuses on helping the person identify their unhelpful thoughts and change them to more realistic ones. It is also likely to involve the therapist encouraging the person to face their fears by gradually engaging more and more with the feared situation, so they can learn that the anticipated outcome is not always the most likely one. This is also sometimes referred to as 'exposure therapy'.

### Applied relaxation

Applied relaxation involves learning different strategies for relaxing, for example by tensing and relaxing specific muscle groups or thinking of relaxing scenes (also known as 'guided imagery').

Applied relaxation is most effective if learnt under the guidance of a trained practitioner, but can also be a useful self-help technique, and a range of recorded instructions are available for free on the internet. Relaxation training works on the idea that, when a person is in a state of anxiety, their nervous system is in constant 'fight or flight' mode, with stress hormones like adrenaline contributing to their nervous state. Through the training, the person engages the 'rest and relax' state of their nervous system, reducing the levels of stress hormones and breaking the pattern of high anxiety levels.

# Other supports for anxiety

## Community and voluntary sector organisations

Several voluntary sector organisations can offer additional support to people experiencing anxiety disorders. This could be in the form of organising support groups, providing access to low-cost therapy or complementary therapies, support to find volunteering or employment opportunities, or befriending services if the person has become socially isolated.

## Helplines

Opportunities to talk are always available over the telephone. Some organisations also offer email helplines, online chat, or text support.

Other helps include support groups, family and friends, and self-help strategies.

Revisit the ALGEE action plan in full on pages 42-57 for further information on other supports general to all mental health conditions.



# What are eating disorders?

## What are eating disorders?

The term 'eating disorder' covers a wide range of behaviours relating to food, including starving (anorexia), binging and purging (bulimia) and binge eating. The reasons and causes behind eating disorders are varied and complex.

Eating disorders are often, but not always, associated with negative body image and low self-esteem. Eating disorders can also be thought of as like anxiety disorders such as obsessive-compulsive disorder (OCD), where the obsession is focused around food-related behaviours, and in some cases, body image.

Although on the surface eating disorders may appear to be about food and weight, they are driven by attempts to deal with underlying emotional and stress-related issues. In this way, they can be viewed as lying on a spectrum with self-harm (attempts at coping strategies which then increase poor mental and physical health in the long run).

Some eating disorders, particularly where starvation and/or vigorous exercise is involved, can also cause changes in body and brain chemistry that make it harder to break cycles of self-destructive behaviour.

Eating disorders often coexist with other poor mental health, in particular anxiety, depression, OCD, personality disorders or substance misuse. People with eating disorders are also more likely to self-harm and are at increased risk of suicide.



# Signs and symptoms

## General signs and symptoms of eating disorders

- General dieting behaviours and attitudes which show that control of food is a primary concern to the person
  - e.g. preoccupation with weight, calories, fat content, etc
- Withdrawal from social circles and previously enjoyed activities. This may reflect a rearranging of schedule/lifestyle to make time for eating disorder behaviours (e.g. exercise, binge sessions or binge/purge sessions)
- Avoiding mealtimes or situations involving food, always having excuses for not eating in public, heightened anxiety at mealtimes – particularly in anorexia and bulimia
- Behaviours focused on food (e.g. planning, buying, cooking meals for others but not consuming meals themselves, interest in recipes and nutrition) – particularly in anorexia and bulimia
- Lying about the amount or type of food consumed or avoiding questions about eating and weight
- Sensitivity to comments or (perceived) criticism about exercise, food, body shape or weight
- Low self-esteem (negative self-perception, feelings of shame, guilt, or self-loathing)
- Experiencing strong feelings of anger, anxiety, or depression (which may trigger eating disorder related behaviour, especially binges)

- Rigid thinking (labelling food as either 'good' or 'bad') – particularly in anorexia and bulimia

There are other eating disorders outside of the three main types known as 'other specified feeding or eating disorders' (OSFED). Information can be found on the [Beat website](#), the UK's leading charity supporting those affected by eating disorders.

## Anorexia nervosa

Anorexia nervosa is a serious, potentially life-threatening eating disorder characterised by self-starvation and excessive weight loss as a result of distorted body image. The person's self-esteem is overly focused on body image, and despite continued weight loss the person views themselves as 'fat'. Anorexia is often accompanied by an inability on the person's part to appreciate the severity of the situation, as they find it hard to see themselves as being unwell.

### Signs and symptoms of anorexia nervosa

- Dramatic weight loss
- Evidence of physical effects of low body weight (e.g. complaining of feeling cold all the time)
- Prevention of weight gain may involve self-induced vomiting, self-induced purging, excessive exercise, or use of appetite suppressants and/or diuretics
- Refusing to eat particular foods, moving on to cutting out entire food groups (e.g. no carbohydrates or 'fattening' foods)
- A self-perception of being too 'fat', with an intense fear of weight gain and obsession with weight, leads to

## Signs and symptoms cont.

persistent behaviour to prevent weight gain/promote weight loss

- Denying that they are hungry
- Developing rituals around food (e.g. rearranging food on plate, only eating foods in a particular order or combinations, chewing for extended periods of time)
- Over-exercising – continuing exercise routines regardless of weather, tiredness, illness or injury, reflecting the perceived need to 'burn off' calories taken in. May include 'overuse injuries' from too much exercise

'Atypical' anorexia can also be diagnosed where some of these elements may be missing, dependent on professional medical assessment.

### Physical health issues linked with anorexia nervosa

Because anorexia nervosa involves self-starvation, the body no longer receives essential nutrients necessary to function normally. As a result, it slows down all its processes to conserve energy, which can have serious impacts on physical health:

- Abnormally slow heart rate and low blood pressure, due to changes in the heart muscle. In the long term this leads to risk of heart failure
- Lack of calcium and vitamin D in the diet leads to a reduction of bone density (osteoporosis), which results in dry, brittle bones and higher risk of bones breaking.
- Muscle loss and weakness as the body breaks down muscle to obtain energy for vital functions

- Severe dehydration can lead to kidney failure
- Fainting, fatigue, and overall weakness
- Sensitivity to the cold or feeling cold most of the time, even in warm temperatures. At very low weight, the body may grow a downy layer of hair (called lanugo) in an effort to keep warm.
- Dry hair and skin, often hair loss
- Normal hormonal function is affected, with absence of periods in women and loss of sexual interest in men (exceptions for this are where anorexia develops before puberty, in which case puberty may be delayed, or in women who take the contraceptive pill, which may maintain their periods artificially).

## Bulimia nervosa

Bulimia nervosa involves episodes of excessive eating (food binges) followed by behaviour which aims to prevent subsequent weight gain, known as purging (e.g. vomiting, abuse of laxatives, excessive exercising, fasting). During binges, the person may feel out of control of their eating and eat well past the point where they would normally feel full.

Sometimes a person with bulimia may initially have had anorexia, or the other way around. It is not uncommon for people to cycle between these two different patterns of eating disorders, although this isn't the case for everyone. Unlike in anorexia, in bulimia the person's weight may be normal, but the underlying fear of weight gain and the person's belief that they are 'fat' may be identical.

Like anorexia, bulimia can present a serious threat to health and life.

### Signs and symptoms of bulimia nervosa

- Repeated episodes of eating very large amounts of food in short periods of time (at least two times per week for a period of three months)
- The person is preoccupied with food and eating, and experiences strong desires and compulsions to eat (food cravings similar to drug cravings)
- The person tries to compensate for the food binges through one or more of the following: self-induced vomiting; self-induced purging (use of laxatives etc.); periods of starving themselves (like in anorexia); using medications like appetite suppressants or diuretics
- Evidence of purging behaviours, e.g. frequent visits to the bathroom during/after meals, signs or smells of vomiting, presence of laxatives or diuretics
- Swelling of the cheeks or jaw area or calluses on the back of the hands and knuckles due to self-induced vomiting
- Discoloured or stained teeth (from stomach acid during vomiting)
- The person perceives themselves as being too 'fat' and has an intense fear of weight gain
- Dramatic weight loss is possible but not necessarily always the case. Nevertheless, the person's self-perception may not seem to accurately reflect their weight, even if normal (i.e., they see themselves as much 'fatter' than others do)

- In 'typical' bulimia nervosa, the person is underweight, but 'atypical' bulimia where the person is of a healthy weight or overweight is also recognised. Frequency of binge/purge cycles may also vary

### Physical health issues linked with bulimia nervosa

Because the person's behaviour can be masked by healthy weight, bulimia can be harder to spot. Nevertheless, the repeated binge/purge cycles have a major impact on the body and can cause serious physical health issues. These include:

- Electrolyte imbalances – electrolytes are body salts like sodium and potassium, key chemicals which play a role in most major body functions. Imbalances come about as a result of dehydration and from purging behaviours, and can cause irregular heartbeat, heart failure and even death alongside a range of other issues.
- Frequent vomiting can lead to inflammation and damage to the person's oesophagus/throat due to stomach acid released.
- Stomach acid can also stain teeth and cause tooth decay.
- Laxatives and cycles of binging/fasting can impair normal function of the digestive system and lead to chronic constipation and other digestive issues.
- Although rare, it is possible for a person to tear their stomach (gastric rupture) during a binge. This can lead to internal bleeding and associated complications.

## Signs and symptoms cont.

### Binge eating disorder

Binge eating disorder is not the same as just overeating. It shares many of the symptoms of bulimia nervosa, but without associated behaviours that compensate for high levels of food intake.

#### Signs and symptoms of binge eating disorder

- Eating significantly larger than normal amounts of food in a short period of time (in comparison to what most people would consume)
- Feeling out of control about their eating, i.e., the person feels they cannot stop eating or control what or how much they are eating, although they may want to
- Evidence of binge eating, e.g. disappearance of large quantities of food, presence of large amount of empty food containers
- Person may eat in secret (usually eat alone, hide food wrappers)
- Usually weight gain/person is often overweight or obese

Binge eating episodes are also associated with three (or more) of the following:

- Eating much more rapidly than normal
- Eating when not feeling physically hungry
- Eating alone/hiding the binges because of feelings of shame
- Feeling disgusted, depressed or very guilty about the binge afterwards
- Feeling distressed by their binges
- There are no compensating behaviours as in bulimia nervosa

#### Physical health issues linked with binge eating disorder

The main physical health consequence of binge eating disorder is the associated risk with an increase in weight. It is important to note that most people who are obese don't have binge eating disorder. However, most people with binge eating disorder have a healthy or above average weight, with many being obese.

Physical health risks are therefore associated with obesity and may include:

- High blood pressure
- High cholesterol levels
- Heart disease
- Type II diabetes
- Gallbladder disease
- Fatigue
- Joint pain
- Sleep apnoea
- As with bulimia nervosa, there is some risk of gastric rupture during binges

# Crises associated with eating disorders

The main crises that may be associated with eating disorders are:

The person is experiencing a medical emergency (e.g. they have fainted)

Follow physical first aid guidelines and seek medical attention.

The person is experiencing suicide thoughts or behaviour

For crisis first aid for suicide thoughts and behaviour see pages 140-149.

The person has self-harmed

For crisis first aid for self-harm see pages 133-139.

The person has experienced a traumatic event

For crisis first aid for traumatic events see pages 150-154.

# First aid best practice for signs of an eating disorder

**Remember to revisit the ALGEE action plan in full on pages 42-57.**

## Avoid approaching in settings or times related to food

Avoid approaching the person in situations that may add to any anxiety they may be feeling or may make them defensive, especially settings which are food related, such as at mealtimes.

## Remember it is normal to feel nervous

It is normal to feel nervous approaching someone about their eating and exercising behaviours but don't avoid talking to them because of this. Speaking to the person may give them a sense of relief at having someone acknowledge their difficulties or that they are struggling to cope, even if this is not readily apparent.

## Try not to focus on weight or food

Focus on the specific behaviours which concern you, as well as underlying emotional distress. Rather than talking about diets and weight loss, give the person room to discuss any feelings they may want to share. Try not to comment positively or negatively about the person's appearance. The way you discuss the person's issue may depend on how long they have been dealing with eating disorder behaviours.

## Use 'I' statements

Discuss your concerns with them in an open and honest way by reflecting back the changes in their behaviour which concern you, such as "I am worried about you" rather than 'you' statements ("You are making me worried") which may come across as accusing, or 'we' statements ("We are worried about you") which may sound as if

they are being picked on.

## Be mindful that the conversation may be difficult

You may find it difficult to listen to what the person has to say, especially if you don't agree with what they are saying about themselves and food. Be prepared that the person may deny there is an issue. The person may be receptive to your attempt to reach out, but there is also a good chance that they may deny that they are experiencing poor mental health.

## Stay calm

Even if you have approached them sensitively, it is possible that they may become angry or defensive or attempt to reassure you that all is well. Try to stay calm if this happens. It does not mean your conversation was not worth having – the person may need time to absorb your comments or concerns.

## Try not to force change

Instead offer support and make them aware that effective treatment is available. You may need to leave information and resources with them or have more than one conversation. Be patient and understand that the person is not trying to be difficult, but that they may struggle to trust others, or that they may not know how to, or be ready to, change.

## Encourage the person to be proud of any positive steps they have taken

Such as acknowledging their difficulties or seeking professional help. These steps may have been very hard for them to take, so giving positive feedback can make a difference.

# Professionals and treatments that can help with eating disorders

For specific helpful resources and contacts sign in to your MHFAider Support App or go to the [Hub of Hope website](#).

Eating disorders are not always recognised by professionals, so it sometimes takes time to get the right diagnosis or treatment. If visiting the GP, it can help if they are told that the person may have an eating disorder.

The treatments listed here are taken from the NICE clinical guidelines on eating disorders. They are intended as a guide to what kind of treatment can be expected under best practice guidelines in England. They are not intended for the MHFAider to suggest as treatments in a specific case but may be helpful to understand what treatments may be offered when the person seeks professional help, or to help advocate for treatment.

Treatment for eating disorders usually involves addressing both the disordered eating or exercise behaviours and physical consequences like weight loss and medical complications, as well as associated poor mental health like depression and anxiety. Treatment should be tailored to individual needs, especially where behaviours have existed for a while.

NICE clinical guidelines recommend the following:

## For anorexia nervosa:

Usually, outpatient treatment involving specialist psychological support by

an eating disorders team, lasting at least six months. Psychological approaches may include:

- Cognitive analytic therapy
- Cognitive behavioural therapy (CBT)
- Interpersonal psychotherapy
- Psychodynamic therapy
- Family therapy
- Inpatient treatment may be required at times if weight is dangerously low. This should be in a specialist eating disorder setting and combine physical and psychosocial interventions. Feeding a person against their will is only used as a last resort
- In addition to individual treatment, children and adolescents should also be offered family interventions (this may include therapeutic help involving the whole family, advice on managing behaviour, and facilitating communication)
- Treatment with medications(including antidepressants) needs to be carefully considered due to the increased risk of side effects in a person of low weight

## For bulimia nervosa:

- As a first step, the person should be encouraged to follow evidence-based self-help programmes. Alternatively, antidepressant may help (usually SSRIs).
- CBT for bulimia nervosa (CBT-BN) is a specifically adapted form of CBT and should be offered to adults over 4–5 months (16–20 sessions).

## Professionals and treatments that can help with eating disorders cont.

- As an alternative, interpersonal psychotherapy may be considered (longer duration of 8–12 months).
- Adolescents may also be treated with CBT-BN, and this may involve whole family approaches.
- Inpatient treatment is usually only considered where there is serious risk of suicide or self-harm.

### For binge eating disorder:

- As a first step, the person should be encouraged to follow evidence-based self-help programmes.
- CBT for binge eating disorder is available as a specifically adapted form of CBT and should be offered to adults with binge eating disorders.
- Alternatives include interpersonal psychotherapy and modified dialectical behaviour therapy (DBT).
- Alternatively, antidepressants may help (usually SSRIs).

Other helps include support groups, community and voluntary sector organisations, family and friends, and self-help strategies.

Revisit the ALGEE action plan in full on pages 42-57 for further information on other supports general to all mental health conditions.

# What is psychosis?

Psychosis is a general term used to describe poor mental health in which a person experiences changes in thinking, perception, mood, and behaviour which can severely disrupt their life. Psychosis involves the person losing some touch with commonly accepted reality, though the extent of this may vary. For a person affected by psychosis, relationships, work, and self-care can be difficult to initiate or maintain.

The onset of psychosis in childhood is rare, however, the rates of onset increase sharply during adolescence. It tends to occur earlier in males, usually in their mid-to-late teens or early twenties. The onset of the condition may be rapid, with symptoms developing over several weeks, or it may be slow and develop over months or years.

It can take one to two years before a person experiencing a first episode of psychosis receives appropriate treatment. Several factors contribute to this delay. One explanation is that some early symptoms of psychosis can involve behaviours and emotions common in adolescents and young adults. Duration of untreated psychosis (DUP) is important. The longer the DUP, the worse the outcome, with more severe overall symptoms, coexisting depression and anxiety, and worse overall functioning.

Most people experiencing a first episode of psychosis will recover, although without appropriate care a high proportion will go on to experience further episodes. In England, the government, as part of mental health

service modernisation, has invested in Early Intervention in Psychosis services, which aim to reduce DUP and facilitate and sustain recovery. These services are for people between the ages of 14 and 65. They provide a range of evidence-based interventions, including psychological and social interventions as well as medical treatment. Working with people and their families, these services also seek to raise awareness of psychosis in the community and reduce the stigma associated with it.

## Importance of early intervention for psychosis

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

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

# Signs and symptoms

## General signs and symptoms of psychosis

As risk factors cannot predict with certainty that a person will develop psychosis, it is important that as MHFAiders we are also aware of early warning signs. This is particularly relevant as early intervention has been shown to be crucial to improve chances of recovery. An episode of psychosis usually comes on in stages, although the length of time it takes to develop can vary between individuals. Some of the early concerning signs may be easy to confuse with 'normal' adolescence in young people or may be shared with other common mental health conditions, but if they are followed by other early warning signs, they should give rise to concern that psychosis may be developing.

Psychosis can manifest itself in a variety of ways. It will impact on a person's emotions, motivation, their thinking, and perception of the world, and lead to changes in their behaviour. Certain symptoms may be associated with and used for diagnosis of different types of psychotic disorders, but there are also some common symptoms which may be noticed when psychosis is first developing. These include:

### Early warning signs

- Emerging unusual beliefs
- Perception that things have changed
- Belief that thoughts are sped up or slowed down
- Loss of energy or motivation

### Changes in emotion and motivation

- Depression
- Anxiety
- Irritability/anger
- Mood swings
- Suspiciousness
- Blunted, flat, or inappropriate emotion
- Changes in appetite
- Reduced energy and motivation

### Changes in thinking and perception

- Difficulties with concentration or attention
- Memory problems
- Sense of alteration of self, others, or the outside world (e.g. feeling that self or others have changed or are acting differently in some way)
- Odd ideas
- Unusual perceptual experiences (e.g. a reduction or greater intensity of smell, sound, or colour)

### Changes in behaviour

- Sleep disturbances
- Social isolation or withdrawal
- Reduced ability to carry out work or social roles

### Taking account of different cultures

In some societies, psychotic experiences are understood as spiritual, positive, and acceptable. The person may willingly offer information and need reassurance from you about their experiences that may make you feel uncomfortable. Be aware of the person's culture, worldview, and any

religious values, as these may influence the presentation of psychosis.

## Schizophrenia

Contrary to popular belief, schizophrenia has nothing to do with 'split personality'. The term schizophrenia means 'split mind' and refers to changes in mental function whereby thoughts and perceptions become disordered.

### Signs and symptoms of schizophrenia

Individuals experience these symptoms in different combinations and to a different extent. It is also important to realise that psychosis is not a constant or static condition. At any given time, a person may be experiencing severe symptoms, mild symptoms, or none.

#### Delusions

Delusions are false beliefs. These can include beliefs of persecution, guilt, having a special mission or being of special birth, or of being under outside control. Although the delusions may seem bizarre to others, they are very real to the person experiencing them.

#### Hallucinations

These are false perceptions. Hallucinations most commonly involve hearing voices. They can also involve seeing, feeling, tasting, or smelling things. These are perceived as very real by the person but are not actually present. Hallucinations can be very frightening. This is especially the case when voices make negative comments about the person or contain unpleasant ideas.

Because the delusions and hallucinations are so real to the person experiencing them, it is unlikely that they will want to consider an alternative explanation. It is important to consider people's cultural backgrounds and the possibility that delusions can derive from real experience such as emotional trauma.

#### Thinking difficulties/thought disorder

The person may have difficulties with concentration, their memory, and ability to plan. These make it more difficult for them to reason, communicate and complete daily tasks. These are also sometimes called 'cognitive impairments'.

Thinking difficulties may also be referred to as thought disorder. The person's thinking may be disorganised, not follow a logical train of thoughts, and jump in unpredictable directions. Thought disorder is often recognised through people displaying unusual speech patterns, where conversation may lack content, stop abruptly, jump from topic to topic, become incoherent, or otherwise lose logical patterns or coherence.

#### Loss of drive

The person lacks motivation, and this can extend even to self-care. This should not be interpreted as laziness.

#### Blunted or inappropriate emotions

The person has a lack of emotions or has inappropriate emotions. They may not react to the things around them or react inappropriately.

## Signs and symptoms cont.

### Social withdrawal

Social withdrawal is a common feature of people experiencing psychosis. The longer the treatment is delayed, the more socially withdrawn a person is likely to become.

### Bipolar disorder (formerly known as manic depression)

People with bipolar disorder have extreme mood swings. They experience periods of depression and mania, often with periods of 'normal' mood in between. Correct diagnosis of bipolar disorder can take a long time. This is because the person needs to have had episodes of both depression and mania. Different people take different amounts of time to move between these two extremes (sometimes years).

Because bipolar disorder impacts strongly on a person's mood, it is often classified alongside depression under the umbrella term of mood disorders. However, because mania can bring with it symptoms of psychosis, it can also be considered as part of a group of psychotic disorders.

#### Symptoms of depression

During episodes of depression, the person has some or all symptoms associated with depression. See the pages on depression for additional information on these.

#### Symptoms of mania

- Increased energy and hyperactivity
  - the person may suddenly be able to do far more than usual. They will appear restless and unable to sit still.
- Elated mood - the person will feel high, happy, full of energy, on

top of the world, invincible.

- Needing less sleep than usual – the person can go for days with very little sleep or none.
- Irritability – this may occur if others disagree with a manic person's unrealistic plans or ideas. It is also a result of fatigue as the person goes longer and longer without proper rest.
- Rapid thinking and speech – the person may talk too much, too fast and keep changing the subject.
- Grandiose delusions – these usually involve very inflated self-esteem. For example, the person may believe that they are superhuman, especially talented, or an important religious figure. There may also be linked suspiciousness or paranoia, e.g. about other people doubting their special powers.
- Hallucinations – in psychotic mania, the person may sometimes experience hallucinations, although this is not always the case.
- Lack of insight – the person is so convinced that their manic delusions are real and don't realise that they are unwell.

Not all people with bipolar disorder will experience symptoms of psychosis. Presence of psychotic symptoms like delusions or hallucinations may be used to assess the severity of the person's condition.

Some people with bipolar disorder experience milder symptoms of mania, commonly referred to as hypomania. They are said to have bipolar II disorder.

**For further information about bipolar disorder see page 64 in the Depression section.**

## Psychotic depression

Sometimes depression can be so intense that it causes psychotic symptoms. For example, the person may have delusions involving guilt, as well as severe physical illness, or hopelessness. Delusions will usually focus on themes consistent with depression, like the person's worthlessness or failure. The person may also experience hallucinations consistent with such themes, for example negative, critical, and blaming voices.

## Postpartum psychosis (or puerperal psychosis)

Postpartum psychosis begins suddenly in the days or weeks after having a baby. The symptoms vary and can change rapidly but can include high mood (mania), depression, confusion, hallucinations, and delusions. It is much less common than postnatal depression. Professional help should be sought as quickly as possible.

The condition can happen to any woman and often occurs suddenly to women who have not experienced poor mental health before, although it can also affect women who have experienced it following previous births. It can be a very frightening experience for the woman, their partner, friends, and family, but women usually recover fully after an episode.

## Schizoaffective disorder

Sometimes it is difficult to tell the difference between schizophrenia and bipolar disorder or depression, as the person has symptoms of both conditions. Such a person may be diagnosed as having schizoaffective disorder. Schizoaffective disorder may have more pronounced symptoms of mania or depression, or a mix of these symptoms, alongside common symptoms specific to schizophrenia. To be diagnosed as schizoaffective disorder, it is important that these symptoms occur at the same time, rather than in distinct timeframes, e.g. a separate period of depression after an episode of psychotic symptoms has resolved. In this way, schizoaffective disorder is not the same thing as a person with psychosis also experiencing depression.

## Drug-induced psychosis

This is a psychosis brought on by the use of drugs. The symptoms usually appear quickly and last a short time (from a few hours to days) until the effects of the drug wear off. The most common symptoms are visual hallucinations, disorientation, and memory problems. This usually results from prolonged or heavy use. In some cases, drug use may trigger another psychotic condition such as schizophrenia in people who are vulnerable to psychosis.

# Crises associated with psychosis

The main crises associated with psychosis are:

The person is experiencing a severe psychotic state.

[For crisis first aid for severe psychotic states see pages 155-156.](#)

The person is experiencing suicide thoughts or behaviour. People with psychotic disorders are at high risk of suicide. Suicide risk increases if the person also has depression or misuses substances, if they avoid following their treatment, and have serious fears about the impact of the psychotic condition on their mental functioning.

[For crisis first aid for suicide thoughts and behaviour see pages 140-149.](#)

The person has self-harmed. People with psychotic disorders are at increased risk of self-harm.

[For crisis first aid for self-harm see pages 133-139.](#)

The person has experienced a traumatic event. People with psychotic disorders often have a history of past trauma.

[For crisis first aid for traumatic events see pages 150-154.](#)

The person is showing aggressive behaviour. Although rare, sometimes a person in a severe psychotic state may threaten violence. This is more likely if alcohol or drug use is also involved.

[For crisis first aid for aggressive behaviour see pages 159-160.](#)

# First aid best practice for signs of psychosis

**Remember to revisit the ALGEE action plan in full on pages 42-57.**

**Remember that people who are experiencing psychosis will often not reach out for help**

Someone who is experiencing profound and frightening changes such as psychotic symptoms will often try to keep them a secret. If you are concerned about someone, approach the person privately in a caring manner, and away from distractions, to discuss your concerns. Understand that the person you are trying to help might not trust you or might be afraid of being perceived as 'different', and therefore may not be open with you.

**Try not to force conversation**

If the person is unwilling to talk with you, don't try to force them to talk about their experiences. Rather, let them know that you will be available if they would like to talk in the future.

**Try to tailor your approach and interaction to the way the person is behaving**

For example, if the person is suspicious and avoiding eye contact, be sensitive to this and give them the space they need. Don't touch the person without their permission, as they may feel intimidated or threatened by this, especially if they are already feeling suspicious.

**Empathise with how the person feels about their beliefs and experiences**

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

harder to communicate with them. The following are some tips which may help make communication a little easier.

**Follow these communication tips**

People experiencing symptoms of psychosis are often unable to think or communicate clearly. Their thoughts and speech may be disorganised at times, jump from topic to topic, or be hard to follow. The following tips may help with communication difficulties:

- Keep what you say short and simple
- Repeat things if necessary
- Be patient and allow plenty of time for the person to process the information and respond to what you have said
- Be aware that even if the person is only showing a limited range of feelings, this does not mean that they are not feeling anything
- Try not to assume the person can't understand what you are saying, even if their response is limited

**Let the person set the pace and style of the conversation, as far as possible**

You should recognise that they may be scared by their thoughts, feelings and experiences which will seem very real to them.

**Highlight the specific behaviours you are concerned about**

Avoid speculating about the person's diagnosis. Remember that as MHFAiders, it is not our role to diagnose someone with a specific condition. It is important to allow the person to talk about their experiences and beliefs if they want to.

## First aid best practice for signs of psychosis cont.

### Offer consistent emotional support and understanding

Reassure the person that you are there to help and support them, and that you want to keep them safe. If you are waiting for help, reassure the person that you will stay with them until help arrives. Reassure them that psychosis is not a weakness or a character defect. Remember that even though it may be hard for you to relate to the person's experiences, it may be possible to find some common ground by focusing on how the experience is making them feel.

### Consider timings when giving information

When a person is experiencing a psychotic episode, it is usually difficult and inappropriate to try to give information about psychosis. When the person is thinking more clearly and in touch with reality, you could ask them if they would like some information about psychosis.

### Remember that early intervention is crucial for long-term recovery from psychosis

The chances of the person not going on to develop further episodes of psychosis are improved if treatment is accessed promptly. When discussing options of professional help, you could ask them if they have felt this way before, and, if so, what they have done in the past that has been helpful (this may also be a good way of finding out about any mental health crisis cards or advance directives they may have in place). If the person decides to seek professional help, you should make sure they are supported both emotionally and practically in accessing services.

### Avoid confrontational or blaming behaviours

Try not to use patronising or sarcastic language.

### Avoid agreeing or disagreeing with any delusions or hallucinations

Try not to share any judgements you may have about the content of their beliefs and experiences.

You should not:

- Dismiss, minimise, or argue with the person about their delusions or hallucinations
- Act alarmed, horrified, or embarrassed by the person's delusions or hallucinations
- Laugh at the person's symptoms of psychosis
- Encourage or inflame the person's paranoia if the person exhibits paranoid behaviour or beliefs
- Pretend that you can also see, hear, or feel the hallucinations they are experiencing
- Take any delusional comments personally

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

### Avoid lying and making any promises that you cannot keep

This can create an atmosphere of mistrust and add to the person's distress. It is important that you are honest when interacting with the person. Try not to assume that they won't remember what you have told them because of their symptoms.

# Professionals and treatments that can help with psychosis

For specific helpful resources and contacts sign in to your MHFAider Support App or go to the [Hub of Hope website](#).

For severe symptoms of poor mental health such as those associated with psychotic disorders and bipolar disorder, it is likely that treatment will be provided by a range of professionals or support services. These include:

## GPs

A GP is the first professional to turn to. A GP can provide the following type of help:

- Make an initial diagnosis
- Refer the person to a Crisis Resolution and Home Treatment Team, Early Intervention in Psychosis Team, or, if not available, the local Community Mental Health/Recovery Team (CMHT) for specialist assessment and advice on treatment
- GPs will not usually prescribe medications for psychotic disorders without input from a psychiatrist, although they may manage them in the longer term once the right type and dosage of medication has been found

## Hospital treatment

At times, people experiencing severe symptoms may need to spend some time in hospital to get treatment and support. Hospital admission is usually used as a last resort and, wherever possible, the person will be admitted on a voluntary

basis after discussing the options with a mental health professional. In rare cases, where the person may lack insight into their difficulties and there is also a serious risk of harm to themselves or others, they may be admitted involuntarily ('sectioned' under the Mental Health Act). The law and process around involuntary admissions is complex and requires several different professionals to be involved before such a decision can be made. People who are sectioned under the Mental Health Act have a legal right to access independent advocacy services that can advise them on their individual rights and circumstances and represent them if appropriate. Mental health professionals should make people aware of these rights if they are involuntarily admitted to hospital and offer details of the local advocacy service.

## Crisis Resolution and Home Treatment Teams

A Crisis Resolution Team (sometimes called Home Treatment Team) provides intensive support for people in a mental health crisis in their own home: they stay involved until their mental health is improved at which point the person, if new to the service, will firstly be referred to the Early Intervention in Psychosis team or Community Mental Health/Recovery Team if not available. A Crisis Resolution Team is designed to provide prompt and effective home treatment, including medication, to prevent hospital admissions and give support to informal carers.

## Professionals and treatments that can help with psychosis cont.

### Early Intervention in Psychosis teams

Early Intervention teams are specialised teams set up to work with people who are experiencing a first episode of psychosis, usually between the ages of 14 and 65. Many services accept direct referrals and will meet people and their families in places they feel comfortable rather than at a mental health service. Early Intervention teams will work closely with family members, ensuring that their needs are also met. This positive response to families and close friends aims to improve their ability to care and is a cornerstone of high-quality practice. Early assessment and treatment leads to better outcomes for people.

### Community Mental Health Teams (CMHTs) also known as Recovery Teams

Local CMHTs (now often referred to as Recovery Teams or Recovery and Support Teams) can provide ongoing help to a person with psychosis or other serious poor mental health to manage medications, self-care, housing, and finances. They can also give general support and counselling to the person and to their family or carers. The make-up of CMHTs and referral routes to them differ from area to area.

Most of the specialist mental health services listed above will employ a range of mental health professionals. These usually include psychiatrists, clinical psychologists and/or psychotherapists, community psychiatric nurses (CPNs) or other psychiatric nurses, occupational therapists, social workers, and other support workers.

Names for these services may differ in different parts of the country, and

sometimes several services are rolled into one to make it easier for different services to work together.

### Shared decision making about treatments for psychosis

Antipsychotics are important for the management of psychosis, specifically for controlling hallucinations and delusions. However, they are strong medications that do have side effects.

The most difficult side effects are weight gain and cardiovascular (heart disease) risk, including the onset of metabolic syndrome – a combination of diabetes, high blood pressure and obesity. Other side effects include difficulty moving or difficulty staying still, and sleepiness.

Some of the side effects can be reduced with a change in dose or medication, or lifestyle changes (such as healthy diet and exercise), but side effects cannot be eliminated entirely.

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

For this reason, it is important that skilled mental health professionals negotiate and discuss the various risks and benefits with the person before making decisions about treatment. Choosing the right medication and reaching agreement on the right

dose can take time and requires good communication.

In the past, treatment for psychotic disorders often excluded alternative treatment approaches like psychological therapy, which were considered to be ineffective. This is now recognised not to be the case, and psychological therapies like cognitive behavioural therapy are recommended explicitly as routine treatment alongside medication. The idea is that they can help the person to develop new strategies to cope with psychotic experiences such as hearing voices. This in turn may later allow the person to manage their symptoms on lower doses of medication than would otherwise be the case, thus minimising side effects.

#### **What is an advance health care directive/mental health crisis card?**

An advance health care directive is a document used by a person with a long-term mental health condition describing how the person wants to be treated when they are unable to make their own decisions. This information may include the signs that indicate when a person is unwell. In most countries, this is not a legal document; it is an agreement made between the person with the condition, their family, and hopefully their usual mental health professional or mental health team. It may include the person's preferences about which hospital they will go to if they are unwell and who should be contacted in case of emergency. Creating such advance plans is recommended as part of NICE

guidelines, and they are usually drawn up with the help of the person's care coordinator (a care coordinator is a designated mental health professional in charge of managing the person's overall care, where they may be seeing several different professionals or getting support from multiple services).

[See Appendix A for information on WRAP® \(Wellness and Recovery Action Plan\).](#)

# Other supports for psychosis

## Support groups

Support groups can be helpful to the person experiencing psychosis and other family members. Such groups operate on the principle that, for many people, psychotic experiences, like hearing voices, seeing visions and tactile sensations, may be linked to difficult life experiences such as extreme stress and trauma, and that people can learn to understand them and grow from them in their own way, if they are given the opportunity to explore them in a safe and non-judgemental environment.

Peer support groups may also be helpful in other ways. Hearing or reading about other people's experiences can validate the person's experiences, help them make sense of those and make them feel less isolated and alone. Peer support can also allow the person to learn from others' experiences of navigating health systems, managing side effects of medications, and the range of treatments that may be on offer.

## Community and voluntary sector organisations

Several voluntary sector organisations can offer additional support to people experiencing psychosis. This could be in the form of organising support groups, providing access to low-cost therapy, or complementary therapies, support to find volunteering or employment opportunities or befriending services if the person has become socially isolated. Similar support may also be on offer to friends and families.

## Self-help strategies

People experiencing psychosis should avoid the use of alcohol, cannabis, and other drugs. People sometimes take substances as a way of coping with symptoms of psychosis or other unpleasant feelings, such as depression, anxiety, boredom, and loneliness, but use of these substances can make recovery harder. It may also interfere with medication working properly and increase its side effects.

Not all self-help strategies may be suitable for all people with psychosis. The benefits of exercise for depression have been well studied but little research has been done on exercise in bipolar disorder. People with bipolar disorder may benefit from an exercise regime but should be wary when there are warning signs of a manic episode. If exercise seems too stimulating during those times, decreasing the frequency or intensity of exercise until the warning signs or episode have passed may be a good idea.

# What is substance misuse?

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

Substance misuse is more common among adults with poor mental health than in the wider population. The coexistence of poor mental health and substance misuse, commonly referred to as dual diagnosis, has, over the years, increasingly been seen as a major challenge for communities.

Substance misuse is more common in men than in women. It often starts during adolescence or early adulthood and often co-occurs with depression and other mood disorders, anxiety disorders, and psychotic disorders. One reason for this co-occurrence is that many people use alcohol or other drugs to relieve unpleasant emotions. However, alcohol or other drug use can also cause other problems in a person's life (e.g. relationship or financial problems), and heavy use may contribute to or exacerbate poor mental health.



# Signs and symptoms

## General signs and symptoms of substance misuse

- Craving (i.e., a strong urge) to use the substance
- Difficulties in controlling substance use, e.g. wanting to cut down use but finding this difficult; taking the substance in larger amounts or for a longer period than intended; using the substance at times or in amounts where it impacts a person's ability to fulfil their work, school, or home responsibilities
- Withdrawal symptoms when substance use is stopped, or the substance is needed to avoid withdrawal symptoms
- Tolerance for the substance (i.e., the person needs to use increasing amounts to get the desired effect over time or they get less effect with the same amount of the substance)
- Neglect of previous interests due to substance use; a lot of time is spent obtaining the substance, using it, or recovering from its effects
- Continuing with substance use despite clear evidence of obvious harmful effects, e.g. physical health issues or negative impact on mental health

## Harmful use

Harmful use includes substance misuse where the person may not be fully dependent on the substance (e.g. they may not crave it or develop tolerance), but where they show a clear pattern of using substances that is causing damage to their health. This damage can be physical (e.g. catching hepatitis from injecting drugs) or

mental (e.g. having episodes of depression due to frequent and heavy use of alcohol).

The immediate direct effects of alcohol or drugs (such as being drunk) or the period of recovering (i.e., hangovers) are not enough to qualify as damage to health in and of themselves. The issues caused by drug use must form part of a wider pattern.

Alcohol and other drugs may also cause acute states of poor mental health due to their direct actions, including forms of substance-induced psychosis.

## Alcohol

Alcohol makes people less alert and impairs concentration and coordination. Some people use alcohol to reduce anxiety and other symptoms of poor mental health. In the short term, it can help with this. In small quantities, alcohol causes people to relax and lower their inhibitions. They can feel more confident and often act more extroverted. However, alcohol use can produce a range of short-term and long-term problems.

### Short-term issues caused by alcohol intoxication

When a person is intoxicated with alcohol (i.e., drunk), they are at risk of several issues, such as:

- Physical injuries – people are more likely to engage in risky behaviour that can lead to injury or death. Alcohol is a big contributor to traffic accidents. Also, intoxication can lead to poor motor coordination resulting in staggering or falling and slurred speech, and even to

medical emergencies such as continual vomiting or unconsciousness.

- Aggression and antisocial behaviour
  - people can become aggressive and are at a much higher risk of committing crimes.
- Sexual risk-taking, e.g. not using contraception, having multiple sexual partners – the consequences of these behaviours can be engaging in sexual activities the person may avoid if sober, unplanned pregnancy, and sexually transmitted infections.
- Suicide behaviour and self-harm – when a person is intoxicated, they are more likely to act on suicide thoughts or to self-harm. Alcohol increases risk in several ways. It acts as a mood amplifier, intensifying feelings of anxiety, depression, or anger, reduces inhibitions, and inhibits the use of more effective coping strategies.
- Alcohol-induced psychosis – this is a form of psychosis brought about by the direct effects of alcohol and involves symptoms like hallucinations (seeing or hearing things which are not there).

### Long-term issues caused by alcohol use

With heavy and prolonged use, alcohol can cause physical, psychological, and social issues. These include:

- Alcohol dependence – people who drink alcohol regularly above the recommended limits, particularly those who start at an early age, have an increased risk of developing alcohol dependence.
- Other substance misuse – people who

use alcohol may be more likely to be introduced to other drugs.

- Depression and anxiety – alcohol is a depressant drug. Depressant drugs interfere with and slow the operation of the central nervous system. Heavy alcohol use increases risk of depression and anxiety. Because alcohol intensifies mood, somebody already experiencing depression is likely to feel worse under the influence of alcohol. Alcohol also disrupts sleep patterns and so can contribute to depression by increasing fatigue. If a person is having suicide thoughts, they are more likely to attempt suicide when under the effect of alcohol. Although in the short term, alcohol can quickly relieve feelings of anxiety, long-term alcohol misuse and acute alcohol withdrawal often increase anxiety levels (which can then drive a cycle of further alcohol use). Associated social and physical issues are also likely to have an impact on depression and anxiety.
- Chronic alcohol use can also bring about states of alcohol-induced psychosis, as may acute alcohol withdrawal. Once the person has stopped using alcohol and gone past the period of physical withdrawal, symptoms of psychosis are likely to clear.
- Some people with existing psychosis may also use alcohol as a means of self-medicating. This may make their symptoms worse, and complicate diagnosis, as it may not be clear whether psychotic symptoms are due to the alcohol or underlying issues.

## Signs and symptoms cont.

- Social problems – alcohol misuse is associated with family conflict, dropping out of school, unemployment, social isolation, and legal problems.
- Physical health issues – in the long term, heavy use of alcohol can produce a range of physical health issues such as liver disease, strokes and brain damage, heart disease (including heart attacks), cancers (especially of the liver, mouth, throat, oesophagus or larynx, or breast cancer in women), diabetes, muscle weakness, pancreatitis, ulcers and gastrointestinal bleeding, nerve damage to hands and feet, weight gain, reduced fertility, and risks to unborn babies.
- Even people who 'only' regularly drink over the low-risk guidelines (see next section, Alcohol unit guide) increase their chances of these medical complications.

### Alcohol and prescribed medication for mental health conditions

Alcohol reacts badly with many psychiatric medications, including some used to treat depression and bipolar disorder. It stops some antipsychotic medications, used to treat the mania of bipolar disorder or other psychotic disorders, from working properly. This means that a person who drinks alcohol may need higher doses of these medications. Taking any medication at higher doses increases the risk of negative side effects. Alcohol may increase the toxicity of medications and cause increased sedation if taking certain types of antidepressants. When a person first begins taking prescribed medication for poor mental health it is important they discuss any potential interactions with

alcohol with a medical professional or pharmacist.

### Alcohol unit guide

If a person chooses to drink alcohol, the NHS low-risk alcohol unit guide can help explain and compare how much alcohol is in a drink.

If a person has physical alcohol withdrawal symptoms (like shaking, sweating, or feeling anxious until they have a first drink of the day), they should take medical advice before stopping completely. For a person who is physically dependent on alcohol, it can be dangerous to stop too quickly without proper advice and support. Acute alcohol withdrawal can cause medical complications, including seizures.

### Drugs

While alcohol is the main substance that is misused, there are a wide variety of other drugs that can cause issues. Drugs are often broadly grouped based on their effects on the nervous system and mental function, which may be sedative (slowing of normal nervous system function), stimulant (increasing of normal nervous system function), or hallucinogenic (mind-altering and distorting normal function of our senses), although some drugs may have multiple effects. Some drugs also have painkilling effects.

As with alcohol, some people use illegal drugs or misuse prescribed medications to try and gain relief from symptoms of depression or other mental health conditions.

### Cannabis (marijuana, hashish, pot, weed)

Cannabis is a mind-altering drug, with both sedative and hallucinogenic properties. It is a mixture of dried, shredded leaves, stems, seeds, and flowers of the hemp plant. Use of cannabis can interfere with performance at work or at school and lead to increased risk of accidents if used whilst driving. Long-term heavy use of cannabis has been found to produce abnormalities in certain parts of the brain.

People who use cannabis are more likely to experience poor mental health, including anxiety and depression, but it is unclear which comes first. Like alcohol, cannabis can intensify mood and so worsen feelings of depression. Its effects include lethargy and reduced ability to make decisions, and as these are also symptoms of depression, they are likely to reinforce each other.

Cannabis can trigger paranoia and anxiety, and cause panic attacks. It can also cause mild hallucinations or more acute states of drug-induced psychosis in those vulnerable to its hallucinogenic effects. There is evidence that cannabis use by adolescents and young adults increases the risk of developing schizophrenia and other forms of psychosis, particularly in people who are vulnerable because of a personal or family history of schizophrenia. Cannabis is also likely to interfere with anti-psychotic medication.

### Opioid drugs (including heroin)

Opioid drugs include heroin, morphine, opium, and codeine. Heroin is processed from morphine, which is a naturally

occurring substance taken from the Asian poppy plant, with strong sedative properties. Heroin is a highly addictive drug, and most people who use it develop a dependency to it. Heroin produces a short-term feeling of euphoria and wellbeing, and relief of pain. Most people who are dependent on heroin also have associated issues such as depression, alcohol dependence and criminal behaviour. People who use heroin are at higher risk of suicide behaviour.

Morphine and codeine are widely used in medical settings for pain control. While there is evidence that people who use such prescription medicines purely for acute pain control are less likely to become addicted to them, there is still a considerable risk of people developing dependence, especially where use is chronic. This means their use needs to be carefully monitored by a medical professional. People may also misuse prescription painkillers for their euphoric effects.

Some people may misuse opioid drugs to self-medicate existing poor mental health, especially feelings of anxiety. Where opioids are used to relieve such feelings of distress, they are more likely to be habit-forming and become addictive.

### Other medications used for non-medical purposes

Several other prescription medicines, such as those used to treat anxiety and sleep problems, are misused by some people for non-medical purposes. This includes sedative medications like

## Signs and symptoms cont.

benzodiazepines (e.g. diazepam/Valium). Misuse of these medications can lead to dangerous situations, such as driving while under the influence. Even when using them under prescription, some people will become dependent on these medications after long-term use, and experience withdrawal effects if suddenly stopping treatment. Older people are the most likely to be affected. When used long-term, these medications can increase the risk of falls and cognitive impairment in older people.

### Cocaine

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

### Amphetamines (including methamphetamine, speed)

Amphetamines belong to a category of stimulant drugs and have the temporary effect of increasing energy and apparent mental alertness. As the effect wears off, a person may experience a range of issues including depression, irritability, agitation, increased appetite, and sleepiness. Amphetamines come in

many shapes and forms and are taken in many ways. They can be in the form of powder, tablets, capsules, crystals, or liquid. Methamphetamine has a chemical structure like that of amphetamine, but it has stronger effects on the brain. The effects of methamphetamine can last 6–8 hours. After the initial ‘rush’ there can be a state of agitation, which can lead to violent behaviour in some individuals. High doses of amphetamine can lead to aggression, intense anxiety, paranoia, and psychotic symptoms. A particular mental health risk is amphetamine psychosis or ‘speed’ psychosis. The person may experience hallucinations and delusions and may also be prone to uncontrolled violent behaviour. The person will recover as the drug wears off but is vulnerable to further episodes of drug-induced psychosis if the drug is used again.

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

### Hallucinogens

Hallucinogens are drugs that affect a person’s perceptions of reality. Examples are LSD, mescaline, ketamine, hallucinogenic ('magic') mushrooms, salvia divinorum ('sage'), and DMT (dimethyltryptamine). As well as heightened senses and feelings of ‘mind expansion’, they cause the person to see, hear or feel things which are not actually there (hallucinations). Some hallucinogens also produce rapid, intense emotional changes. A particular experience associated

with hallucinogens is flashbacks, where the person re-experiences some of the perceptual effects of the drug when they have not been recently using it. Some hallucinogens like ketamine also produce strong dissociative effects, which make a person feel like their mind and body are separated.

Not only is it possible for people to experience 'bad trips' (distressing hallucinations and experiences) when taking hallucinogens, but the immediate effects of such substances may also put them at risk of physical harm and accidents while under the influence. In addition to this, hallucinogens may amplify feelings of anxiety in those who already have an anxiety disorder. Because they cause symptoms of psychosis, they are unhelpful to people at risk of developing psychotic disorders and may trigger further episodes in those with a history of psychosis.

### **Ecstasy (MDMA, 'E')**

Ecstasy is a stimulant drug that also has hallucinogenic effects. Users can develop an adverse reaction that in extreme cases can lead to death. To reduce this risk, users need to maintain a steady fluid intake and take rest breaks from vigorous activity. While intoxicated, ecstasy users report ecstatic moods (hence the name), heightened senses, and strong feelings of empathy with others. When coming off the drug they often experience the reverse, i.e., depressed mood for two to three days after use, and inability to sleep properly immediately after use.

As a result of its strong impact on mood, ecstasy may complicate mood disorders like depression, and in particular bipolar disorder, in which recovery involves trying to smooth out the highs and lows in the swings from mania to depression. It can also bring on drug-induced psychosis. The long-term effects of using ecstasy are of particular concern.

### **Inhalants**

Inhalants are breathable chemical vapours that produce mind-altering effects. The effects of inhalants range from an alcohol-like intoxication and euphoria to hallucinations, depending on the substance and the dosage. Use of inhalants also starves the brain of oxygen, causing a brief 'rush'. Inhalants may be solvents (e.g. paint thinners, petrol, glues), gases (e.g. aerosols, butane lighters), nitrites, and other substances.

Young people are the most likely to misuse inhalants, partly because inhalants are readily available and inexpensive. The intentional misuse of common household products to get high can be fatal. Young people are usually unaware of the serious health risks and those who start using them at an early age are likely to become dependent on them. These chemicals may destroy cells in the brain, the liver, and the kidneys.

### **Tobacco**

Tobacco is so widely used that we don't usually think of it as relating to poor mental health. However, there is a high rate of poor mental health in people who use tobacco. The rate of smoking in

## Signs and symptoms cont.

people with poor mental health is much higher than in the general population.

Smoking is particularly frequent in people with psychosis. It is possible that tobacco is used as a type of self-medication by some people with poor mental health to improve mood and cognitive functioning. Although tobacco contains a vast number of different chemicals, its addictive effects are known to be maintained by the stimulant drug nicotine.

### Caffeine

While caffeine is perfectly legal, it can contribute to anxious states and disrupt sleep. It should be used in moderation by those experiencing poor mental health.

Caffeine gives a boost and increases feelings of alertness, but in higher doses it produces effects like anxiety.

### New psychoactive substances – ‘legal highs’

New psychoactive substances, often known as ‘legal highs’, are substances designed to create effects like existing illegal drugs, including stimulant drugs like cocaine and ecstasy. ‘Legal highs’ are used to avoid prohibitive laws by having a chemical structure just different enough from existing prohibited drugs to avoid being controlled. Even though legal, this does not mean they are safe to use. In fact, the lack of available research on them means their effects on users may be unpredictable and include serious risks to physical and mental health. It is also not uncommon for such substances to contain traces of illegal drugs or be mixed with substances not fit for human consumption (e.g. cement).

# Crises associated with substance misuse

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

The person is experiencing suicide thoughts and/or behaviour.

[For crisis first aid for suicide thoughts and behaviour see pages 140-149.](#)

## First aid best practice for signs of substance misuse

### Consider the person's readiness to talk

Understand that the person will have their own perception of their substance use. Ask them about their substance use and if they believe their substance use is an issue. Consider the person's ability to talk about their substance use at this time by asking about areas of their life that it may be affecting, for example, their mood, work performance and relationships. Be aware that the person may deny, or might not recognise, that their substance use is problematic and that trying to force the person to admit they are experiencing poor mental health may cause conflict.

### Be aware of the person's recall of events

When discussing the person's substance use, bear in mind that they may recall events that occurred while they were under the influence of alcohol or drugs in a different way to how they actually happened, or that they may not recall events at all.

### Use 'I' statements

Discuss your concerns with them in an open and honest way by reflecting back the changes in their behaviour which concern you, such as "I am worried about how much you've been drinking lately" rather than 'you' statements ("You are drinking too much") which may come across as accusing, or 'we' statements ("We are worried about your drinking") which may sound as if they are being picked on.

### Rate the act, not the person

Identify and discuss the person's behaviour rather than criticise their character or lecture them, for example, "Your drug use seems to be getting in the way of your friendships". Avoid expressing moral judgements or frustration at the person about their substance use.

### Stick to the point

Focus on how the person's substance use is affecting them and don't get drawn into arguments or disagreements.

## First aid best practice for substance misuse cont.

### Collect information

When having a conversation with the person around how their substance use impacts on their life, you may wish to explore what type of substances they use, how much or how often they use them, and how they impact on them personally and on others around them.

### Help the person to explore reasons for substance misuse

It may also be useful to get them to reflect on their reasons for using substances, whether they perceive their use as problematic, and whether they actively want to make a change to their behaviours. Try to have an open-ended conversation that allows the person to explore the issues at hand.

### Try to find out whether the person wants help to change their substance use

Ask the person if they would like information about substance misuse or any associated risks. If they agree, provide them with relevant information. Offer your help and discuss what you are willing and able to do. Have the phone number for an alcohol and other drug helpline, and perhaps the address of a reputable website, with you to offer them. Be prepared for a negative response when suggesting professional help. The person may not want help when it is first suggested to them and may find it difficult to accept help. Stigma and discrimination can be major barriers to seeking help. If this is the case, explain to the person that there are several approaches available for treating substance misuse. If the person won't seek help because they don't want

to stop using completely, explain that the treatment goal may be to reduce consumption rather than to quit altogether. Reassure the person that professional help is confidential.

### Remember the importance of early intervention for substance misuse

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

### Have realistic expectations for the person

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

- Changing substance use habits is not easy
- A person's willpower and resolve are not always enough to help them stop problematic substance use, even if they are keen to stop
- Giving advice alone may not help the person change their substance use
- A person may try to change or stop their substance use more than once before they are successful

- If abstinence from substances is not the person's goal, reducing the quantity of substances used is still a worthwhile objective

### Provide tips for low-risk drinking

Below are some specific ways to help a person who wants to change their problematic use of alcohol, if appropriate. Some of these suggestions may also be helpful for a person who is misusing drugs. You can advise the person to:

- Know the alcohol content of their drink
- Know what a standard drink is and be aware of the number of standard drinks they consume
- See if the number of standard drinks is listed on the beverage's packaging
- Eat while drinking
- Drink plenty of water on a drinking occasion to prevent dehydration
- Drink beverages with lower alcohol content and switch to non-alcoholic drinks when they start to feel the effects of alcohol
- Don't let people top up their drink before it is finished, so they don't lose track of how much alcohol they have consumed
- Avoid keeping up with their friends drink for drink or drinking games. There is often social pressure to get drunk when drinking. Be assertive when they feel pressured to drink more than they want or intend to. They have the right to refuse alcohol and say, 'no thanks' without explanation, or use different ways they can say 'no' such as 'I don't

feel like it', 'I don't feel well', or 'I am taking medication'. Practise different ways of saying 'no'. Saying 'no' to alcohol gets easier the more they do it and the people who care about them will accept their decision not to drink or to reduce the amount that they drink.

- Drink slowly, for example, by taking sips instead of gulps and putting their drink down between sips
- Have one drink at a time
- Spend their time in activities that don't involve drinking
- Make drinking alcohol a complementary activity instead of the sole activity
- Identify situations where drinking is likely and avoid them if practical
- Remember that reducing alcohol intake and changing drinking patterns is difficult but they should not give up trying
- Find further information on how to reduce the harm and health risks associated with problematic drinking
- Be aware that alcohol may interact with other drugs and medications (prescribed or over-the-counter) in an unpredictable way which may lead to a medical emergency

### Supporting a person who does not want to change

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

## First aid best practice for substance misuse cont.

the person, as you may be able to have a beneficial effect on their use.

### Speak with a professional

You can speak with a health professional who specialises in substance misuse to determine how best to approach the person about your concerns, or you could talk to others who have dealt with such difficulties about effective ways to help the person. Be prepared to talk to the person about seeking professional help again in the future. However, pressuring the person, denying them basic rights such as shelter or food, or using negative approaches, is counterproductive.

Remember that the person cannot be forced to get professional help except under certain circumstances, for example if a violent incident results in the police being called or following a medical emergency.

### Self-care

It is also vital to look for support for yourself, especially if you are directly impacted by the negative consequences of someone's substance use.

### Boundaries

Set boundaries around what behaviour you are willing and not willing to accept from the person. Avoid making excuses for the person or cover up their substance use or related behaviour. Be compassionate and patient while waiting for the person to accept that they need help – it is ultimately the person's decision. Changing substance misuse is a process that can take time.

# Professionals and treatments that can help with substance misuse

For specific helpful resources and contacts sign in to your MHFAider Support App account or go to the [Hub of Hope website](#).

Most people misusing alcohol and drugs don't receive health or other services for these issues. Delays in services and failure to seek help can cause issues with family and employment, damage physical health, and increase the risk of developing other poor mental health such as depression and anxiety disorders.

A variety of health professionals can provide help to a person who is misusing substances. If the person is uncertain about what to do, encourage them to consult a GP first. The GP might refer the person to a drug or alcohol service, or to a mental health professional if they also have other poor mental health. In the UK, drug and alcohol workers are often referred to as 'keyworkers'.

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

- Overcome any physiological dependence on alcohol or drugs
- Overcome any psychological dependence (e.g. use of alcohol or drugs to help the person cope with anxiety or depression)

- Overcome habits that have been formed (e.g. a social life that revolves around drinking or drug use)

Although most drug and alcohol services work towards an aim of getting the person to become abstinent (i.e., not use drugs or alcohol at all), such treatment goals are agreed on in partnership with the person. Where someone is unwilling or unable to consider abstinence, drug and alcohol services may set a goal of reducing use instead. This is also known as harm reduction. One aim of harm reduction is to keep the person involved with treatment rather than risk alienating them which may cause them to abandon treatment and prevent them from seeking support in future. This is important as dropout rates for drug and alcohol treatment tend to be very high.

The following treatments are known to be effective and recommended by NICE guidelines. They are intended as a guide to what kind of treatment can be expected under best practice guidelines in England. They are not intended for the MHFAider to suggest as treatments in a specific case but may be helpful to understand what treatments may be offered when the person seeks professional help, or to help advocate for treatment.

## Brief intervention

If a person is drinking or using drugs at a level that could damage their health, then brief counselling by a GP or other

## Professional and treatments that can help with substance misuse cont.

health professionals can help them reduce or stop using. Brief intervention can help to motivate the person to enter long-term treatment. This type of intervention generally takes two sessions, each lasting from ten minutes up to an hour. The health professional looks at how much the person is using, gives information about risks to their health, advises them to cut down, discusses the advantages and disadvantages of changing and options for how to change, motivates the person to act by emphasising personal responsibility, and monitors progress. This is done using an empathic rather than a coercive approach, by ensuring feedback is non-judgemental.

### Withdrawal management

If the person is dependent on alcohol or drugs, they will have to withdraw from the substance before other treatments can start. This should be done under professional supervision. This may be done on an outpatient basis or may require intensive inpatient treatment, as some drugs have serious and risky withdrawal effects when stopped.

However, withdrawal is not enough and should be combined with other treatments to prevent the person from relapsing. Withdrawal is only part of the recovery process, and many lifestyle changes are necessary to change behaviours associated with drinking or drug use.

### Psychological treatments

There are a range of psychological approaches recommended for treating substance misuse. These include:

- Cognitive behavioural therapy, focused on alcohol use (which teaches the person how to cope with cravings and how to recognise and cope with situations that might trigger relapse)
- Cognitive behavioural therapy is not routinely offered to people for cannabis or stimulant use or to people on opioid maintenance treatment (methadone, see below), but may be offered to treat coexisting poor mental health
- Behavioural therapy, focused on drug or alcohol use (which teaches the person to change behaviours related to drug or alcohol use)
- Motivational interviewing (which helps motivate and empower a person to change)
- Social network and environment-based therapies focused on drug or alcohol use (which helps the person to build social networks that will be supportive of change, i.e., find and create environments not focused on substance use)
- Behavioural couples' therapy – this may be helpful for people with mild alcohol dependence, harmful alcohol use or drug use who have a regular (non-using) partner willing to be involved in treatment. It focuses on the impact of drug or alcohol use on the relationship
- Contingency management – this is used with people who misuse drugs and involves offering the person incentives such as shopping vouchers or privileges for negative drug test results or for harm reduction actions such as having a hepatitis or HIV test. Contingency

management works on the principle and evidence that reinforcing positive/wanted behaviours is more likely to lead to desired changes to behaviour than punishing negative/unwanted behaviours

### Medications

There are several types of medications that can assist a person to stay off substances. For people who misuse alcohol, these include anti-craving medications, medications that give an unpleasant effect if the person drinks, or medications for the treatment of underlying anxiety and depression. While antidepressants like SSRIs are used as part of treatment. NICE guidelines advise against using antidepressants alone. For people dependent on opioid drugs, methadone maintenance therapy is available.

Medications may need to be used under close supervision to manage withdrawal symptoms and then be phased out gradually once withdrawal from the original substance has been achieved.

### Dual diagnosis

People who misuse substances often have another mental health condition (dual diagnosis). Use of the substance may have started to deal with emotional difficulties. This means that it is important that any other mental health condition is treated as well, preferably at the same time.

# Other supports for substance misuse

## Support for families and carers

NICE guidelines recommend that families and carers of people who misuse substances, in particular drugs, should be consulted about their concerns and the impact the drug use has on themselves and other family members, including children. Family members and carers should also be routinely offered assessments of their personal social and mental health needs, be offered guided self-help strategies (signposting to high quality self-help materials with an initial session showing how these should be used) and signposted to self-help carers/family support groups. Where none of this proves useful, staff should offer individual family meetings to educate about drug use, identify individuals' sources of stress related to drug use, and explore helpful coping behaviours they can adopt.

## Family and friends

Family and friends can help the person to seek treatment and offer support to change their substance use, e.g. by reminding them of strategies they are practising to cope with cravings. They can also help reduce the chances of a relapse after a person has stopped using substances. People are more likely to start using again if there is an emotional upset in their life, and family and friends can try to reduce this possibility. It is useful to warn the person that not all family and friends will be supportive of their efforts. Where a person's social life revolves heavily around alcohol or substance use, changing use may inevitably lead to changes or losses of relationships where the other person does not consider the substance use as problematic.

People are more likely to recover if:

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

Other helps include support groups, community and voluntary sector organisations, and self-help strategies.

Revisit the ALGEE action plan in full on pages 42-57 for further information on other supports general to all mental health conditions.

# What is problem gambling?

The motivations for gambling vary. Some people gamble to win money, while for others, gambling offers fun and excitement or an opportunity to socialise. However, when gambling becomes an issue, these motivations may change. A person who problem gambles may be more likely to gamble to:

- Escape problems or negative emotions
- Build self-esteem
- Make up for gambling or other financial losses

Problem gambling refers to difficulties over time in limiting money or time spent on gambling, which leads to adverse consequences for the person, others, or for the community. The term problem gambling extends to those whose gambling is having a great enough impact on their life and who have received a diagnosis of a gambling disorder but may also include people with less severe symptoms.

People who problem gamble are likely to experience poor mental health or live with a diagnosable mental health condition, such as depression, anxiety, and substance use issues. A person with bipolar disorder may gamble heavily during a manic episode.

People who problem gamble often have false beliefs about the chances of winning, e.g. superstitions about luck or a belief that they can 'beat the system'. They may also feel the need to gamble with increasing amounts of money to achieve the same level of

excitement they experienced when they first started gambling.

Any form of gambling can become an issue. However, some types of gambling can cause more issues than others, e.g. gaming machines.



# Signs and symptoms

A gambling disorder involves persistent or repeated gambling behaviour that significantly impairs the person's life or causes them distress. In addition, the person will have several of the following symptoms over a 12-month period:

- Spends more money gambling over time to get the same amount of excitement
- When trying to reduce or stop gambling, has feelings of irritation and restlessness
- Has made repeated unsuccessful attempts to control their gambling
- Spends a lot of time thinking about gambling
- Often gambles to cope with negative feelings
- Gambles to chase losses
- Lies to hide the extent of their gambling
- Has been affected in their relationships or employment because of gambling
- Relies on financial aid from others to cover gambling losses

## General signs and symptoms of problem gambling

Shown below are the warning signs for problem gambling. A person may exhibit a few of these signs and not be problem gambling or exhibit only one sign and experience significant problem gambling. These signs are only an indication that there may be an issue. However, the more signs a person exhibits, the more likely they are problem gamble. It is also important to note that while some may gamble at a specific venue, more frequently, people are gambling online at home. These signs apply to both.

### Gambling behaviours

- Frequently thinks and talks about gambling
- Gambles almost every day or often
- Increases the time they spend gambling or has a pattern of gambling for longer than intended
- Expresses a strong desire or craving to gamble
- Complains of boredom or is restless when not gambling
- Gambles rather than doing things they previously enjoyed
- Continues to gamble despite promising to stop
- Repeated unsuccessful attempts to control, cut back or stop gambling
- Gambles to escape problems
- Celebrates their wins by gambling more
- Demonstrates a pattern of returning to gambling to recover losses
- Is evasive about gambling losses
- Lies to cover up or fund gambling activities
- Commits illegal acts to fund gambling, e.g. embezzlement, fraud
- Experiences legal problems related to gambling
- Becomes defensive or angry when asked about their gambling
- Blames others for their gambling or its consequences
- Does not look after their health because of their gambling activities, e.g. does not take medication or eat a healthy diet

**After gambling, expresses:**

- Remorse
- Guilt
- Depressed feelings
- Hopelessness
- Fear of others finding out
- Worry over where they will get money to cover living expenses
- Anger towards themselves, or family and friends

**Signs evident while gambling**

- Gambles for three or more hours without a break of at least 15 minutes
- Focuses so intensely on gambling that they don't react to what is going on around them
- Stays on to gamble after friends leave the venue
- Stops gambling only when the venue is closing and finds it difficult to stop gambling at closing time
- Regularly starts gambling as soon as the venue is open
- Withdraws cash two or more times while at the gambling venue or leaves the venue to find money so that they can continue gambling
- Asks for a loan or credit from the venue or borrows money from others while at the venue
- Gambles until all the money they have with them is used up
- Shows significant changes in mood during a gambling session
- Displays anger, e.g. swears to themselves, grunts, kicks, or strikes gaming machine
- Blames the venue or gaming machine for losing

**Financial signs**

- Does not want to spend money on anything but gambling
- Increases their usage of or acquires additional credit cards
- Has mounting debts or is consistently late in paying bills or misses payments entirely
- Frequently contacted by debt collectors or owes money to a loan shark
- Takes on extra jobs or works for overtime pay, but has no money to show for it
- Makes promises to pay back family and friends but never does so
- Believes that gambling will solve financial difficulties or bring material wealth
- Valuables disappear (and may reappear) without explanation
- Hides financial statements or is secretive about money
- Unexplained missing amounts of money from the house or bank accounts
- Over time, increases the amount of money spent on gambling

**Signs evident at home and in social settings**

- Neglects the basic care of their children, or breaks promises to their children about buying them things or spending time with them due to gambling activities
- Social life or relationships have been negatively affected because of gambling
- Becomes isolated from others because of gambling
- Disappears from social events to gamble
- Unable to be emotionally present because they are preoccupied with gambling

# Crises associated with problem gambling

The main mental health crisis that may be associated with problem gambling is:

The person is experiencing suicide thoughts or behaviour. Suicide thoughts and behaviour are more common in people with problem gambling. The

person may see suicide as a way to avoid difficult confrontations with loved ones or creditors, or as a viable solution to financial problems due to life insurance pay-outs.

[For crisis first aid for suicide thoughts and behaviour see pages 140-149.](#)

# First aid best practice for signs of problem gambling

[Remember to revisit the ALGEE action plan in full on pages 42-57.](#)

## Do not assume that problem gambling is a phase

If you suspect that someone you know problem gambles, it is important to help them because there can be significant negative consequences. These can include relationship breakdowns, financial problems, criminal sanctions, loss of employment, family violence, and poor mental health, including suicide thoughts and/or behaviour.

## Consider the person's readiness to talk

Understand that the person will have their own perception of their gambling behaviours. Ask the person about their gambling and if they believe it is an issue. Consider the person's ability to talk about their gambling behaviour at this time by asking about areas of their life that it may be affecting, for example, their mood, work performance, finances, and relationships. Be aware that the person may deny, or

might not recognise, that their gambling behaviour is problematic and that trying to force the person to admit they are experiencing poor mental health may cause conflict.

## Use 'I' statements

Discuss your concerns with them in an open and honest way by reflecting back the changes in their behaviour which concern you, such as "I feel worried when I don't know when you are coming home or how much money you will have spent" rather than 'you' statements ("You upset me when you are out all night and spend our money") which may come across as accusing, or 'we' statements ("We are worried about you being out all night and spending money") which may sound as if they are being picked on.

## Rate the act, not the person

Identify and discuss the person's behaviour rather than criticise their character or lecture them, for example, "Your gambling behaviour seems to be making you

anxious" rather than "You are an addict". Avoid expressing moral judgements or frustration at the person or blaming them for their problem gambling.

### Stick to the point

Focus on how the person's gambling is affecting them and don't get drawn into arguments or disagreements.

### Help the person to explore reasons for problem gambling

It may also be useful to get them to reflect on their reasons for gambling, whether they perceive their gambling as problematic, and whether they actively want to make a change to their behaviours. Try to have an open-ended conversation that allows the person to explore the issues at hand.

### Try to find out whether the person wants help to change their gambling behaviour

Ask the person if they would like information about problem gambling. If they agree, provide them with relevant information. Tell them about the local resources available to help people who problem gamble. These services may include professional gambling services and culturally diverse services. Because financial problems can be a big part of gambling, you should be aware of resources that can help the person to manage their financial difficulties. The person may also need to access other types of help for their problem gambling, e.g. medical help, legal services, mental health services, financial counselling, or social assistance.

### Remember the importance of early intervention

It is important to treat problem gambling as soon as possible. The consequences of untreated problem gambling include: the development of poor mental health or mental health conditions such as depression and anxiety, and increased risk of suicide thoughts and/or behaviour; interpersonal problems such as the loss of important relationships and arguing with family and friends; poor work or study performance or loss of employment; financial difficulties and financial hardship for other family members; and legal problems relating to gambling behaviour or financial problems.

### Have realistic expectations for the person

Although it may be obvious to those around them, the person may not see their gambling as an issue, or they may not see it as an issue until they experience a crisis that they cannot solve themselves. The person may also go through cycles of awareness and denial. If the person does not want to change their gambling, you should sensitively ask if gambling and its consequences are getting in the way of the life they want to live. Let the person know that you will be available to help them when they are ready to change their gambling.

### Give hope for recovery

You can encourage the person to seek professional help for their problem gambling by pointing out that:

- Problem gambling can be successfully treated. Many people who problem

## First aid best practice for signs of problem gambling cont.

gamble have benefited from professional help, support groups and self-help strategies

- Seeking help is a sensible thing to do, rather than a sign of weakness
- The sooner the problem is addressed, the easier it is to overcome
- Any professional help will be confidential

### Help the person to make a list of strategies they can use

Whether or not the person wants to change completely, you can help them to reduce the negative impact of gambling. If the person decides to use these or any other self-help strategies, offer to support them. These could include to:

- Learn about the strategies that gambling providers use to keep people gambling and maximise profits, e.g. gambling machines are designed to keep people playing and spending money
- Find out about and use self-exclusion mechanisms in gambling venues
- Avoid going to gambling venues, even if they are not planning on gambling, e.g. going to a pub for a meal where gambling is available
- Find out about and use software programmes that block or restrict access to gambling websites
- Avoid spending time with people who are associated with gambling activities
- Identify and use other ways to handle gambling urges
- Be transparent about finances with their partner or family, e.g. mutual access to bank and credit card records

- Allow someone else to manage their finances, e.g. partner or family member
- Set up accounts and loans so that a second signature is required
- Arrange to have access to a limited amount of money each day that covers daily expenses, e.g. lunch, parking, coffee
- Only gamble with money that they can afford to lose
- Don't use borrowed money, personal investments, or savings to gamble
- Leave bank cards or credit cards at home
- Limit the amount of time and money spent on gambling
- Balance time spent on gambling with other activities and take regular breaks while gambling
- Restrict gambling activities to ones that they have greater control over
- Don't gamble when alcohol or other drugs have impaired judgement
- Don't gamble when angry or upset, or to escape from problems or feelings

### Note any positive changes the person has made

Congratulate them on these. As the person attempts to change their gambling, it is important to focus on the future rather than on past mistakes.

## Supporting a person who does not want to change

If a person does not want to reduce or stop their gambling, you cannot make them change. It is important that you maintain a good relationship with the person, as you may be able to have a beneficial effect on their behaviour.

### Speak with a professional

You can speak with a health professional who specialises in problem gambling to determine how best to approach the person about your concerns, or you could talk to others who have dealt with such difficulties about effective ways to help the person. Be prepared to talk to the person about seeking professional help again in the future. However, pressuring the person, denying them basic rights such as shelter or food, or using negative approaches is counterproductive.

'Interventions', where a group of people confront the person about their problem gambling, are only recommended as a last resort. If you decide to organise an intervention, do it in a way that helps the person feel supported and cared for, rather than punished or shamed.

### Self-care

It is also vital to look for support for yourself, especially if you are directly impacted by the negative consequences of someone's gambling.

### Boundaries

Set boundaries around what behaviour you are willing and not willing to

accept from the person. Avoid making excuses for the person, covering up gambling behaviour, gambling with the person, taking the person to gambling activities, and giving the person money. Be compassionate and patient while waiting for the person to accept that they need help – it is ultimately the person's decision. Changing gambling behaviour is a process that can take time.

## Supporting a person through relapse

Be aware that the person may have tried and failed repeatedly to control, cut back, or stop gambling. While changing their gambling, the person may make promises that they are unable to keep and may experience a relapse. Although this is an issue, a relapse does not indicate that the person cannot recover. If the person experiences a relapse you should continue to offer support. Let the person know that this is not a sign of long-term failure of recovery. Explain that problem gambling takes time to develop, and it may take some time, and more than one attempt, to change. Keep in mind that supporting a person who problem gambles can be difficult and you should know how to access support for yourself, for instance from a gambling helpline or support group, counsellor, or trusted friend or family member.

# Professionals and treatments that can help with problem gambling

For specific helpful resources and contacts sign in to your MHFAider Support App or go to the [Hub of Hope website](#).

A variety of health professionals can provide help to a person who problem gambles. They are:

- GPs
- Psychologists
- Gambling counsellors
- Psychiatrists
- Financial counsellors. Financial counsellors don't provide counselling for problem gambling, but can provide information, support, and advocacy to assist people in financial difficulty

## Cognitive behaviour therapy

Cognitive behaviour therapy is a psychological treatment that changes the way the person sees situations and their thinking patterns (the cognitive component), and also reduces negative feelings and behaviours (the behaviour component). This therapy attempts to overcome gambling-specific thinking errors that may maintain gambling behaviours, such as a belief in particular superstitions that increase 'luck' and selectively recalling wins over losses. It can be carried out by a therapist working with an individual or a group.

## Motivational interviewing

Motivational interviewing is a counselling method that helps people to explore and resolve uncertainties about whether they want to change. It allows the person to consider the gains they receive from gambling, while helping to improve their awareness of the negative aspects and consequences of their gambling behaviour, and helps them to identify reasons to choose not to gamble.

# Other supports for problem gambling

If the person is considering stopping or reducing their gambling, they may be concerned about this creating a gap in their life that gambling used to fill, e.g. reduction in social activities. You should suggest activities that the person can do that do not involve gambling (e.g. going to watch a film or to a restaurant) and that they reconnect with family and friends.

Other helps include support groups and community and voluntary sector organisations.

Revisit the ALGEE action plan in full on pages 42-57 for further information on other supports general to all mental health conditions.



# Mental health crises



# What are panic attacks?

A panic attack is a sudden onset of intense apprehension, fear, or terror. These attacks can begin suddenly and develop rapidly. This intense fear appears inappropriate for the circumstances in which it is occurring.

The person experiencing a panic attack often has a sense of impending doom or death. Many of the symptoms are physical ones such as dizziness, shaking, feeling sweaty, nausea, hyperventilating and rapid heartbeat. Many of the physical symptoms can appear like those of a heart attack or asthma attack.

Once a person has one of these attacks, they often fear another attack and may avoid places where attacks have occurred.

People may also avoid exercise or other activities that can produce physical sensations like those of a panic attack. It is common for people to have a panic attack at some time in their lives. Few go on to have repeated attacks, and fewer still go on to develop panic disorder or agoraphobia. Although anyone can have a panic attack, people with anxiety disorders are more prone to them.

Some panic attacks don't appear to be triggered by anything specific. These are called 'uncued' panic attacks. Other panic attacks may be associated with a feared situation. For example, a person with social phobia may experience a panic attack in a social setting.

There are some medical conditions that have symptoms like panic attacks (for example, arrhythmias of the heart or an asthma attack). It is therefore important for the person to have a medical assessment to determine whether they are experiencing a panic disorder or a physical illness.



# Crisis first aid for panic attacks

Remember that you may need to be flexible in the order of the MHFA action plan when giving MHFA to suit the needs of the situation.

Crisis first aid for panic attacks will largely focus on Action 1 (Approach the person, assess and assist with any crisis) of the MHFA action plan (ALGEE).

## Assess

A panic attack will develop abruptly and usually has its peak within ten minutes. A person having a panic attack will experience several of the following symptoms at the same time, including:

- Palpitations or increased awareness of heartbeat
- Sweating
- Trembling or shaking
- Feeling of choking, shortness of breath or smothering
- Chest pain or discomfort
- Nausea or abdominal distress
- Feeling of unreality or detachment from oneself or from one's surroundings
- Feeling dizzy, unsteady, light-headed, or faint
- Fear of losing control
- Fear of dying
- Numbness, tingling or pins and needles
- Chills or hot flushes

## Assist

### Ask

If someone is experiencing symptoms and you suspect that they are having a panic attack, you should first ask them if they know what is happening and whether they have ever had a panic attack before. If the person says that they have had panic attacks before, and believe that they are having one now, ask them if they need any kind of help, and give it to them. Rather than making assumptions about what the person needs, ask them directly what they think might help.

### Create a safe space

If you are helping someone you don't know, introduce yourself. Invite the person to sit down somewhere that is comfortable. Be mindful of their personal space when doing so as they may not want to be touched if very anxious – ask before touching them.

### Panic attack or medical issue

The symptoms of a panic attack sometimes resemble the symptoms of a heart attack or other medical issue. It is not possible to be totally sure that a person is having a panic attack. Only a medical professional can tell if it is something more serious. If the person has not had a panic attack before, and doesn't think they are having one now, you should follow physical first aid guidelines. The first step is to help the person into a supported sitting position (for example, against a wall). If the person loses consciousness, apply physical first aid principles. Check for breathing and pulse and call an ambulance.

## Crisis first aid for panic attacks cont.

Ask the person, or check to see, if they are wearing a medical alert bracelet or necklace. If they are, follow the instructions on the alert or seek medical assistance.

### Communicate effectively

Reassure the person that they are experiencing a panic attack, remind them that the frightening thoughts and sensations will eventually pass. Reassure them that they are safe. Avoid belittling the person's experience. Acknowledge that the terror feels very real.

Speak to the person in a reassuring but firm manner and be patient. Speak clearly and slowly and use short sentences. It is important that you remain calm and that you don't start to panic yourself.

### The focus technique

If the person is using coping strategies that are working for them, encourage them to continue using them. After they've engaged in the coping strategies, tell them that they're doing a good job.

Alternatively, encourage the person to try to focus on something or several things that are non-threatening and visible, such as the time passing on their watch or items in a supermarket. You can use several senses to do this such as sight, touch, and hearing. It is important that you do not pressure the person to do something they do not want to do.

### The slow breathing technique

Encourage them to try to gradually slow their breathing down by taking slow, even breaths. You can help them get their breathing under control by demonstrating and talking them through how to do this. It is important that you do not pressure the person to do something they do not want to do.

### After the panic attack has ended

After the panic attack has subsided, and once the person is feeling calmer, ask them if they know where they can get information about panic attacks. If they don't know, offer some suggestions. Suggest to the person that if the panic attacks recur, and are causing them distress, they should speak to an appropriate health professional. Follow the MHFA action plan for anxiety and reassure the person that there are effective treatments available for panic attacks and panic disorder.

# What is self-harm?

Self-harm is a behaviour and not a mental health condition. People self-harm to cope with emotional distress or to communicate that they are distressed. While it can be treated as an individual issue, self-harm can be seen as a reflection of distress, inner turmoil, and despair.

From the perspective of an MHFAider, self-harm can also be seen as a common crisis associated with mental health conditions, such as depression, anxiety, or psychotic conditions. Recovery therefore usually involves addressing both the behaviour and the underlying poor mental health which bring about the distress.

It is also important to acknowledge that for some people, especially those who have been abused as children, acts of self-harm occur seemingly out of the person's control or even awareness, during 'trance like', or 'dissociative' states. Therefore, the term 'self-harm' is used rather than 'deliberate self-harm'. It is also worth noting that 'non-suicidal self-injury' is also a term used for self-harm in many countries.

Self-harm is a very wide-ranging term, used to refer to many different actions. These may include:

- Cutting or scratching skin
- Branding (burning, friction burn)
- Picking at skin or re-opening wounds
- Hair-pulling (trichotillomania)
- Hitting, bone breaking, punching walls, head-banging, provoking fights
- Taking personal risks e.g. walking into traffic, misusing drugs and alcohol
- Multiple piercing or tattooing may also

be a type of self-injury, especially if pain or stress relief is a factor

- Drinking harmful chemicals, swallowing objects other than food and drink

## Self-harm is not the same thing as attempted suicide

Self-harm can often be a means of staying alive, rather than trying to take one's life. People may also self-harm for different reasons and in different ways than they may consider for suicide, or they may not consider suicide at all.

- Nevertheless, people who self-harm are at increased risk of suicide. This may reflect the distress which underpins both self-harm and suicide attempts.
- There is also a risk that, although the person does not intend to take their own life, they may seriously harm themselves by accident.

The only way to know for sure whether a person is experiencing suicide thoughts or behaviour is to ask them directly.

## Why do people self-harm?

There is no one reason for why people self-harm, and everybody's experience will be different. However, there is a common theme of underlying distress where self-harm is being used as a coping strategy.

People may self-harm to:

**Cope with, or validate, the emotional pain of psychological trauma**

Hurting themselves becomes an external reflection of the way they feel inside.

## Self-harm cont.

### Survive overwhelming emotions and control feelings of helplessness and powerlessness

Intense feelings can be numbed or released by acts of self-harm and may give the person a sense of regaining control and make them 'feel better'.

### Fulfil a (perceived) need to punish themselves

This includes for both actual and perceived transgressions and is an attempt to feel something when they feel disconnected from their emotions and themselves.

### Communicate feelings of distress and despair

A person may try to communicate feelings of distress where they may lack the ability to do so in another way, or where their environment may not be receptive to their attempts to express this in another way.

### Inflict pain on the body to lead to the release of endorphins

Endorphins are the body's natural painkillers. They can provide a temporary lift to mood, but this can then become the starting point for a vicious cycle of using self-harm to manage overwhelming emotions. Once the temporary lift in mood passes, people may feel intense guilt or shame, which then further feeds the cycle. This is relevant because self-harm is strongly associated with low self-esteem, shame, and self-blame.

There is a persistent myth around self-harm being about 'attention seeking'. This is not often the case. Most people who self-harm take extreme care to hide it from other people, and many may not come to the attention of medical services at all.

### Other expressions of distress

#### - risk-taking behaviour

Sometimes people may not self-harm in one of the ways described above, but still take risks within their daily lives that seem out of the ordinary. Such behaviours may reflect underlying distress and poor mental health.

The reasons why people take unnecessary risks vary between people and over time. Taking certain types of risk gives people a 'buzz' from adrenaline. They may also be trying to damage themselves, their relationships, or their financial position because they believe that they don't deserve their health, friends, family, or wealth. Or risky behaviour may provide a release for feelings of emotional distress. In the case of physically dangerous activities, there may be an underlying wish to die by suicide.

#### Examples of risk-taking behaviours

- Driving more quickly than usual
- Getting into frequent fights
- Engaging in high-risk sports
- Exposing themselves to unnecessary dangers in the workplace (e.g. undertaking risky procedures, not using safety equipment)
- Not taking precautions against sexually transmitted diseases
- Neglecting personal or household security
- Taking drugs or drinking to excess, or sharing needles when injecting drugs
- Not taking prescribed medication
- Taking unnecessary financial risks
- Endangering personal relationships (e.g. flirting openly, indulging in affairs, provoking, or insulting friends)

# Crisis first aid for self-harm

Remember that you may need to be flexible in the order of the MHFA action plan when giving MHFA to suit the needs of the situation.

Crisis first aid for self-harm will largely focus on Action 1 (Approach the person, assess and assist with any crisis) of the MHFA action plan (ALGEE).

## Assess

Because many people hide their self-harm, it may not be readily apparent at first. However, there are some warning signs that you can look out for. These include:

- Unexplained or frequent injuries
- Blood on clothing or sheets
- Keeping fully covered, especially during warmer weather
- Avoiding situations where revealing clothing is expected (e.g. sports like swimming)

It is also important to watch out for signs that the person is experiencing other crises. The main crises associated with self-harm are:

The person experiences suicide thoughts and/or behaviour. People who self-harm are known to have an increased risk of suicide.

[For crisis first aid for suicide thoughts and behaviour see pages 140-149.](#)

The person has experienced a traumatic event. People who self-harm often have a history of trauma and/or abuse.

[For crisis first aid for traumatic events see pages 150-154.](#)

## Assist

### Physical injury

Depending on the nature of the injury, medical attention may be needed to avoid risk of infection or serious physical health complications. If a person has self-harmed by self-poisoning, always ensure they get prompt medical attention, as it is possible for people to accidentally cause themselves long-term damage. If in doubt, follow physical first aid guidelines and seek medical advice.

If the MHFAider has no concerns that the person is in crisis, they can ask the person about how they are feeling and how long they have been feeling that way, and move on to Action 2.

# First aid best practice for self-harm

**Remember to revisit the ALGEE action plan in full on pages 42-57.**

## Show you have some understanding of self-harm

Directly express your concerns about the person but be sensitive in your approach. It can be helpful to make it clear to the person that you have some understanding of self-harm, e.g. by saying, "Sometimes, when people are in a lot of emotional pain, they may hurt themselves to cope. Is that how your injury happened?"

## Avoid dismissing the person's behaviour as manipulative or attention seeking

Tell the person that you care and want to help. Remember that blaming or shaming the person is more likely to reinforce the cycles of shame and distressing emotions which often underlie self-harm.

## Avoid focusing on stopping the self-harm

Try to explore what other coping strategies they already use and help them to use the ones which don't involve self-harm. You can also explore additional coping strategies and discuss with the person whether they might find them helpful.

Help them think of ways in which they could relieve their immediate distress or delay acting on the urge to self-harm, such as having a hot bath, listening to loud music, or using ice cubes or elastic bands. There is no right or wrong answer here, as different things may work for different people, but encourage the person to keep an open mind and try new strategies they may not have attempted before as it may take some trial and error to work out what

is effective for them. Encourage the person to share their feelings with people they trust when they have the urge to self-harm.

## Encourage the person to write down these strategies

By reflecting on past instances of self-harm the person can also begin to identify patterns and what triggers any urges, including specific thoughts and feelings.

## Don't set goals, pacts or ultimatums relating to their self-harm

For example, "If you don't self-harm for the next three days, I will do that thing you want me to do."). This may become an additional source of pressure. Understand that some people may not want to stop self-harming for many reasons, and that you cannot force another person to change and are not responsible for their behaviour. However, you can offer relevant information about self-harm and practical help with developing alternative coping strategies if the person is interested in this.

## Look out for other symptoms

Where it becomes apparent that the person is also experiencing a mental health condition like depression, anxiety or psychosis, or has experienced trauma, provide information on this also. NICE guidelines for self-harm recommend that all people who present in a medical setting due to self-harm should be offered a comprehensive assessment by a mental health professional. This allows for diagnosis of underlying poor mental health and appropriate treatments to be offered. It also explores any relevant issues in the person's immediate

environment, their life difficulties and social circumstances, as well as what risk and protective factors may play a part in crisis situations for them.

### Communicate boundaries

Be honest and upfront about the fact that you may not be able to keep their self-harm a secret and may need to seek help if you are concerned about the seriousness of their injuries but explain that you will try to speak to them about this first where possible. It is important to bear in mind that not everybody who self-harms wants to change their behaviour. You can offer support but are ultimately not responsible for somebody

else's behaviour and cannot control what they do. It may be helpful to acknowledge that they have their reasons for wanting to continue, while also highlighting that your priority is to keep them safe.



# Professionals and treatments that can help with self-harm

The treatments listed below are taken from the NICE clinical guidelines on self-harm. They are intended as a guide to what kind of treatment can be expected under best practice guidelines in England. They are not intended for the MHFAider to suggest as treatments in a specific case but may be helpful to understand what treatments may be offered when the person seeks professional help, or to help advocate for treatment.

Treatment for self-harm is likely to be tailored based on the person's underlying mental health needs. NICE guidelines for self-harm also recommend:

- 3–12 sessions of psychological therapy tailored to the person's needs (usually involving cognitive behavioural, psychodynamic, or problem-solving elements)
- Medication is not routinely offered to address self-harm alone (although it may be prescribed for underlying depression, anxiety etc.).
- If stopping self-harm is unrealistic in the short term, the focus is on harm reduction by reinforcing existing coping strategies and developing new coping strategies as an alternative to self-harm. This may also involve discussing less destructive or less harmful methods of self-harm as an alternative to current methods. Harm reduction does not apply to self-poisoning – there is no safe way to self-poison.

# Other supports for self-harm

## Community and voluntary sector organisations

Several voluntary sector organisations can offer additional support to people experiencing anxiety disorders. This could be in the form of organising support groups, providing access to low-cost therapy, or complementary therapies, support to find volunteering or employment opportunities or befriending services if the person has become socially isolated.

## Helplines

Opportunities to talk are always available over the telephone. Some organisations also offer email helplines, online chat, or text support.

Other helps include support groups, family and friends, and self-help strategies.

Revisit the ALGEE action plan in full on pages 42-57 for further information on other supports general to all mental health conditions.

# What are suicide thoughts and behaviour?

**Suicide is the most serious crisis associated with poor mental health, so we need to consider it as the highest priority of the MHFA action plan every time we provide MHFA to someone.**

## Language around suicide

We use the terms 'suicide thoughts' and 'suicide behaviour' in replacement of outdated language that has been found to increase stigma.

## Suicide thoughts

We define suicide thoughts as the thoughts someone may have when they no longer feel they can continue to live.

## Suicide behaviour

Making plans and acting on suicide thoughts is called suicide behaviour, whether the outcome is life or death. Acting on thoughts is also referred to as a 'suicide attempt'.

## Dies/died by suicide

When a person dies this way, we say they 'died by suicide' or 'took their own life', over other phrases such as 'committed suicide' or 'completed suicide'.

## Suicide attempt

We never say that a suicide attempt was 'successful' or 'unsuccessful'. Instead, we say that the outcome of suicide behaviour is 'life' or 'death'.

It is common for people to use the term 'commit suicide'. This dates back to when suicide and suicide attempts were against the law and a person who died by suicide 'committed' a crime. As suicide is no longer a crime, this language is inappropriate.

## Prevalence of suicide thoughts and behaviour

Suicide thoughts are relatively common, suicide behaviour is much rarer, and suicide behaviour with the result of death is rarer still. However, suicide is a major public health issue, both in England and globally. The human and economic costs of death by suicide are substantial, and suicide behaviour with the outcome of life can often result in permanent disability. Each year, people of all ages and from all walks of life die by suicide. You are far more likely to meet someone who is having thoughts of suicide than to come across someone having a heart attack. Therefore, understanding how to assist in this crisis is important.

What figures and numbers cannot reflect are the invisible impacts of suicide. People often refer to the ripple effect caused by suicides, where friends, families and communities who are left behind struggle to understand and make sense of their loss. The impact of one person's death spreads across the networks of everyone they were connected to.

## Reasons behind suicide thoughts and behaviour

The reasons a person may experience suicide thoughts or behaviour are unique to them. Some reasons may be:

- They are facing a situation or situations that, from their Frame of Reference, seem so difficult that ending their life is the only way to solve them

- The emotional/mental pain they are experiencing is so acute that suicide is seen as a way of bringing that to an end
- They want to end the situation they are in
- The pain they are in outweighs their coping strategies or resources

### Suicide is preventable

People who experience suicide thoughts or behaviour don't want to die; they simply don't want to live with the pain they experience any longer. We can learn to spot the warning signs so we can help identify and support someone experiencing suicide thoughts. Openly talking about suicide thoughts can save a person's life.

## Myths and facts about suicide

### 1. Myth: Once a person is seriously considering suicide, there is nothing you can do.

Fact: Most suicide crises are time-limited and based on unclear thinking. People attempting suicide want to escape their problems. Instead, they need to confront their problems directly to find other solutions – solutions which can be found with the help of concerned individuals who support them through the crisis period, until they are able to think more clearly.

### 2. Myth: If you ask a person about their suicide thoughts and/or plan, you will encourage the person to die by suicide.

Fact: The opposite is true. Asking someone directly about their suicide thoughts will often lower their anxiety level and act as a deterrent. The crisis and resulting emotional distress will already have triggered the thought in a vulnerable person. Your openness and concern in asking about suicide will allow the person experiencing pain to talk about their thoughts which may reduce their anxiety. This may also allow the person with suicide thoughts to feel less lonely or isolated, and perhaps be a bit relieved.

### 3. Myth: A person who attempts suicide will always have suicide thoughts.

Fact: Most people who are at risk have suicide thoughts for only a brief period in their lives. With proper assistance and support they will probably never have suicide thoughts again.

### 4. Myth: People who talk about suicide don't take their own life.

Fact: Most people who take their own lives give definite warning signs of their suicide behaviour. People who make suicide attempts and threats must be taken seriously.

### 5. Myth: All suicides happen without warning.

Fact: Studies reveal that the person with suicide thoughts gives many warning clues and warnings regarding their suicide behaviour. Alertness to these warning signs may prevent suicide behaviour.

## Suicide thoughts and behaviour cont.

6. Myth: People with suicide thoughts always later carry out suicide behaviour.

Fact: Most people with suicide thoughts are undecided, often right up until the last minute, about living or dying, and they may 'gamble with death', leaving it up to others to save them. Few people attempt to take their own life without first letting others know how they are feeling. This cry for help is often given in code. If recognised, these distress signals can be used to save lives.

7. Myth: Improvement following suicide thoughts or behaviour means that the risk of suicide is over.

Fact: Most suicides occur within three months after the onset period of 'improvement', when people have the energy to turn suicide thoughts into action. Relatives and physicians should be especially vigilant during this period of time.

8. Myth: Suicide occurs more frequently among certain classes of people.

Fact: Showing no class prejudice, suicide is represented proportionately in all strata of society.

9. Myth: All people with suicide thoughts are loners.

Fact: People with suicide thoughts will often isolate themselves from others, however, this does not mean that all people who enjoy spending time alone have suicide thoughts.

10. Myth: If a person really wants to die by suicide, no one has the right to stop them.

Fact: Just because suicide implies voluntary action that does not mean that the person really wants to die. Often, a person with suicide thoughts simply wants to escape from pain and even though they may not realise this, death is not the only answer. The chances are the person does not have to die for the pain to stop.

# Crisis first aid for suicide thoughts

Remember that you may need to be flexible in the order of the MHFA action plan when giving MHFA to suit the needs of the situation. Suicide thoughts or behaviour are the main crises associated with depression, but also many other mental health conditions.

Crisis first aid for suicide thoughts and behaviour will largely focus on Action 1 (Approach the person, assess and assist with any crisis) of the MHFA action plan (ALGEE).

Depression is a major risk factor for suicide, although not everyone who attempts suicide experiences depression, and all other mental health conditions carry an increased risk of suicide. It is important that we remember the need to assess for risk of suicide regardless of the signs or symptoms that first made us approach the person as an MHFAider. Also remember that sometimes warning signs that the person may be experiencing suicide thoughts and/or behaviour may only become apparent as we go through later stages of the MHFA action plan, for example whilst listening and communicating non-judgementally.

## Assess

**Be aware of your own attitudes and beliefs about suicide and the impact they may have on your ability to provide help.**

**If you feel unable to ask the person about suicide thoughts, find someone else who can.**

Act promptly if you think someone is considering suicide. Even if you only have a mild suspicion that the person is experiencing suicide thoughts, you should still approach them.

People may show one or many of these signs, and some may show signs not on this list, e.g. use of suicide chat rooms/pro-suicide internet sites. Important warning signs that a person may be experiencing suicide thoughts are (29):

- Expressing thoughts and/or behaviour to hurt or die by suicide
- Looking for ways to die by suicide: seeking access to pills, weapons, or other means
- Talking or writing about death, dying or suicide
- Hopelessness or thoughts of having no reason to live or purpose to life
- Feelings of rage, anger, or a desire to seek revenge
- Increasing alcohol or other drug use or engaging in reckless activities
- Withdrawing from friends, family, or society
- Anxiety, agitation, feeling trapped, inability to sleep or sleeping all the time
- Dramatic changes in mood (including sudden improvement in mood following an episode of depression)
- Saying goodbye, or putting affairs in order
- Sudden unexplained 'recovery'

## Asking about thoughts of suicide

Anyone could have thoughts of suicide. If you think someone might be having thoughts of suicide, you should ask that

## Crisis first aid for suicide thoughts cont.

person directly. Contrary to common belief, this type of questioning does not encourage people to pursue suicide behaviour. It signals that you care, that you realise they may be considering suicide, and that you are ready to talk with them about it. The opportunity to discuss the emotions surrounding thoughts of suicide is often a great relief to people.

Unless someone tells you, the only way to know if they are thinking about suicide is to ask directly. Once you have noticed signs of suicide thoughts and/behaviours, you could ask:

- “Are you having thoughts of suicide?” or
- “Are you thinking about ending your life?”

Tell the person your concerns about them, describing behaviours that have caused you to be concerned about suicide. However, understand that the person may not want to talk with you. In this situation, you should offer to help them find someone else to talk to. Remember to thank the person for sharing their feelings with you and acknowledge the courage this takes.

### Assess how high the risk of suicide is

Take all thoughts of suicide seriously and act. Don’t dismiss the person’s thoughts as ‘attention seeking’ or a ‘cry for help’.

Determine whether someone has plans to take their life. It can be very difficult for someone to acknowledge that they are thinking of suicide, and they may deny that they are thinking of suicide when first asked. Be aware that those at the highest

risk for acting on thoughts of suicide are those who have a specific suicide plan, the means to carry out the plan, and a time set for doing it. However, the lack of a plan for suicide is not sufficient to ensure safety.

Suicide behaviour may also become apparent to you through their behaviour – have they made arrangements for when they are dead, e.g. recent making of a will, cancelling deliveries, sending pets away. However, the MHFAider must always ask directly.

The following questions can help you assess the immediate risk for suicide:

1. “Do you have a suicide plan? How specific is this plan – do you know how, when and where you would attempt suicide?”
2. “Do you have what you need to carry out your plan (pills, gun etc.)?”
3. “Have you been using drugs or alcohol?” Intoxication can increase the risk of a person acting on suicide thoughts on impulse.

**If suicide behaviour seems imminent dial 999 or take the person to accident and emergency. Try to address any immediate dangers, and don’t leave the person alone.**

If the person says they are hearing voices, ask what the voices are telling them. This is important in case the voices are relevant to their current suicide thoughts.

### Assessing someone from another culture

If the person is from a different cultural or religious background to your own, keep

in mind that they might have beliefs and attitudes about suicide that differ from your own. Be aware that it is more important to genuinely want to help than to be of the same age, gender, or cultural background as the person.

While it is more important to ask the question directly than to be concerned about the exact wording, you should not ask about suicide in leading or judgemental ways, e.g. "You're not thinking of doing anything stupid, are you?"

### Try to find out about their prior behaviour

People are at greater risk of dying by suicide if they have attempted to do so in the past, if they have self-harmed, or if they have displayed risk-taking behaviour. However, prior behaviour alone is not a sign of current risk. Try to find out:

- Have they attempted suicide before?
- Has anyone close to them ever experienced suicide thoughts or behaviour?
- Do they self-harm in any way?
- Have they been taking greater risks recently (e.g. drinking or taking drugs in excess, driving more quickly, taking risks with sexual partners)?

- Try to find out about their supports  
If people feel totally alone and without any resources, they are at greater risk of suicide behaviour. In contrast, a sense of connectedness to others has been shown to be a protective factor, reducing risk. Ask the person:

- Whether they have told anyone (else) about how they are feeling
- Whether there have been changes in their employment, social life, or family
- Whether they have received treatment for poor mental health or are taking any medication
- What resources do they have to support themselves? Who do they think they could turn to for help?

## Assist

### Communication

Be patient and calm while the person is talking about their thoughts. Express empathy for the person.

Listen to the person without expressing judgement, accepting what they are saying without agreeing or disagreeing with their behaviour or point of view. Remember that their thoughts and behaviours are not due to weakness or laziness – the person is unwell and is trying to cope.

Ask open-ended questions, i.e., questions that cannot be simply answered with 'yes' or 'no', to find out more about the way they are feeling. Show that you are listening by summarising what the person is saying. Clarify important points with the person to make sure they are fully understood.

Don't avoid using the word 'suicide'. It is important to discuss the issue directly without expressing negative judgement. Use appropriate language

## Crisis first aid for suicide thoughts cont.

when referring to suicide by using the terms 'suicide' or 'die by suicide'. Avoid using terms to describe suicide that promote stigmatising attitudes.

### Creating a support plan

It may be appropriate to help the person create a support plan. A support plan is an agreement between the person and the MHFAider that sums up actions to keep the person safe.

It may be helpful for the person to keep the support plan in an easily accessible place, where they are likely to see it if in crisis (e.g. by the door, as a note on their phone etc.). It may also be helpful for the MHFAider to keep a copy of the support plan to enable them to better support the person, especially if they are likely to do so over an extended period. Support plans can also be used to support the mental health of a person as part of their wider recovery journey. See information on WRAP® (Wellness Recovery Action Plan®) in Appendix A.

The support plan should follow the following format:

#### My support plan

1. How do I want my friends or relatives to support me?
2. What can I do to help myself feel better? What has helped me before?
3. Who can I speak to?
4. Who should I contact in an emergency?

The support plan should:

- Focus on what the person should do

rather than what they shouldn't

- Be clear, outlining what will be done, who will be doing it, and when it will be carried out
- Be for a length of time that will be easy for the person to cope with, so that they can feel able to fulfil the agreement and have a sense of achievement
- Include contact numbers that the person agrees to call if they are having thoughts of suicide e.g. the person's doctor or mental health professional, a suicide helpline, or friends and family members
- Include strategies that the person can use to help themselves feel better in a moment of crisis. Examples can include exercise, expressing themselves by writing down how they feel, writing down a list of positive people in their life, phoning a friend, finding an activity to distract themselves etc. There is no right or wrong solution here, the key is that the strategies help the person feel better in the moment and allow them to hold off on acting on thoughts of suicide
- Identify who or what (people or strategies) have helped the person before. Find out whether these supports are still available. Ask the person how they would like to be supported (e.g. come to an appointment with them, check in with them and ask if they are OK). Ask if there is anything you can do to help, but don't try to take on their responsibilities

### Communicate confidentiality boundaries

You must never agree to keep a plan for suicide or risk of suicide a secret.

If the person refuses to give permission to disclose information about their suicide thoughts, then you may need to breach their confidentiality to ensure their safety. Give an explanation why (for example, “I care about you too much to keep a secret like this. You need help and I am here to help you get it”).

Treat the person with respect and involve them in decisions about who else knows about their suicide thoughts and/or behaviour. Keep in mind that it is much better to have the person angry at you for sharing their suicide thoughts without their permission to obtain help, than to lose the person to suicide.

### Signposting to professional help following a crisis

Don't assume that the person will get better without help or that they will seek help on their own. People who are experiencing suicide thoughts often don't ask for help for many reasons, including stigma, shame, and a belief that their situation is hopeless and that nothing can help.

Encourage the person to get appropriate professional help as soon as possible.

Find out information about the resources and services available for a person who is considering suicide. Give this information to the person and discuss options for seeking help with them. If they don't want to talk

to someone face to face, encourage them to contact a suicide helpline.

If the person is reluctant to seek help, keep encouraging them to see a mental health professional and contact a suicide prevention helpline for guidance on how to help them.

# Crisis first aid for suicide behaviour

## Assist

### How to help someone at immediate risk of suicide behaviour

1. Ensure your own personal safety. Don't get involved physically if the person is distressed and threatening, and observe from a safe position until help arrives.
2. Stay with the person if you think that the risk of suicide is high or arrange for someone to be with them while they get through the immediate crisis.
3. Seek immediate help. Phone their GP and ask for an emergency home visit, call emergency 999, take the person to a hospital accident and emergency department, or take the person to a GP or call Samaritans on 116 123 (seven days a week, 24 hours a day).
4. If the person is consuming alcohol or drugs, try to discourage them from taking any more.
5. Try to ensure that the person does not have ready access to any means to take their life.
6. Encourage the person to talk and use active listening. The fact that the person is still alive, and that they are talking to you about their thoughts, means they are not quite sure about suicide. Point this out to them as a positive thing. Remind the person that thoughts of suicide are common and don't need to be acted on. Reassure the person that there are solutions to their thoughts and feelings, or ways of coping other than suicide behaviour. Remember that, although you can offer support, you

are not responsible for the actions or behaviours of someone else and cannot control what they might decide to do.

**If the person has already harmed themselves, administer first aid and call emergency services, asking for an ambulance.**

If someone has taken an overdose (of medications or illegal drugs) they may become unconscious. Other methods, e.g. carbon monoxide poisoning or hanging, may also result in the person becoming unconscious.

Any unconscious person needs immediate medical attention. Conscious people need monitoring as they may deteriorate into unconsciousness.

**If the person is unconscious:**

1. Phone 999 for an ambulance. State that the person is unconscious from a drug overdose.
2. Try to find out what substances have been used. This information will assist the ambulance officers to give the most appropriate help.
3. Keep the person warm, especially if alcohol is involved.

**If the person is conscious:**

1. Phone or take the person to the nearest accident and emergency department for advice if appropriate.
2. Don't give the person any food or fluids unless advised by a health professional.
3. Reassure the person that help has been sought and that you will stay with them.
4. Try to find out what substances have been used. This information will assist the medical staff to give the most appropriate help. The harmful effects of some medicines taken in overdose (e.g. paracetamol) take several hours to occur (sometimes over 24 hours) so even if a person who has taken an overdose says they feel well you should still ensure that they seek medical help urgently.
5. Keep the person warm, especially if alcohol is involved.

Some people self-harm for reasons other than suicide. This may be to relieve unbearable emotional distress, to stop feeling numb, or other reasons. Self-harm may be upsetting to witness.

**For further information on crisis first aid for self-harm see pages 133-139.**

## Taking care of yourself

Supporting a person with suicide thoughts or behaviour can be shocking, stressful, and emotionally exhausting, and it is therefore important that you look after yourself. Don't underestimate

the effect on your own wellbeing. Find ways of reducing the immediate stress and find someone to talk to about your experience. You may also want to write your own support list. It is important to keep in mind that despite our best efforts we may not be able to prevent suicide.

# What is a traumatic event?

A traumatic event is where a person is exposed to actual or threatened death, serious injury or sexual violation, or experiences a sense of horror (e.g. experiencing, witnessing, or becoming aware of something horrific).

Examples of traumas include:

- Individual traumas – accident, assault (physical, emotional, or sexual)
- Ongoing traumas – abuse, neglect, bullying, torture
- Mass traumas – natural disasters, acts of terror

The person does not need to be directly involved in the event for it to be traumatic. The person might witness it happening to someone else or learn about a traumatic event that has occurred to someone close to them, or be exposed to repeated or extreme details of the event. This is often referred to as 'vicarious trauma'.

## MHFA might not always happen immediately after the traumatic event

For instance, there are some types of trauma that are not single discrete incidents. Common examples of recurring trauma include sexual, physical, or emotional abuse, or torture. In these cases, the MHFA action plan will be used when the MHFAider first becomes aware of what has been happening.

Sometimes memories of traumatic events may return suddenly or unexpectedly, and this can be weeks, months or years after the original event(s) took place. Again, MHFA will be used when the MHFAider first becomes aware of this.

It is important to acknowledge that people can differ tremendously in how they react to traumatic events. Types of trauma may affect some individuals more than others. A history of trauma may also make some people more susceptible to later traumatic events, while other people may become more resilient as a result.

## Acute stress disorder and post-traumatic stress disorder (PTSD)

In acute stress disorder the symptoms will begin to fade, and the person will begin to resume their normal activities, within a month of experience, witnessing, or hearing about the event. In PTSD, the symptoms will continue for longer. Only some people experiencing acute stress disorder will develop PTSD.

People are more likely to develop PTSD if their response to the traumatic event involves intense fear, helplessness, or horror.

## Symptoms of acute stress disorder and PTSD

- Re-experiencing the trauma (recurrent dreams, flashbacks, and intrusive memories)
- Anxiety in situations associated with the event, often leading to avoidance
- Emotional numbing
- Reduced interest in the outside world
- Persistent increased arousal (irritability, outbursts of rage, insomnia)

# Crisis first aid for traumatic events

Remember that you may need to be flexible in the order of the MHFA action plan when giving MHFA to suit the needs of the situation.

Crisis first aid for traumatic events will largely focus on Action 1 (Approach the person, assess and assist with any crisis) of the MHFA action plan (ALGEE).

## Assess

A person who has experienced a traumatic event may react strongly right away, showing you that they need immediate assistance. Others may have a delayed reaction. This means that if you are helping someone you know and see on a regular basis, you may be continually assessing them for signs of distress over the weeks following the event.

## Assist after a traumatic event

### Safety

If relevant, you need to ensure your own safety before offering help to anyone. Check for potential dangers, such as fire, weapons, debris, or other potential risks, like people who may become aggressive, before deciding to approach a person to offer your help.

### Approach

If you are helping someone who you don't know, introduce yourself and explain what your role is. Find out the person's name and use it when talking to them. Remain calm and do what you can to create a physically safe environment, by taking the person to a safer location or removing any immediate dangers.

### Physical injury

If the person is injured, it is important that their injuries are attended to. If you can, offer the person physical first aid for their injuries, and seek medical assistance. If the person seems physically unhurt, you need to watch for signs that their physical or mental state is declining and be prepared to seek emergency medical assistance for them. Be aware that a person may suddenly become disoriented, or an apparently uninjured person may have internal injuries that reveal themselves more slowly.

### Immediate needs

Try to determine what the person's immediate needs are for food, water, shelter, or clothing. However, if there are professional helpers nearby (police, ambulance, or others) who are better able to meet those needs, don't take over their role.

### Forensic evidence

If the person has been a victim of assault, you need to consider the possibility that forensic evidence may need to be collected (e.g. cheek swabs, evidence on clothing or skin). Work with the person in preserving such evidence, where possible. For example, they may want to change their clothes and shower, which may destroy forensic evidence. It may be helpful to put clothing in a bag for police to take as evidence and suggest to the person that they wait to shower until after a forensic exam. Although collecting evidence is important, you should not force the person to do anything that they don't want to do.

## Crisis first aid for traumatic events cont.

### The focus technique

Encourage the person to try to focus on something or several things that are non-threatening and visible, such as the time passing on their watch or items in a supermarket. You can use several senses to do this such as sight, touch, and hearing. It is important that you do not pressure the person to do something they do not want to do.

### Don't make any promises you may not be able to keep

For example, don't tell someone that you will get them home soon, if this may not be the case.

### Assist after a mass traumatic event

In addition to the general principles outlined above, there are several things you need to do.

#### Emergency help

Find out what emergency help is available. If there are professional helpers at the scene, you should follow their directions.

#### Comfort and dignity

Be aware of and responsive to the comfort and dignity of the person you are helping, for example by offering them something to cover themselves with (like a blanket) and asking bystanders or media to go away.

#### Give information

Tell the person about any available sources of information for survivors (for example, information sessions, fact sheets and

phone numbers for information lines) as they become available. Give the person truthful information and admit that you lack information when this is the case. Don't try to give the person any information they don't want to hear, as this can be traumatic in itself.

### How to talk to someone who has experienced a traumatic event

#### Speak clearly and avoid clinical and technical language

Communicate with the person as an equal. If the person seems unable to understand what is being said, you may need to repeat yourself several times.

#### Be aware that providing support doesn't have to be complicated

It can involve small things like spending time with the person, having a cup of tea or coffee, chatting about day-to-day life, or giving them a hug.

#### Expect varied reactions

Behaviour such as withdrawal, irritability and bad temper may be a response to the trauma, so try not to take such behaviour personally. Try to be friendly, even if it seems like the person is being difficult. The person may not be as distressed about what has happened as you might expect them to be, and this is fine. Don't tell the person how they should be feeling. Tell them that everyone deals with trauma at their own pace. Be aware that the person may experience survivors' guilt: the feeling that it is unfair that others died, or were injured, while they were not.

**Be aware that cultural differences may influence the way some people respond**  
For example, in some cultures, expressing vulnerability or grief around strangers is not considered appropriate.

#### **Try not to encourage the person to talk about their trauma**

Encouraging a person to share their experience may cause them to revisit or relive their trauma. If the person is ready and does want to talk, don't interrupt to share your own feelings, experiences, or opinions.

#### **Avoid saying anything that might trivialise the person's feelings**

Such as 'don't cry' or 'calm down', or trivialise their experience, such as 'you should just be glad you're alive'.

### **How to assist over the following weeks or months**

If you are helping someone you know after a traumatic event, you may support them to cope with their reactions over the next few weeks or months.

#### **Encourage the person to communicate their needs**

Encourage the person to tell others when they need or want something, rather than assume others will know what they want. Be aware that the person may suddenly or unexpectedly remember details of the event and may or may not wish to discuss these details.

#### **Identify sources of support**

Also encourage them to identify sources of support, including loved ones and friends, but remember that it is important to respect the person's need to be alone at times.

#### **Self-care strategies**

Encourage the person to take care of themselves, to get plenty of rest if they feel tired, to do things that feel good to them (e.g. take baths, read, exercise, watch television), and to think about any coping strategies they have successfully used in the past and use them again. Encourage them to spend time somewhere they feel safe and comfortable. Discourage the person from using negative coping strategies such as working too hard, using alcohol or other drugs, or engaging in self-destructive behaviour.

## Crisis first aid for traumatic events cont.

### When should the person seek professional help?

Not everyone will need professional help to recover from a traumatic event. Research has shown that to prevent post-traumatic stress disorder, providing psychological help to everyone within three months following a traumatic event is not helpful and may even have an adverse effect on some people.

However, if the person wants to seek help, you should support them to do so. Be aware of the types of professional help that are available locally, and if the person does not like the first professional they speak to, you should tell them that it is OK to try a different one. If the person hasn't suggested that they want professional help, the following guidelines can help you to determine whether help is needed.

If at any time the person shows signs of suicide thoughts or behaviour, you should seek professional help. [Follow crisis first aid for suicide thoughts and behaviour covered on pages 147-152.](#)

If at any time the person misuses alcohol or other drugs to deal with the trauma, you should encourage them to seek professional help.

After four weeks, it is expected that most people find resolution from the immediate consequences of the traumatic experience. You should encourage the person to seek professional help if, four weeks or more after the trauma:

- They still feel very upset or fearful

- They are unable to escape intense, ongoing distressing feelings
- Their important relationships are suffering as a result of the trauma (e.g. if they withdraw from their family or friends)
- They feel jumpy or have nightmares because of or about the trauma
- They can't stop thinking about the trauma
- They are unable to enjoy life at all because of the trauma
- Their post-trauma symptoms are interfering with their usual activities

# Crisis first aid for severe psychotic states

Remember that you may need to be flexible in the order of the MHFA action plan when giving MHFA to suit the needs of the situation.

Crisis first aid for severe psychotic states will largely focus on Action 1 (Approach the person, assess and assist with any crisis) of the MHFA action plan (ALGEE).

## Assess

If someone lives with a psychotic disorder, they may at times experience severe psychotic states when they become very unwell. Some people experience a severe psychotic state only rarely, perhaps every few years; others experience them more frequently, and some may experience these states several times a year.

A severe psychotic state can occur without an apparent cause or may be triggered by something specific. Possible triggers include extra stresses or life events (even positive life events such as a new job or a holiday). Forgetting to take medication, or choosing not to, can also trigger a psychotic episode and this is one of the reasons that it is recommended for people to continue using their medication as prescribed.

A severe psychotic state may develop gradually over a few days, or it may seem to come on very suddenly. For this reason, early signs of a psychotic state should be addressed as quickly as possible.

A person in a severe psychotic state can have:

- Overwhelming delusions and hallucinations
- Very disorganised thinking
- Bizarre and disruptive behaviours

The person will appear very distressed, or their behaviours will be disturbing to others. When a person is in this state, they can come to harm unintentionally because of their delusions or hallucinations, e.g. the person believes they have special powers to protect them from danger such as driving through red lights, or the person may run through traffic to try to escape from their terrifying hallucinations.

**Violent acts are rare, however, if a person experiencing psychosis does become aggressive follow the crisis first aid for aggressive behaviour on pages 159.**

## Assist

**Try to create a calm, non-threatening atmosphere**

Talk slowly, quietly, firmly, and simply. Keep the environment free from distractions (for example, turn off the television or radio). Don't get too close to the person. Being close may be dangerous and it may also make the person feel hemmed in and threatened. This can make it more likely that they will lash out. Therefore, keep at a reasonable distance and avoid direct continuous eye contact. Don't touch the person and respect their personal space.

## Crisis first aid for severe psychotic states cont.

### Communication

It is important to communicate with the person in a clear and concise manner and use short, simple sentences. Speak quietly in a non-threatening tone of voice and at a moderate pace. If the person asks you questions, answer them calmly.

### Avoid reasoning with someone experiencing acute psychosis

Try not to express irritation or anger. Don't argue, threaten, shout or criticise. It will probably make the person feel angrier or out of control. Remember that they may be acting in this way because of delusions or hallucinations that are very real and very frightening to them. It is possible that the person might act upon a delusion or hallucination. Remember that your primary goal is to de-escalate the situation and therefore you should not do anything to further agitate the person. Try to maintain safety and protect the person, yourself, and others around you from harm.

### Express empathy for the person's emotional distress

However, it is important that you don't pretend that the delusions or hallucinations are real for you. Focus on their emotional experience instead by saying things like "I can see that you are very upset by what you are experiencing".

### Comply with reasonable requests

This will give the person a sense that they are somewhat in control, which may be helpful if they feel overwhelmed, threatened and out of control of their

experience. However, don't make promises that you can't keep.

### Advance directive or mental health crisis card

If the person has an advance directive or mental health crisis card, you should follow those instructions. These are pre-written plans which allow a person with a diagnosed mental health condition to communicate their preferences about future treatment and care in advance, for periods when they are very unwell.

### Contacting family or friends

Try to find out if the person has anyone they trust (e.g. close friends, family) and try to get them to help. You should also assess whether it is safe for the person to be alone and, if not, ensure that someone stays with them until help can be found.

### Contacting emergency services

Sometimes it is not possible to de-escalate the situation and if this is the case, you should call 999 for help from emergency services. Describe the person's concerning behaviour and symptoms clearly when doing so.

When any unfamiliar helpers arrive, explain to the person you are supporting who they are and how they are going to help. If your concerns about the person are dismissed by the services you contact, you should persevere in trying to seek support for them.

# Crisis first aid for severe effects from alcohol use

Remember that you may need to be flexible in the order of the MHFA action plan when giving MHFA to suit the needs of the situation.

Crisis first aid for severe effects from alcohol use will largely focus on Action 1 (Approach the person, assess and assist with any crisis) of the MHFA action plan (ALGEE).

## Assess

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

### Alcohol intoxication

Alcohol intoxication substantially impairs the person's thinking and behaviour. When intoxicated the person may engage in a wide range of risky activities, such as having unprotected sex, getting into arguments or fights, or driving a car. The person may also be at higher risk of suicide behaviour.

### Alcohol poisoning

Alcohol poisoning is a dangerous level of intoxication that can lead to death. The amount of alcohol that causes alcohol poisoning is different for every person.

### Alcohol withdrawal

Alcohol withdrawal refers to the symptoms a person experiences

when they stop drinking or drink substantially less than usual. It is not simply a hangover. Unmedicated alcohol withdrawal may lead to seizures or other serious medical complications.

## Assist

If in doubt about the health and safety of the person, follow physical first aid recommendations and call emergency services on 999.

# Crisis first aid for severe effects from drug use

Remember that you may need to be flexible in the order of the MHFA action plan when giving MHFA to suit the needs of the situation.

Crisis first aid for severe effects from drug use will largely focus on Action 1 (Approach the person, assess and assist with any crisis) of the MHFA action plan (ALGEE).

## Assess

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

### Drug intoxication

Drug intoxication can lead to impairment or distress, e.g. the person may have poor judgement, engage in risky behaviours, or become aggressive. The effects vary depending on the type and amount of drug and vary from person to person. It can be difficult to make a distinction between the effects of different drugs. Illegal drugs can have unpredictable effects, as they are not manufactured in a controlled way.

### Overdose

Overdose occurs when the intoxication level leads to risk of death.

Sudden death may occur with inhalant use, due to heart failure. This is more likely if the person becomes agitated or engages in physical exertion, e.g. the person gets frightened and runs away.

### Overheating or dehydration

Overheating or dehydration can occur in a hot environment while on some drugs (e.g. ecstasy) without adequate water intake. This causes the person's body temperature to rise to dangerous levels.

### Assist

If in doubt about the health and safety of the person, follow physical first aid recommendations and call emergency services on 999.

# Crisis first aid for aggressive behaviour

Remember that you may need to be flexible in the order of the MHFA action plan when giving MHFA to suit the needs of the situation.

Crisis first aid for aggressive behaviour will largely focus on Action 1 (Approach the person, assess and assist with any crisis) of the MHFA action plan (ALGEE).

## Facts about aggressive behaviour

Most people with poor mental health are not dangerous to others. Only a small proportion of violence in society is due to poor mental health. Depression and anxiety have little or no association with violent behaviours towards others. When a person experiencing a psychotic episode is aggressive, it is generally out of fear and the person believing they are acting out of self-defence. The misuse of alcohol or other drugs has a stronger association with violence.

## Assess

Aggression has different components to it – verbal (e.g. insults or threats), behavioural (e.g. hitting objects or walls, throwing things, invading someone's personal space) and emotional (e.g. raised voice, person looks angry). What is perceived as aggression may vary between people and across cultures. It is best to prevent aggression wherever possible by de-escalating the situation as soon as you become aware of it. If

you are concerned that the person is becoming aggressive, you need to take steps to protect yourself and others.

## Assist

### Ensure your own personal safety

Don't get involved physically to stop the behaviour (for example a fight) or to restrain the person, unless in self-defence. Always ensure you have access to an exit and consider taking a break from the conversation to allow the person a chance to calm down.

### Take any threats or warnings seriously

If you are frightened, seek outside help immediately. You should never put yourself at risk and always ensure you have access to an exit. If the person's aggression escalates out of control at any time, you should remove yourself from the situation and call for help from emergency services by ringing 999.

### Communicating with emergency services

If you believe the aggression is related to poor mental health, try to make this clear in your call and describe the person's symptoms and behaviours rather than trying to make a diagnosis of your own.

If relevant, explain that you need their help to obtain medical treatment and to control the person's aggressive behaviour.

Always tell the police if the person does or does not have a weapon.

## Crisis first aid for aggressive behaviour cont.

### Police attendance

Emergency services may choose to dispatch an ambulance if relevant but be aware that an ambulance team may not attend without police also attending (and that ambulance crews and police teams may arrive at different times).

If the police become involved, and you suspect that the person's aggression is related to poor mental health, or intoxication with alcohol and/or drugs, you should tell them that this is the case. If you believe the person is intoxicated, tell the police/emergency services what substances they have used if you know this.

### How to de-escalate the situation

#### Try to create a calm, non-threatening atmosphere

Talk slowly, quietly, firmly, and simply. Keep the environment free from distractions (for example, turn off the television or radio). Consider inviting the person to sit down if they are standing.

#### Comply with reasonable requests

This will give the person a sense that they are somewhat in control, which may be helpful if they feel overwhelmed, threatened and out of control of their experience. However, don't make promises that you can't keep.

#### Communication

Speak to the person slowly and confidently, with a gentle tone of voice. Try not to respond in a hostile, disciplinary

or challenging manner. Try not to argue with the person. Avoid raising your voice or talking too fast. Be aware that the person may overreact to negative words; therefore, use positive words instead (e.g. "stay calm" instead of "don't fight"). Stay calm and avoid nervous behaviour (e.g. fidgeting, making abrupt movements).

#### Personal space

Being close may be dangerous and it may also make the person feel hemmed in and threatened. This can make it more likely that they will lash out. Therefore, keep at a reasonable distance and avoid direct continuous eye contact. Try not to touch the person or restrict the person's movement (e.g. if they want to pace up and down the room).

#### Be aware of exacerbating aggression

Remain aware that the person's symptoms or fear causing their aggression may be exacerbated if you take certain steps (e.g. involve the police). Avoid threatening them, as this may increase fear or prompt aggressive behaviour. Consider taking a break from the conversation to allow the person a chance to calm down.

# Appendix A – WRAP®

## What is Wellness Recovery Action Plan® (WRAP®)?

WRAP® is a tool that can be used by anyone who wants to create positive change in the way they feel and their experience of life.

Use of WRAP® can help us in our recovery journeys of personal discovery. It can help us to live well, and to deal with the distress, vulnerabilities, and challenges that we all face in our lives.

## Why is WRAP® special?

Most people write their WRAPS® on paper. Some people add pictures and photographs. Others create them online. WRAP® has the following advantages:

- It is based on common sense and experience
- It is easy to use for individuals, groups, and self-help settings
- It stresses how we all go through similar processes – but in individual ways
- It moves us from being managed to self-management
- You can mix and match
- It can be shared with family, friends, carers, or it can be just for me

## What is in a WRAP®?

People usually build their WRAPS® around the following structure:

**My wellness toolbox:** Things I can do to help myself stay well or feel better when I am not feeling well.

**Daily maintenance plan:** The things I need to do every day to maintain my wellness.

A useful start to ‘get the ball rolling’ is to describe myself when I am feeling well.

**Triggers:** These are the external events or circumstances that, if they happen, can make me feel distressed.

**Early warning signs:** These are subtle signs of change that indicate that I may need to take some further action.

**When things are breaking down:** In spite of my best efforts, my distress may progress to become very uncomfortable, serious and even dangerous. But I can still take action on my own behalf. This is my plan that will help me reduce my distress when it has progressed to this point. It is quite directive, with fewer choices and some very clear instructions for myself.

**Crisis planning:** In spite of my best planning and assertive action, I may find myself in a situation where others take over some responsibility for my care. In my crisis plan, written when I am well, I instruct others about how to take care of me when I am not well. This will help friends, family members and carers.

**Post-crisis plan:** This part differs from the rest of my WRAP®. It constantly changes as I heal.

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## Appendix B – Personality disorders

Personality disorders are complex and there are currently no internationally recognised interventions. However, due to the high numbers of diagnoses in England, you may find it helpful to understand what personality disorders are.

The information below does not include all types of personality disorders, nor does it provide first aid best practice for personality disorders.

For more information visit [Personality Disorder UK](#).

### What is personality?

Personality is vital in defining who we are as individuals. It involves a unique blend of traits which include attitudes, thoughts, behaviours, and moods, as well as how we express these traits in our contacts with other people and the world around us. Some characteristics of an individual's personality are inherited, and some are shaped by life events and experiences. Our personality influences our thoughts, beliefs and behaviours; they are what make us unique. Our personality is intrinsic to who we are – it shapes how we think, perceive, and respond to events and other people. Personality develops over time from the early years of life onwards and can change as we adapt to new situations and new relationships with other people.

### What is a personality disorder?

Most people have an early life that enables them to develop a stable understanding of self and others, to cope with the stresses of life, to sustain satisfying relationships

with family and friends, and to behave in ways compatible with generally accepted norms.

Personality disorders are conditions where a person differs significantly from commonly accepted norms, in terms of how they think, perceive, feel, or relate to others. Changes in how a person feels and their distorted beliefs about other people can lead to unusual behaviour.

Another way to think of personality disorder is as an extreme exaggeration of a spectrum of personality traits common to all human beings, with the extremity, persistence, and inflexibility of these traits. For example, most people may distrust others at some point in their lives, and there are certainly circumstances where a lack of trust is warranted and may be wise. However, where suspiciousness becomes so marked and pervasive that the person mistrusts everyone they encounter, regardless of evidence to the contrary, they will struggle to form meaningful and mutually supportive relationships with other people.

Personality disorders are common and complex: people with personality disorder can present with a range of other mental health, physical health and social issues, e.g. depression, anxiety, eating disorders, post-traumatic stress disorder, bipolar disorder, substance misuse, housing problems, and long-standing interpersonal problems. Some also commit offences and are periodically imprisoned. A small number pose a risk to other people. However, in common with other mental health conditions, someone with

personality disorder is far more likely to harm themselves than another person.

Personality disorders typically emerge in adolescence and continue into adulthood. Experiences of distress or fear during childhood, such as neglect or abuse, are common.

Many people recover from personality disorders over time. Psychological treatment is often helpful and cognitive behavioural therapy (CBT), dialectical behaviour therapy (DBT), interpersonal therapy (IPT), psychodynamic psychotherapy and schema therapy have all been shown to be effective in the treatment of personality disorder. However, there is not one approach that suits everyone and treatment should be tailored to the individual. Often support is all that is needed (e.g. at times of stress, including bereavement) whereas other people may need specialist help for longer periods.

Some suggest 'recovery' is a term that does not recognise the experience of personality disorders because someone cannot 'recover' a healthy sense of self in relation to others and the world when it never initially developed; in which case the notion of 'emergence' from a personality disorder may be more appropriate.

It should also be noted that there are some who criticise the concept of personality disorder on the basis that what may be considered 'behavioural norms' is highly dependent on culture and social contexts. Different cultures

may have different understandings of what personality traits are considered acceptable or desirable, and what falls outside the social norms in one part of the world may not do so in another.

## Appendix B – Personality disorders cont.

### General signs and symptoms of personality disorders

#### Common features of personality disorders

- Being overwhelmed by negative feelings such as distress, anxiety, worthlessness, or anger
- Avoiding other people and feeling empty and emotionally disconnected
- Difficulty managing negative feelings without self-harming (for example by cutting or burning oneself, misusing drugs and alcohol or taking overdoses) or, in rare cases, threatening other people
- Behaviour which may be considered 'odd'
- Difficulty maintaining stable and close relationships, especially with partners, children, and professional carers
- Sometimes, periods of losing contact with reality

Symptoms often get worse with stress. To be considered for a personality disorder diagnosis, symptoms must be pervasive and affect a range of areas across the person's life, e.g. work, social life, intimate and family relationships.

There are ten recognised forms of personality disorder in the UK. The most common is borderline personality disorder (BPD), now often called emotionally unstable personality disorder (EUPD), and many people believe it is massively under-diagnosed. Only one of the ten recognised forms of personality disorder – severe antisocial personality disorder (ASPD) – is

linked to increased levels of violence. NICE first issued clinical guidance on prevention, recognition, and management for BPD and ASPD in 2009.

#### Borderline (or emotionally unstable) personality disorder

A person with borderline personality disorder is emotionally unstable, often has impulses to self-harm, and usually has very intense and unstable relationships with others.

#### Symptoms

- Intense but unstable emotions which may shift rapidly based on external circumstances
- Continual efforts to avoid (real or perceived) abandonment
- Intense, but unstable relationships with others, marked by seeing the person as 'all good' or 'all bad'
- Difficulties maintaining a consistent sense of self and self-identity (e.g. values and beliefs may change drastically depending on the social circles the person is in)
- Impulsivity and a tendency to engage in impulsive, often risk-taking behaviour (e.g. risky sexual encounters, substance misuse, dangerous driving, binge eating)
- Struggling with repeated suicide thoughts or behaviours and/or self-harm
- Feeling empty or like they don't exist
- Stress-related paranoid ideas or periods of dissociative symptoms (feeling disconnected from self or the world)
- Difficulty with intense feelings of anger,

which may seem inappropriate for the situation

Borderline personality disorder is not usually diagnosed before the age of 18 but symptoms can be recognised in younger people. 'Borderline' was originally used by psychiatrists to suggest that the condition was on the border of neurosis and psychosis. Many experts think that this is no longer the most appropriate term to use, and many prefer to use the term emotionally unstable personality disorder.

A person with BPD/EUPD will display a range of symptoms that will have a significant impact on their life. Not all people with BPD/EUPD will display all the above symptoms, and people displaying very different collections of symptoms can receive a diagnosis of BPD/EUPD. Some diagnostic systems may also differentiate between different types of BPD/EUPD.

People with BPD/EUPD come from many different backgrounds but most will have experienced trauma, neglect, or abandonment as children. Although some people may have borderline personality disorder for a long time, many do recover from the condition and effective treatments are available.

## Antisocial (or dissocial) personality disorder

A person with an antisocial personality disorder sees other people as vulnerable and may intimidate or bully others without remorse. They lack concern

about the consequences of their actions.

### Symptoms

- Lack of concern, regret, or remorse about other people's distress
- Irresponsibility and disregard for normal social behaviour
- Difficulty in sustaining long-term relationships
- Little ability to tolerate frustration and to control their anger
- Lack of guilt, or not learning from their mistakes
- Blaming others for problems in their lives

Note: The term 'antisocial' as used here should not be confused with everyday usage of the term, which often refers to people who prefer to stick to themselves and not socialise much. 'Antisocial' in this context refers to 'repeated breaking of social norms and rules' (= against society). This is why the term 'dissocial' is also sometimes used.

## **Appendix B – Personality disorders cont.**

### **Crises associated with personality disorders**

The main crises that may be associated with personality disorder are:

The person is experiencing suicide thoughts and/or behaviour.

**For crisis first aid for suicide thoughts and behaviour see pages 140-149.**

The person has self-harmed. Personality disorders are associated with increased risk of self-harm: many people with personality disorder self-harm and some engage in impulsive or dangerous lifestyles and therefore have a higher risk of accidental or unnatural death.

**For crisis first aid for self-harm see pages 133-139.**

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