

12. mental health & supporting those in crisis



This module explores the mindset shift necessary to support someone through a crisis.

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1. welcome

welcome to
WHERE WE ARE AT
mental health
& supporting
those in crisis



Welcome to **Where We Are At**, a training course for Provincial Peer Support Workers. We're glad you're here! This course is made up of 16 modules, all designed to support your training in peer support work.

The purpose of module **12. mental health & supporting those in crisis** is to explore the mindset shift necessary to support someone through a crisis.

Any of the modules in this training can stand alone, but you'll notice they are very interconnected. All of the concepts and core values have many layers, and they will look a little different when you see them through the lens of different topics. For example, self-determination will look a little different when we look at it through the lens of learned helplessness, grief and loss, or goal planning, but the main message will always be the same.

You will get to experience all of those layers and intersections when you move through each module of the training. Feel free to navigate back and forth between modules as you move along since learning never has to be linear. There will be references to other modules intersected throughout.

Thank you for joining us on this educational journey!

2. gratitude



Before we begin this new
learning journey, we ask that you reflect
on the following question:

What am I grateful for today?

We know that taking time to reflect can give us the clarity and strength to do what can sometimes be difficult emotional work.

Download the **reflection journal** below and use it to record your thoughts. Please don't rush. Take all the time you need. This journal will be used for several questions throughout the module.



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60 KB

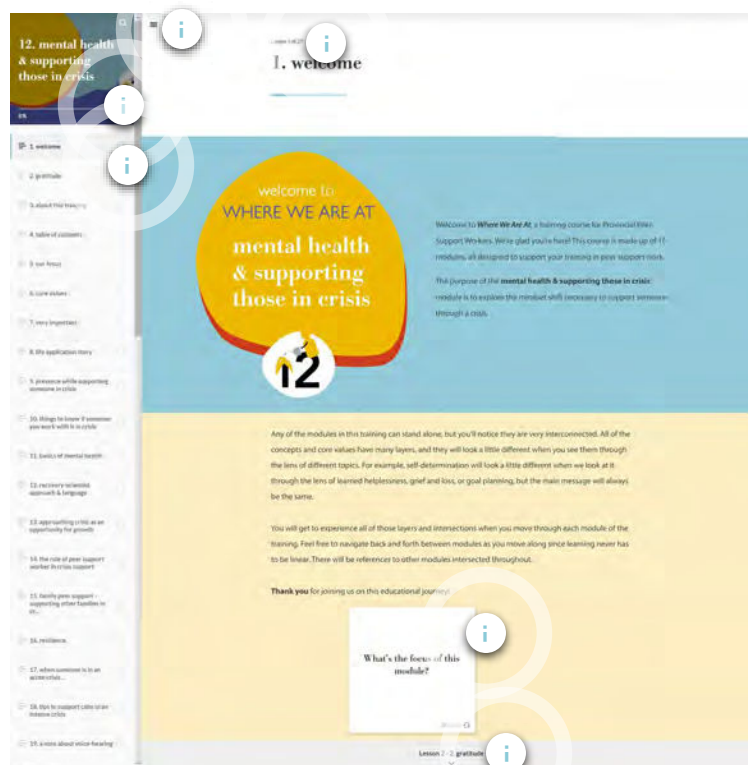


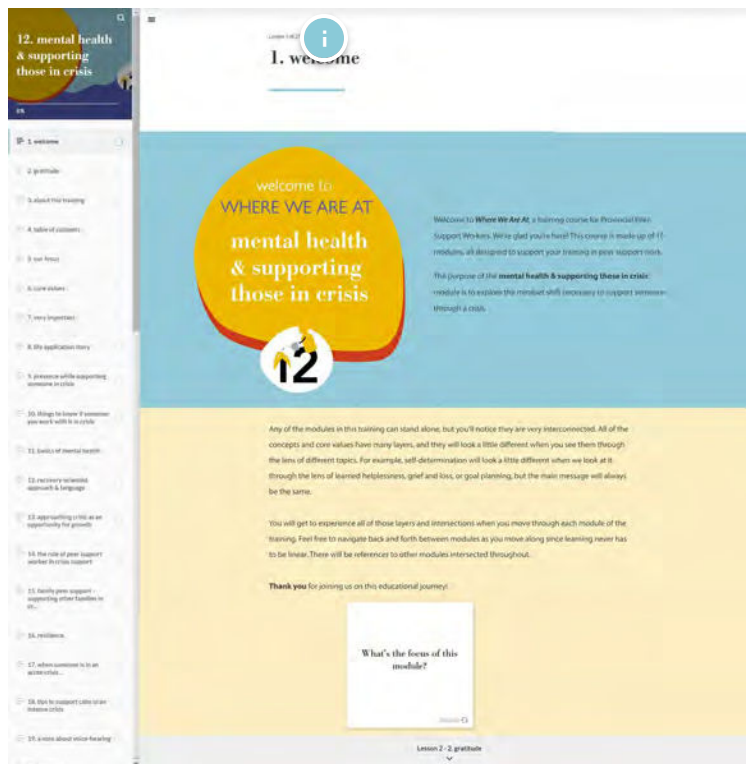
3. about this training

The course content has been guided by consultations that were held with peer support workers. It's with the utmost respect for their experience and wisdom that we share these learnings.

course navigation

You may have questions on how to use this course. We designed an interactive diagram to give you the chance to explore the different functions on the screen. Click the buttons below to learn more.





Lesson titles

Lesson 1 of 27

Above each lesson title, the lesson count is shown.

CONTINUE

reflection journal

As you discovered in the previous section, included in this training is a reflection journal. The journal is designed for you to use throughout the training. It's full of reflective questions related to the topics being explored that will get you engaging in the world around you with curiosity.

Feel free to use the journal in a way that works for you:

- 1 You can print it off and write in it or just use it to support reflective processing
- 2 You can use the fillable PDF version and complete it online
- 3 You can write in your own journal, using the questions as guides

We encourage you to find a safe, comfortable spot to engage with these questions.

CONTINUE

where we are at

provincial peer support worker training curriculum

The *Where We Are At* educational curriculum includes 16 modules. You'll find a brief description of each below.

1. the foundations

An overview of all the practices and knowledge that will be transferable to all of the modules in this training.

2. peer support & wholeness

Provides an introduction to peer support work and explores differences between the peer support role and other roles within the mental health and substance use systems.

3. categories & containers: unpacking our biases

Helps you understand how and why we judge.

4. self-determination

Looks at self-determination, the theory of self-determination and how peer support workers can support creating an ecology where people trust their own inner wisdom.

5. cultural humility

Explores how to approach your peer support work through the lens of cultural humility and helps you understand how culture (and the destruction of culture) shapes our lives.

6. understanding boundaries & what it means to co-create them

Examines boundary creation within the context of peer support, grounded in the core value of mutuality.

7. connection & communication —

Focuses on cultivating compassion and empathy, listening deeply to understand, and asking powerful questions to increase reflection and connection.

8. healing-centred connection: principles in trauma-informed care —

Brings together all the learnings from previous modules to support the creation of environments and relationships that are safe and trauma-informed.

9. social determinants of health —

Explores the social determinants of health and how social, economic and other factors lead to better or worse health outcomes.

10. supporting someone who is grieving —

Examines how to understand grief and loss in order to support someone who is grieving, without trying to “fix” or “save” them.

11. substance use & peer support —

Explores the principles and methodologies around the harm reduction approach to substance use disorders and some of the history around the criminalization of substance use.

12. mental health & supporting those in crisis —

Explores the mindset shift necessary to support someone through a crisis.

13. goal planning —

Focuses on how peer support relationships can support the creation and meeting of goals.

14. building personal resilience —

Explores ways to build resiliency, create wellness plans and practice self-compassion.

15. family peer support —

Explores family peer support work and how, by working from a place of shared lived experience, family peer support workers can create positive change for families by building long-term relationships based on trust with those supporting loved ones.

16. working with youth & young adults

Explores the unique application of peer support principles to working with youth and young adults.



4. table of contents

Below you'll find a short overview of what topics you'll find in this module.

As you move through these topics, please remember you can always return to this page to revisit the main ideas being explored in each lesson.



very important —

Explains that this module does not replace or supersede your own agency's training for dealing with mental health emergencies.

life application story —

A story that demonstrates principles around supporting those in crisis.

presence while supporting someone in crisis

Describes how important it is to support someone in crisis, and at the same time, look out for your own needs.

things to know if someone you work with is in crisis

Shares tips for what you should know – and what you can do – when someone is in crisis.

basics of mental health

Gives an overview of the public and private mental health system and the services typically available in B.C. so you will understand the language you may hear in your workplace from other practitioners.

recovery-oriented approach & language

Looks at person-first language as it relates to supporting someone with a mental health crisis.

approaching crisis as an opportunity for growth

Explains how peer support and the Recovery Movement encourage a shift in perception about crisis to be accepting of the ups and downs of life.

the role of peer support worker in crisis support —

Reviews the part peer support workers can play to support someone in a crisis, as well as the need to look out for your own well-being and pay careful attention to agency policies.

family peer support – supporting other families in crisis —

Explains how peer support workers can approach supporting families in crisis.

resilience —

Describes how the quality of resilience is developed by dealing with hardship and difficulty. Also emphasizes the importance of taking care of your own needs when supporting people in crisis.

when someone is in an acute crisis... —

Looks at the types of acute crisis a person might experience.

tips to support calm in an intense crisis —

Shares specific guidance on what to do when someone you support is experiencing an extreme crisis.

a note about voice-hearing

Explains the condition of voice-hearing.

self-harm

Describes some reasons a person might self-harm.

suicide

Shares ways to support a peer who is suicidal as well as some warning signs of suicide.

hope

Explains how maintaining a hopeful attitude is essential when supporting those in crisis.



5. our focus

What's the focus of this module?

1 of 1

The path towards healing, wellness and recovery is not a linear journey: setbacks (or blips and dips) are a part of that journey. In this module, we'll explore a mindset shift when supporting someone through a crisis. This will involve normalizing setbacks as a regular part of healing, a shift that will make us better able to support ourselves as we support others.

Peer support is all about relationships grounded in mutuality so we'll approach this topic from that perspective.

after reviewing this module, you'll be able to...



Describe the basic steps and approaches to take when supporting someone in crisis.



Recognize and identify signs that someone is experiencing suicidal ideation and understand what you can do to support them.



Formulate a peer support-based (relational, mutual, non-clinical) response to supporting someone through a crisis.

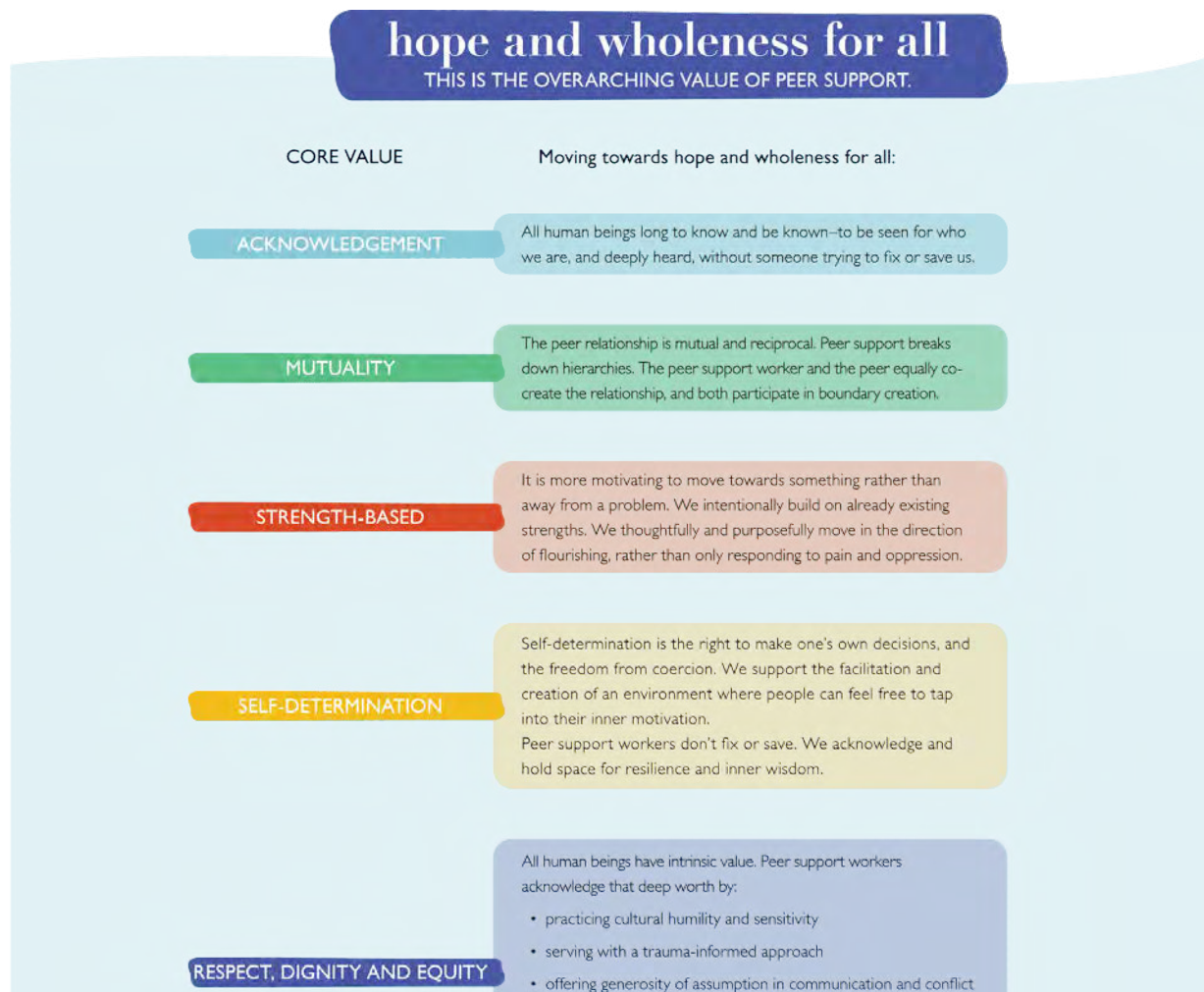


Assess your own window of tolerance for supporting someone in crisis so you can create a plan to support yourself from vicarious traumatization.



6. core values

The following core values are essential for peer support work. At the end of this module, you'll be asked to decide which ones are key to this topic.



- mindfully addressing personal biases

Peer support is about meeting people where they are at and serving others with a knowledge of equity.

BELONGING AND COMMUNITY

Peer Support acknowledges that all human beings need to belong and be a part of a community. Peer support recognizes that many people have barriers that keep them from developing community. We actively work towards deconstructing those social blockades that prevent inclusion and acceptance. Peer support workers serve with a social justice mindset, and intentionally practice empathy, compassion & self-compassion.

CURIOSITY

We are always intentional about how curiosity and inquiry support connection, growth, learning and engagement.

This curiosity isn't fueled by personal gain but by a genuine interest in connection. We encourage curiosity while respecting the boundaries and protecting the privacy of the people we support.


We are continually curious, but not invasive, while challenging assumptions and narratives. We ask powerful questions. We offer generosity of assumption to those who think differently than we do. We know that listening and asking questions are more important than providing answers.

***Note on the meaning of the term "generosity of assumption" from the glossary of terms:** Assumptions happen when we don't know the whole story, and allow our brains to fill in the blanks. Often we make negative assumptions about people or situations. Generosity of assumption means that we extend someone the most generous interpretation of their intent, actions, or words.

7. very important



Our intention with this module is to share a little about mental health and some tips on how to de-escalate someone when they are experiencing a crisis.



This module is written for a broad demographic. It's not meant to be exhaustive. It's written from a relational perspective and is designed to support you to build skills to be able to navigate potentially difficult terrain. Don't consider this module to be protocol. There's much more to learn. **Consider taking a course like [Mental Health First Aid](#), and a suicide prevention program like [S.A.F.E.R.](#) (Suicide Attempt Follow-up, Education & Research), or ASIST (Applied Suicide Intervention Skills Training).**

This training does not consider liability issues. Liability issues and the like need to be explained and overseen by your employing agency. Anything in their policy and procedures manual has precedence over what's written in this module.

Peer support programs will serve different demographics. Some programs will have direct clinical support, some will not. Your agency needs to figure out how to handle the need for clinical support. As we've stated throughout the training, you are not a clinician and it's important that you don't take on that role.

If at any point you feel lost and don't know what to do when supporting someone in a crisis, know who you need to call. **Always have a phone with you, and make sure to have the number of who you need to call ready.** You don't want to be wasting precious time looking for a phone number. Perhaps you will call a clinician, but you might call your supervisor or even 9-1-1.

If you need help, ask for it.

It's absolutely essential that you know your agency's emergency policies. These can usually be found in a policy manual, or through a co-worker or manager.

☐

What does your agency say about emergency situations?

☐

What's their policy on suicide prevention?

☐

What liability issues do you need to know, and what happens if these policies aren't followed correctly? You certainly don't want to find yourself having legal problems due to ignorance of a policy

☐

What do you do when you suspect the person you're working with is in danger?

☐

What's your working alone policy? Are home visits allowed? Can you go to someone's home alone, or do you need to have someone else with you?

☐

Does agency policy allow you to drive the people you support in your car? If yes, what insurance do you need to do so safely? Can you drive someone who's in crisis and is agitated?

You may not experience an emergency while doing peer support work, though some workers do encounter emergencies often, depending on where they work. Many peer support workers working in substance use experience emergencies every day because of the current opioid crisis.

It's better to err on the side of caution and check in with a supervisor when you feel uncertain about a situation. This is both an expression of mutuality and acknowledgement that you're part of a support community.



8. life application story



Check out this scenario with Kirsty and Sonia.

scenario

Kirsty, a peer support worker, had been meeting up with her peer, Sonia, who was dealing with a particularly stressful time in her life. As Sonia began talking about the situation at home and with her family, she suddenly started having a panic attack. Kirsty wasn't quite sure what she should do, as she hadn't encountered this situation with a peer before.

"Is there something that I can do for you right now?" she asked.

Sonia didn't respond.

"Do you need me to call someone?" Kirsty asked. She checked in with herself and noticed that she was feeling panicked and she really wanted to change the situation. She took a deep breath and steadied her own breathing.

"I'm going to get some air," said Sonia.

"Do you want me to stay here or come with you?" asked Kirsty.

Sonia asked Kirsty to join her, and together they left the building and walked around the corner to some green space. They sat on a bench, and Sonia continued to have a panic attack. Kirsty felt uncertain how to deal with this situation and was already thinking of resources to which she could refer Sonia. Maybe she should offer to drive her to the hospital? But she was here now, so again she tried to sit with her own discomfort.

"Is there something that helps you when you've had panic attacks in the past?" asked Kirsty.

"Yeah," said Sonia, "I'm just trying to focus on my breathing at the moment. Sorry," she added, embarrassed.

"You don't have anything to be sorry for. Sometimes when I feel anxious, I like to take off my shoes and feel the earth beneath my feet." Without thinking, she took her shoes off and planted them in the grass. Sonia decided to try that too, and they both sat on the bench with their bare feet against the earth.

Eventually, Sonia started talking more about how trapped she felt in her current situation, and how it felt like she was always doing everything wrong. A few times, Kirsty jumped in and tried to offer encouragement or suggestions. She noticed that she had a hard time just sitting there and listening to Sonia describe her distress. She tried to focus on the earth beneath her feet and hold space for Sonia without trying to rush to find a solution. Eventually, Sonia's breathing calmed. Together, they brainstormed some coping strategies and came up with a crisis plan, but only when Sonia was ready to go there. After their time together, Kirsty checked in with her supervisor and debriefed.

When Kirsty went home, she noticed that she felt both exhausted and full of unsettled energy. She went for a run, cooked a nice meal with her roommate and watched a comedy.

9. presence while supporting someone in crisis



The greatest gift you'll ever give someone who is in the midst of a crisis is your presence, your attention and your care.

As we cover in module **10. supporting someone who is grieving**, supporting someone often means sitting in the discomfort of not knowing what to do. In the life application story in lesson 8, Kirsty felt very uncomfortable when Sonia was experiencing a panic attack. It would've been easy for her to jump into an elevated panic mode. If Kirsty's anxiety had continued to elevate, it might have impacted Sonia in a negative way. If Sonia's panic had gotten worse, then Kirsty would need to know what to do. She would need to know her agency's policies and have a clear idea of the steps she would need to take and who she would need to call.

Instead, she breathed together with Sonia, and they both grounded themselves by sinking their feet in the grass. Together, they were able to relax, and Sonia's panic attack subsided. Keep in mind this situation could have gone differently as there are no guarantees on what will work in the moment. There are many variables, which is why it's important to know who to call.

What can we learn from this scenario? Perhaps that there is no one right way to do this. Had Sonia's panic not subsided, then Kirsty would have needed to take a different approach to support her. This may have meant calling someone. Kirsty could have asked Sonia if there was someone she would like to talk to, perhaps a friend or counsellor. A peer support worker has to be willing to try some different approaches, as long as the person isn't a danger to self or others.

If you are supporting someone who's in the midst of dealing with severe anxiety and panic, that can actually cause a stress response in you. As we cover in module **8. healing-centred connection: principles in trauma-informed care**, those situations can trigger your sympathetic nervous system and cause your stress hormones to release. Kirsty acknowledged her own stress and anxiety and made a conscious effort to calm herself down in the moment. Later, when she went home and decided to go for a run, spend time with her roommate and watch a funny movie, she was supporting her body to calm down. Acts of self-care like these go a long way toward soothing our nervous systems.

It's also important to note that crisis looks different for everyone, depending on their life situation, specific mental health diagnosis, supports and resources and any health issues they may be experiencing. There's no "one size fits all" definition of a crisis, and there's no "one size fits all" approach to supporting someone in crisis.

We will dig into some approaches to supporting someone in crisis throughout this module, and also some ideas on how you can support yourself too. Remember you are not alone. You'll be a part of a team of people who will be there to support you when you need it.

CONTINUE

questions for reflection

Answer these questions in your reflection journal.



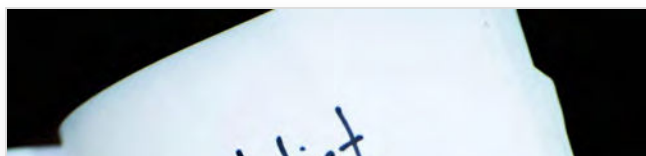
Have you ever been in a situation where you supported someone dealing with a mental health crisis? If so, how did you respond?

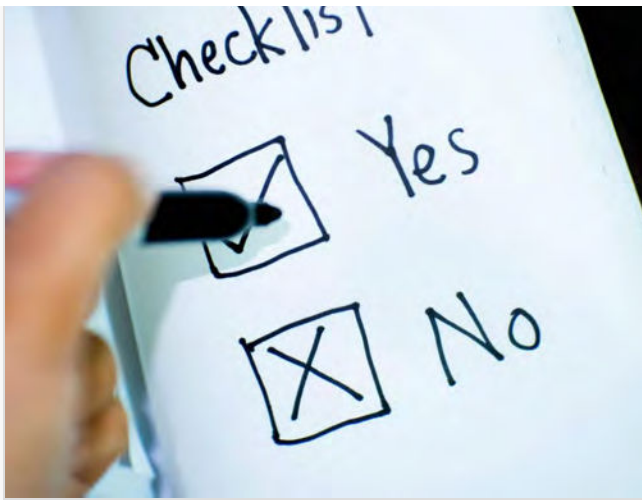
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Did someone support you?

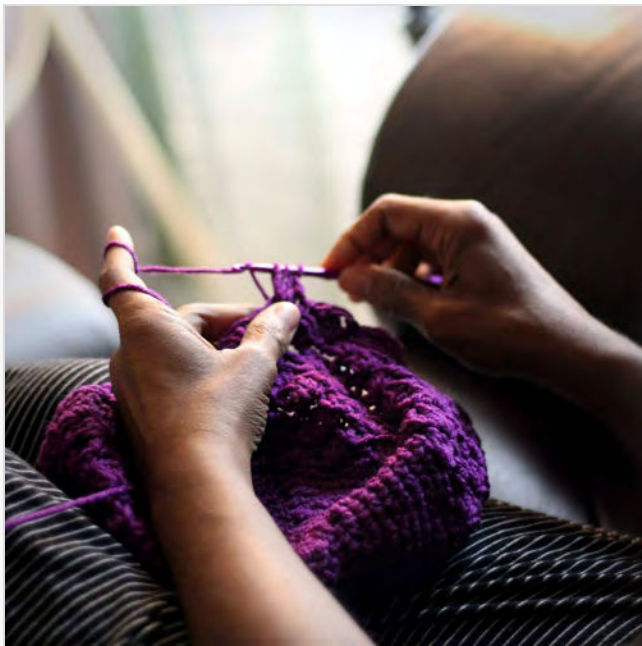
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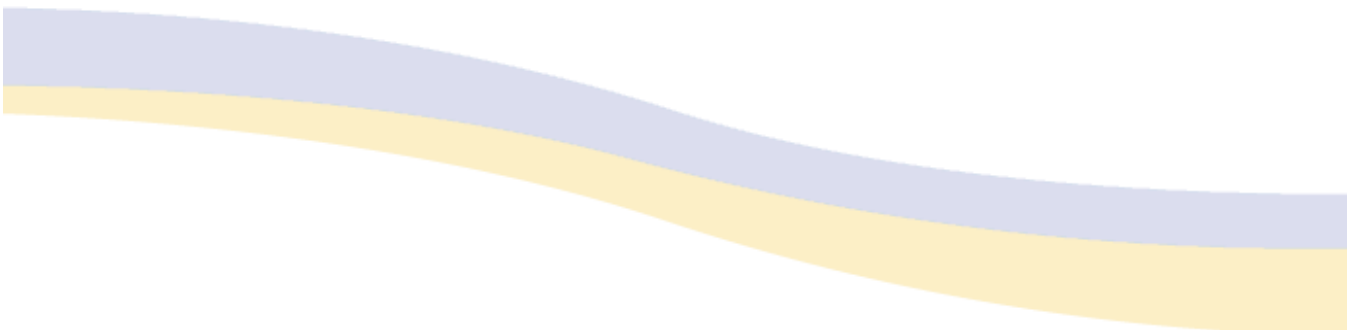
Was that support helpful?

3 of 4



What are some things you can do to support your body after a hard day at work?

4 of 4



10. things to know if someone you work with is in crisis

As we have covered in other parts of this training, you are not clinicians. As such, you should never provide clinical care to anyone, especially those in the midst of a mental health crisis. You're on the support team, and that means you'll likely be supporting someone who's experiencing a crisis at some point. This module will give you some skills you can use to support someone experiencing a mental health crisis.

To review the difference between clinical care and peer support, expand the box below:

REVIEW: Clinical approach vs. Peer support approach

A **clinical approach** focuses on assessment, diagnosis and treatment. A clinical approach also involves medication and medical support.

A **peer support approach** focuses on the relationship and mutuality.

Both the peer support and clinical approach include a desire to support the person's recovery and the achievement of their human potential.

The perspective of a peer is essential to impacting people's lives and creating a recovery-focused culture. The peer perspective changes everything we do with the people we support right down to the language we choose to use.

In addition, the foundation of the peer support role is based on the fact that you have lived experience. In the clinical model, staff are trained to reveal very little about their personal life. They're taught to not self-disclose and to always keep the focus of the work on the service users, rather than on themselves.

Things to know when someone you work with is in a mental health crisis

Please keep these issues in mind when you are supporting someone who is experiencing a mental health crisis.

1

2

Know your organization's policies and procedures on what to do in emergency and crisis situations. What's expected of you? Who do you call? When do you need to call? Who can support you if you encounter an emergency?

3

If you're connected with a clinical team, know what's required of you. Have clear conversations about your role, what you're required to report, and your responsibilities with the clinical team and with the people you're supporting.

4

Even if someone has the same diagnosis as you, their situation is different. Don't ever give clinical advice, as your advice will be specific to your situation.

5

Family peer support workers tend to support families through crisis. Again, do not offer clinical advice, and remember that you're there to support the personal needs of the family member. Your situation may be quite different from what your peer and their family are dealing with.

6

Though you might have some education about medications and other treatments, peer support workers never offer advice about medications or clinical treatments. Some peer support workers might attend doctor's appointments with peers as a support person, but they do not ever give medical advice.

7

Consider taking extra trainings such as [Mental Health First Aid](#) or [S.A.F.E.R.](#) (Suicide Attempt Follow-up, Education & Research), or ASIST (Applied Suicide Intervention Skills Training). The BC Peer Support Training Curriculum cannot be as comprehensive as those specific pieces of training.

8

If someone is dealing with a crisis related to a past trauma, remember that peer support workers aren't trained as trauma counsellors. Don't offer support or advice that can be perceived as trauma counselling.

9

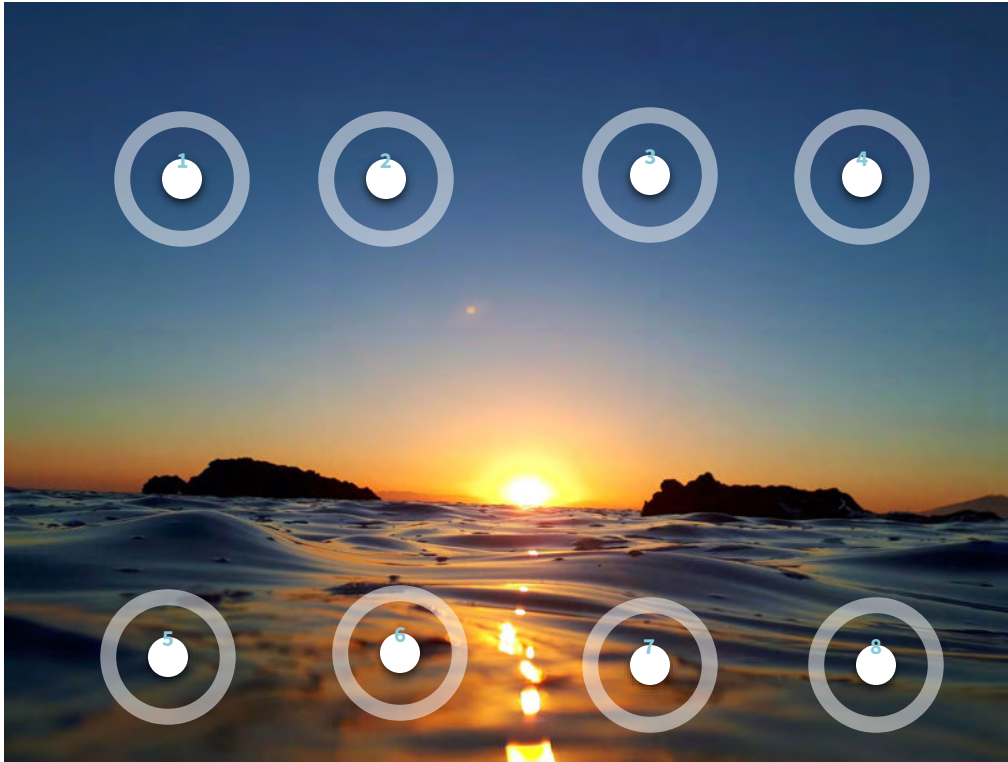
If you are meeting with people in the community or in their homes, make sure your agency has a working alone policy.

10

Have a fully charged mobile phone with you at all times when you're working in the community.



What you CAN do in the moment, when supporting someone who's experiencing a mental health crisis:



Listening

Listening, and perhaps supporting someone to reframe their thinking, is very supportive for someone experiencing a crisis.

Connection

Provide emotional support and connection, something that psychiatrists and nurses don't have as much time or opportunity to give.

Experiences

Share your past experiences with crisis and any transformative, hope-filled moments that supported a shift in you.

Advocacy

Advocate for your peer in situations where their needs aren't being met.

Practices

Share powerful practices that can invite calm during crisis (like the example in our life application story).

Presence

Offer empathy and your presence. Just being there can make a world of difference for someone!

Hope

Hope is like a balloon. When someone is in acute crisis, they may not be able to hold their own balloon. You get to hold it for them.



Support

Support your peer to access important resources they're unable to because of the crisis.

If your peer has a clinical team, remember it's important to work together with them.



CONTINUE

One of the most powerful things you can do to support someone in crisis is to have a conversation about crisis situations before they actually happen. You can ask them what they would need from you if they were to experience a crisis. If you're equipped with this information, you won't be left guessing. You will KNOW what they need and want. It's a good idea to have this conversation very early in the relationship.

Wellness Recovery Action Plan (WRAP) is a program that supports people to create a wellness plan for themselves. This includes a Crisis Plan, in which participants tell supporters what they'll need if they experience a crisis. A crisis plan gives people a sense of control even when their lives are spinning out of control. Check your community to see if there are WRAP groups available in your area.

We know from module **8. healing-centred connection: principles in trauma-informed care** that trauma is the experiential feeling of helplessness that follows a traumatic incident. Trauma is not the incident itself. Sometimes when people experience an acute crisis, it can bring up those feelings of loss of control, meaning a person can be traumatized over and over again if they experience crisis multiple times. Having a crisis plan can support someone to retain a sense of control, and possibly avoid retraumatization.

things to do following a crisis

If someone you're working with has gone through a crisis, it's important to talk about it **after** the crisis has passed. What can you learn from their crisis experience? Can you create a plan together to prevent it in the future? What can you do to support them differently if it happens again?

This can be a collaborative process. Again, don't be shy to have these conversations. In the spirit of mutuality, feel free to share some of your experiences. The person might be feeling shame. They are less likely to feel shame when they know they're not alone.

Talk about what went well in the crisis. What were the strengths of the situation? What were the strengths of all the players involved?

Also, if the person has a clinical team, or some supports, make sure to include them in these dialogues.

11. basics of mental health

This lesson is meant to support you to understand the language you may hear in your workplace from other practitioners. Peer support is always about relationship and connection. It's not about providing clinical care.

Peer support programs have different policies regarding what they share about a person's history and diagnosis. Some peer support workers will have access to a peer's medical file, while others will not. **It's important to know key details about a peer's direct needs.** However, knowing too much of their history and diagnosis before you meet them isn't always beneficial. As we explore in other modules, everyone has a worldview and biases. Some clinicians experience clinician's illusion (see module **3. categories & containers: unpacking our biases**) and might not believe in recovery. If you read too much information about a person before you get to meet them, you might subconsciously be influenced by the contents of their file. Make sure you know the important things you need to know to give the person the best support you can, and don't worry about the rest.

some peer support programs that work on a referral basis ask for details like:

☐

What are the person's strengths?

☐

What resources do they have?

☐

Is there a particular goal they are working towards?



This referral can include any needed clinical information.

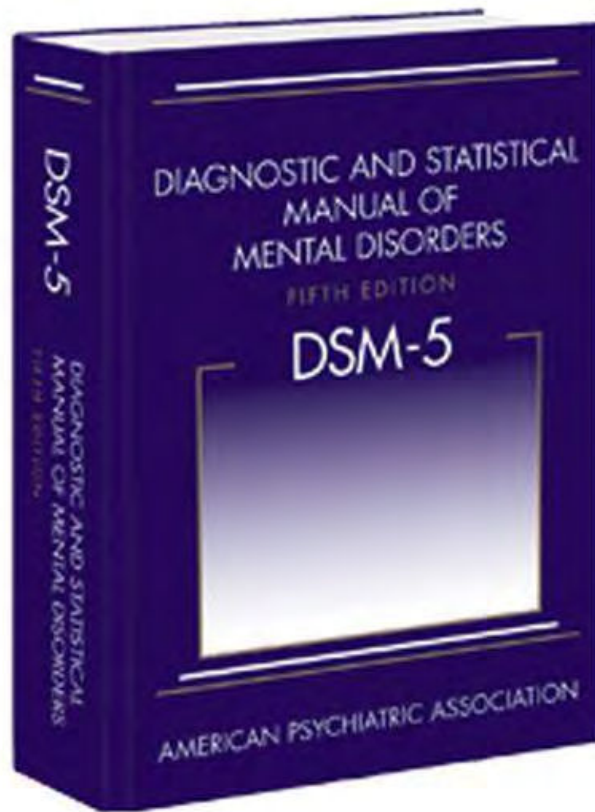
It's also advantageous to be educated about mental health as well as the signs and symptoms of crisis. As a peer support worker, medication is never something that's a part of your work. It's important to leave all recommendations and advice about medication to the clinical team of the person you're supporting. You should never give advice about medication. However, it may be possible to discuss your experience with medication if you make it clear you are only sharing from your perspective. This type of sharing may be helpful to some people.

It's also a good idea for you to have some general knowledge about different medications and how they can impact people's daily lives. For example, you might notice a side effect that needs to be pointed out to a peer's clinical team.

Since your role is to focus on relationship and connection, having some background education on mental health will give you a deeper understanding of how to support someone.

The DSM (Diagnostic Statistical Manual) 5 is the resource book that doctors use to make mental health diagnoses. A mental health diagnosis can't be determined by a blood test. Diagnosing someone can be a subjective, trial and error type of process. Psychiatrists are typically the ones who make those diagnoses.

Within the mental health system and peer support, there are many different views and opinions about things like diagnoses, medications and treatment. Some people do well with medication, others do well without. It can be quite a controversial topic. It's important when doing peer support work that we understand our own biases around these issues and do our best to support others with a neutral approach.



CONTINUE

mental health diagnoses

This training will not go into diagnoses details but does offer some broad information below. It's important to remember that in peer support we always focus on the connection and the relationship.

You likely already know a little about mental health. You may or may not be working with someone who has a similar diagnosis to your own. It's important to remember that your situation will be different than theirs. As we covered earlier, do not give medical advice about diagnoses or medication.

We encourage each agency to provide you with the education, information and support you need around specific mental health diagnoses.

Please reach out to clinicians on your team when you feel someone is becoming unwell. If you notice any differences in behaviour, or increased symptoms popping up, please seek out clinical support.^o

If you suspect someone is really unwell, do not enter their home by yourself. Please reach out for support first.

the basic mental disorders include, but are not limited to:

mood disorders

Includes bipolar, major depression and other mood disorders.

psychotic disorders

Includes schizophrenia.

anxiety disorders

Includes generalized anxiety disorder, obsessive-compulsive disorder and panic disorder.

post-traumatic stress disorder (PTSD)

A psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event such as a natural disaster, a serious accident, a terrorist act, war/combat or rape, or who have been threatened with death, sexual violence or serious injury.

complex post-traumatic stress disorder (CPTSD)

CPTSD includes symptoms of PTSD along with having difficulties managing emotions and relationships.

substance use/misuse

Substance use refers to the use of drugs or alcohol, and includes substances such as cigarettes, illegal drugs, prescription drugs, inhalants and solvents. Substance misuse occurs when using alcohol or other drugs causes harm to you or to others. Substance misuse can lead to addiction.

schizoaffective disorder

People with schizoaffective disorder have the symptoms of schizophrenia and a mood disorder. Mood disorders, such as bipolar disorder or depression, are medical problems that affect how you feel.

eating disorders

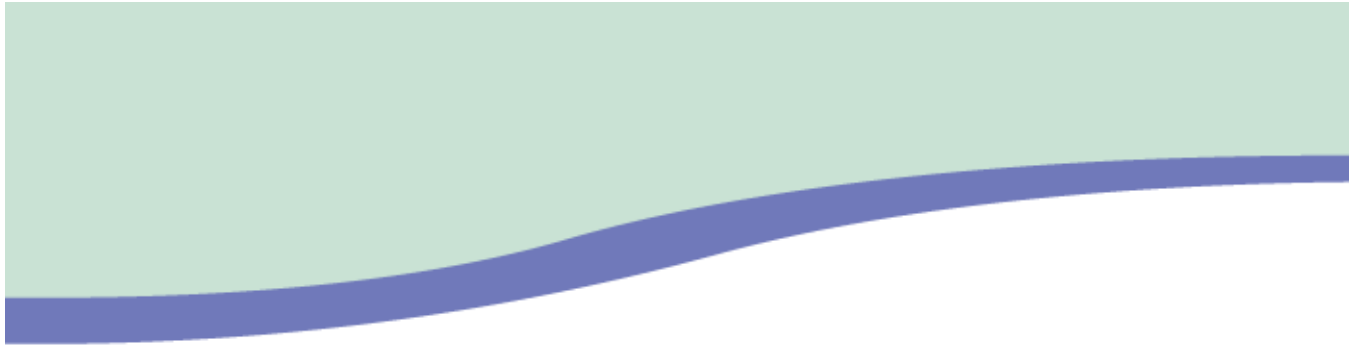
Includes anorexia nervosa, bulimia nervosa. Eating disorders fall into a complex category, as they are mental disorders and they involve the medical system as well as the mental health system. People with eating disorders can sometimes fall through the cracks because of this overlap. Not all mental health centres have services for people with eating disorders.

avoidant restrictive food intake disorder (ARFID)

Someone with Avoidant/Restrictive Food Intake Disorder (ARFID) isn't consuming enough calories for their body to function optimally. This can lead to delayed weight gain or growth in children, and dangerous weight loss and inability to maintain basic body functions in adults.

orthorexia

Someone with orthorexia has an excessive preoccupation with eating healthy foods, to the point where it can negatively affect their physical and mental health. It's important to note that while eating nutritious food is beneficial to one's overall health, having an unhealthy fixation on it can be detrimental.



CONTINUE

the mental health system

There are many different avenues for finding support to improve mental health.

in B.C., public health care dollars are funnelled to five different health authorities. They are:

☐

Fraser Health

☐

Interior Health

☐

Island Health



Northern Health



Vancouver Coastal



[Provincial Health Services Authority \(PHSA\)](#) is a provincial organization that provides service to all five health authorities. They oversee some province-wide programs that are open to anyone. One program they oversee is [B.C. Mental Health and Substance Use Services](#), or BCMHSUS. BCMHSUS provides healthcare services to people with complex needs, including severe and persistent mental health and substance use issues, from across the province. They also lead knowledge exchange, health promotion and literacy.

The five main health authorities decide how they want to distribute their health dollars. Each one manages their money differently depending on their needs. This is why peer support services are different within different health authorities.

Some health authorities fund their own rehabilitation and recovery programs (of which peer support is one), and others contract non-profit agencies to deliver services. For example, Fraser Health, the biggest health authority in B.C., manages all their clinical and acute services, including mental health centres and in-patient units, internally. They contract most of their community rehabilitation programs out to non-profit entities (peer support, vocational programs, clubhouses, housing programs).

There are many non-profits in B.C. that run peer support programs. Some may receive government funding, others may fundraise and some might be a combination of the two.

CONTINUE

acute services & the law

This section is included in the training simply so you can understand the current laws of B.C. We are not stating agreement with the B.C. Mental Health Act. We feel that in a module about mental health crisis, you should have a basic understanding of how the law works in B.C.

Most hospitals in B.C., with the exception of more rural towns, have psychiatric wards. This is where people tend to go during a mental health crisis because they need more support than community supporters are able to give. Sometimes if a person has a strong support system, they may be able to manage a crisis at home. Depending on the severity, sometimes hospital is the only option.

The B.C. [Mental Health Act](#) is a very complex document. It guides the laws in B.C. around how someone who is in the midst of a mental health crisis receives formal mental health services. In 2004, the Canadian Mental Health Association (CMHA) BC Division created a document called [BC's Mental Health Act in Plain Language](#). It's an older document but reading it along with the current Mental Health Act may be helpful.

A person can go to the hospital voluntarily if they're at least 16 years old. If they're under 16, a guardian's permission is needed. They can also be sent involuntarily.

A voluntary service user can leave a facility at any time.

YOUR RIGHTS under BC's MENTAL HEALTH ACT

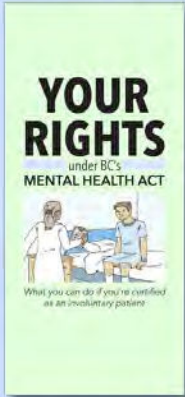
If you've been certified as an involuntary patient under the *Mental Health Act*, you still have rights.

You have the right:


- to know where you are
- to know why you've been certified
- to be examined by a doctor to see if you still need to be in the hospital
- to ask for a review panel hearing to challenge your certification
- to ask for a second medical opinion from another doctor about your psychiatric treatment
- to speak with a lawyer

Learn more about your rights

Ask a nurse for a copy of **Form 13** or a "Your Rights under BC's Mental Health Act" pamphlet, which has more details about each of these rights.



This poster was created by the Mental Health Act Rights Advice research team (bcmmentalhealthrights.ca). Funding for this research was provided by



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FOR HEALTH RESEARCH
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according to BC's Mental Health Act in Plain Language, a person can't be involuntarily admitted to the hospital unless they meet all three of the following criteria:



Has a mental disorder and



Needs care, management and control in a designated facility to keep them from putting at risk their well-being or the well-being of someone else or to keep their mental or physical condition from getting worse and



Could not rightfully be admitted as a voluntary service user

In order to be admitted to a psychiatric ward involuntarily, or to be “certified,” a person needs a medical certificate written by a physician that states that the person meets the above three criteria. This can be written up to 15 days prior to admission.

With one certificate, the law states that a person can be held against their will for up to 48 hours. In order to extend that stay, the person needs an examination and a second certificate signed by another physician within that 48 hours.

When someone is involuntarily admitted, they are subject to reviews. They can be discharged anytime they are deemed to not be at risk of danger to self or others. However, if they’re still assessed as a danger to self or others, they can also remain an involuntary service user for several months until the psychiatrists assess them to be ready to leave.

Many peer support workers are now working for in-patient facilities. You may have the opportunity to work in one. To offer that little piece of hope to people who are admitted to a psychiatric ward is an amazing gift! The way peer support works in hospital settings is different for each hospital. Some peer support workers offer one-to-one support. Others work with the Occupational Therapy department and do group work and activities.

CONTINUE

residential short-term stays



Some areas have community-based, health authority-run, short-stay facilities for voluntary service users. These can be much nicer places to stay than in-patient psychiatric wards, but not all communities have these as an option.

Many peer support agencies in the U.S. have peer-run respite centres. Someone can voluntarily stay in one of these centres until they feel ready to get back into the community. They're run entirely by peer support workers. Someday we might have some of these centres right here in B.C.!

CONTINUE

private support

Some people manage their mental health by accessing private psychiatrists, psychologists and counsellors. MSP (Medical Services Plan) does cover private visits to a psychiatrist, and in some communities, people who aren't

being seen at a mental health centre can see a psychiatrist privately. But there are often long waitlists for these types of services.

Psychologists and counsellors are not covered by MSP, but some people have coverage through extended health plans. In some communities, there may be programs available that support people to get counselling services, especially when related to trauma.

Knowing what's available in your community can be very useful to the people you support. But also keep in mind that many people use the public system because they aren't able to access private resources due to the high financial costs associated.



12. recovery-oriented approach & language

In other modules in this training, we have spoken about person-first language. We also want to cover that in this module with the lens of supporting someone with a mental health crisis.

In any field, people can use jargon in their speech. People can also use language that's illness-focused rather than recovery-focused.

jargon

Special words or expressions used within a specific profession that can be challenging for others to understand.

recovery-focused language

language that promotes optimism, supports recovery and respects a person's autonomy.

As a peer support worker, you'll sometimes find yourself working in environments where using jargon and illness-focused language are the norm. However, as important as it is for us to use strength-based, person-first, recovery-oriented language, **it's not your responsibility to change the whole system. That's just too large of a burden to bear. By practicing recovery-focused language, you'll influence the mental health system; but changing the entire system is never your job.**

Hope needs to be at the forefront of all the language we use, as well as the underlying belief that it IS POSSIBLE for everyone to recover. If the language you're using doesn't reflect that underlying belief, then it's not recovery-oriented.

CONTINUE

Recovery-oriented Approach	Illness-focused Approach
vision of people	

Recovery-oriented Approach	Illness-focused Approach
Sees the person as a holistic being.	Evaluates people's behaviours through the lens of illness.
Understands the power language and labels can have on someone.	Refers to people with labels and describes them using diagnostic language.
Acknowledges the presence of stigma in the world surrounding mental health.	
vision of the recovery	
Believes a person can recover and have a good quality of life, despite having significant mental health challenges.	Believes a person recovering will always need help and service from the mental health system.
vision of abilities	
Focuses on a person's strengths and abilities instead of their limitations. Believes everyone has strength and works hard to support their efforts to rediscover their strengths.	Focuses on someone's perceived deficits and does not acknowledge strengths.
vision of self-determination	
Encourages the practice of self-determination and choice. A "treatment plan" is not created without a person's input and consent.	Encourages everyone to comply with the system. When a person goes against the "treatment plan," they are considered "non-compliant" and "treatment-resistant."
vision of team attitudes	

Recovery-oriented Approach	Illness-focused Approach
<p>The team</p> <ul style="list-style-type: none"> • Willingly challenges personal biases and assumptions • Focuses on sharing and facilitating hope • Holds people up with unconditional high regard 	<p>The team</p> <ul style="list-style-type: none"> • Is unaware of biases and assumptions regarding what it might be like to live with a mental health diagnosis, or is unwilling to challenge them • Assumes what they know about living with a mental diagnosis is correct • Sees a person's struggles as chronic and generally expects negative outcomes

CONTINUE

specific language to avoid

Remember, language is a living dynamic thing. A good pointer is to always ask the individual you're working with about their preferred language.

Instead of this....	Say this....
Sam is a schizophrenic.	Sam has been diagnosed with schizophrenia

Instead of this....	Say this....
Jill is high functioning.	Jill requires low support. Her strengths are... and she may need support with...
Sue is low functioning.	Sue needs high support. Her strengths are... and she may need support with...
Bob is decompensating.	Bob isn't doing well right now. He is experiencing...
Jacob is crazy.	<p>Jacob is living with a mental health diagnosis.</p> <p>Or:</p> <p>Jacob is experiencing psychosis, hallucinations and seems disoriented.</p> <p>(With a recovery-oriented approach, we choose to get out of the habit of using "crazy" as regular slang.)</p>
Jeff is non-compliant.	<p>Jeff is choosing to do ____ instead.</p> <p>Jeff is unsure what he wants.</p> <p>Jeff isn't certain that the recommendations he's been given are right for him.</p>
Sarah is manipulative.	Sarah is working hard to get her needs met.
Richard is chronic.	Richard has been struggling for a long time.

Instead of this....	Say this....
Fred is a drug addict.	<p>Fred is using substances in a potentially harmful way.</p> <p>Fred is experiencing problematic substance use.</p> <p>Fred is a person with a substance use disorder (SUD).</p>
Jas is resistant to treatment.	<p>Jas is choosing not to...</p> <p>Jas has chosen to do...instead</p>
Grace is manic.	<p>Grace is exhibiting some signs of mania.</p> <p>Or even better: Grace told us about some of the signs that indicate things are breaking down for her. We are seeing some of those signs right now.</p>
Katherine is anti-social.	<p>Katherine says that she prefers to spend most of her time alone.</p> <p>OR</p> <p>Katherine only wants to spend time with people she doesn't have to mask around, that just get her, and where it's safe to be herself.</p>

Instead of this....	Say this....
Sally is delusional/psychotic.	<p>Sally is exhibiting symptoms of psychosis.</p> <p>Or even better: Sally told us about some of the signs that indicate she is experiencing psychosis. We are seeing some of those signs right now.</p>
Frank is a frequent flyer.	Frank frequently accesses services.
Brittany is a mentally ill person.	Brittany is a person living with a mental health diagnosis.
Saul is a homeless person.	Saul is currently experiencing homelessness.
Jack committed suicide.	<p>Jack died by suicide.</p> <p>We lost Jack to suicide.</p> <p>Jack ended his own life.</p>
Ling is having a temper-tantrum...	Ling is having a meltdown which is something that's out of their control. What can we do to support X until it passes...
Kamal is non-verbal.	Kamal is non-speaking but uses these alternative ways to communicate (signing, AAC, typing, etc.)...

Shifting to a recovery-oriented language is hard. It really is. It's especially challenging for peer support workers when working in spaces where other practitioners are immersed in illness-based worldviews.

This is one of the reasons that it's important to have a peer support community of practice. It can be very hard to be the person on a team trying to shift the mindsets of others you work with. Surrounding yourself with other peer support workers and other like-minded people can bolster your energy for the hard work of transforming services to become more recovery-oriented. You can't do this alone.

Remember, you can only control your own behaviour. Please don't feel like you need to take on the role of changing the whole system. But the beautiful thing that can happen with a movement is that, over time, it does cause amazing shifts and changes.

Remember that you're a part of this transformative movement. You're not alone.

CONTINUE

questions for reflection

Answer these questions in your reflection journal.



Have you ever had someone speak with you using illness-focused language? How did you feel when they did that?

1 of 2



**How will you remind yourself to
use recovery-oriented language?**

2 of 2



13. approaching crisis as an opportunity for growth

“When people are willing to listen to each other’s stories without providing analysis, and at the same time compare and contrast experiences, possibilities for transfiguring meaning are endless. When we become part of each other’s narratives, we not only offer possibility for alternate (mutually enriching) interpretations, our new shared story becomes a way to negotiate future challenges and crises while building real communities.”

Shery Mead & David Hilton, *Crisis and Connection*, 2002

CONTINUE

It's likely most of us wish that life, and the process of recovery, will be linear. We start to believe that when we're on the right track we'll always stay on course and nothing will deter us. We feel "unstoppable!" However, that's not what happens. Something inevitably gets in our way and knocks us off the path.

The toxic expectation that life should be good at all times seeps into our worldview and creates a goal to always be happy, fulfilled and "successful." However, as we with lived experience know, that's not the way life works. Setbacks, ups and downs, uncertainty, loneliness and crisis are all part of being human, even when we believe we are doing everything "right."



Challenges and crisis can happen to anybody – no one is immune. When we're able to change our mindset about the expectation of "a perfect life" and accept that our lives will never be free from setbacks or crisis, we can embrace opportunities that grow our resilience. We can learn to become more adaptable and sturdy. We can develop a strength that allows us to get back up after setbacks. We can let go of the debilitating shame that's so common when we experience crisis. We can learn to offer ourselves compassion and kindness when we

struggle. We can learn to shift our mindset, create stronger support systems and lean on others when needed, because we know we're not alone.

In **the foundations** module we cover uncertainty. A crisis ALWAYS involves the worst kind of uncertainty. Hope comes when we realize that uncertainty creates an open door for new possibilities. It creates a crack in the darkness of despair and lets the light shine through!

As a peer support worker, you give support when someone is in the midst of a crisis or setback. But it's important to remember that while you may feel like you're in a good place in your recovery, you may also experience a setback. There is absolutely no shame in this. It's okay. You've done hard things before, and you can get through hard things again.

A great way to build your acceptance of the ups and downs of life is to share recovery stories with others. Sharing these stories, especially under the guidance of a skilled facilitator, can build your sense of connection with others and foster a common spirit of empathy and encouragement.



CONTINUE

things to remember when experiencing a crisis, or supporting someone through a crisis:

☐

When we embrace hope, we welcome the possibility for healing and growth.

☐

When we understand that setbacks are part of the process of growth, and they come with being human, then we're able to get back on our feet more quickly.

☐

When we reframe our thinking about crisis, we realize the progress we've made in our recovery has not been derailed.

☐

When we have support, self-compassion, determination and a plan, we can get back on our feet faster than we have in the past, even after a serious setback.

Shery Mead's article, "[Crisis as an Opportunity for Growth and Change](#)," shares a new perspective for us:

Peer support is a culture of healing. As people practice new ways of "being" through even the most difficult times, possibilities for breaking old patterns and creating new opportunities are endless. Crisis then just becomes another word for redefining our experience and ourselves so that instead of needing to be locked up, we can begin to break free.



Please read Shery Mead's entire article. Then take a few minutes to reflect in your journal on the six ways of thinking that she discusses.



1 of 1

CONTINUE

In her article, "Crisis as an Opportunity for Growth and Change," Shery Mead lists six ways of thinking about people through very difficult times. Those ways are listed on the left below. Match each way with the description that best matches it.

≡ Building mutual relationships

Relationships that are constantly negotiated allow us to build mutual respect and trust

≡ Being with "big" feelings

Intense feelings can be rich with information

≡ Understanding the "story"

People's versions of their own stories impact the way they make meaning

of experiences



Sharing ways that “stories”
are understood

Hearing others share similar stories to
our own allows us to see our stories as
connected



Challenging the current story

When we compare and share stories,
we begin to challenge the ways we
think about ourselves



Creating a new, shared story

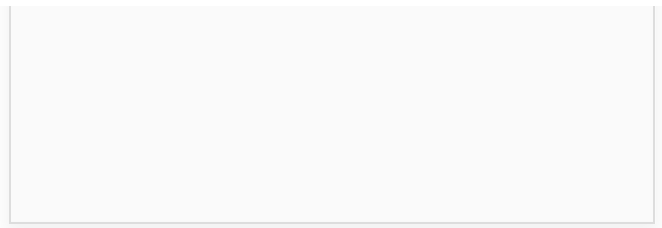
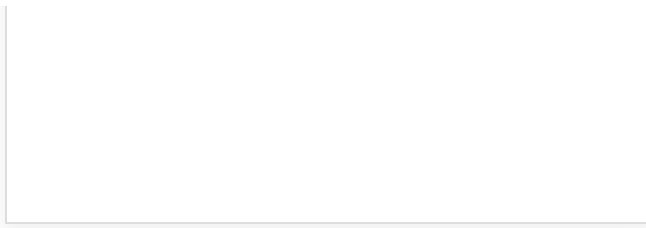
With deepened relationships we take
more risks, share vulnerabilities &
create new stories

SUBMIT

CONTINUE

crisis

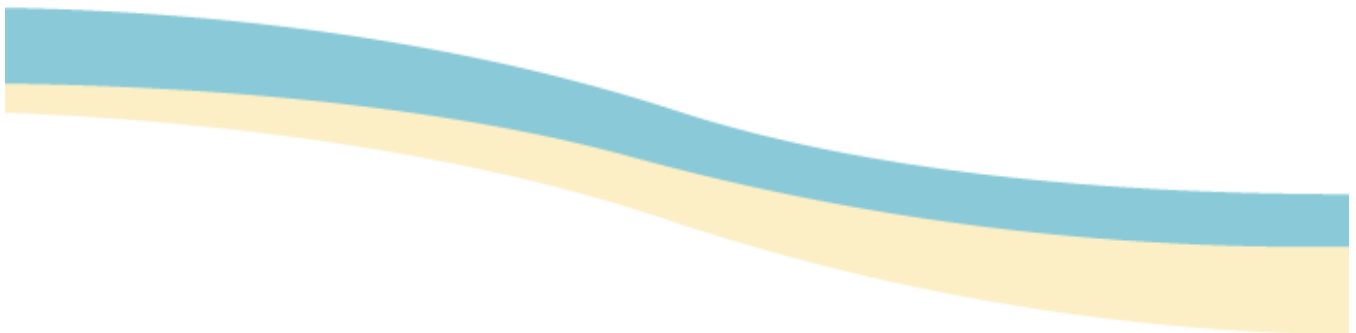
**A time of intense difficulty,
trouble or danger**



1 of 1

An accepted definition of a crisis is a time of intense difficulty, trouble or danger. A person in crisis is unable to cope with regular life and is under severe emotional pain. The state of crisis is acute.


Throughout the training, we have talked about how we all have judgements, assumptions and biases. Sadly, when people are in deep crisis, their behaviour can sometimes be brushed away as attention-seeking by practitioners. As peer support workers, it's important to withhold judgement when we're working with people who are in crisis, and it's VERY important not to minimize their experience. If we do, it can be a form of gaslighting.



14. the role of peer support worker in crisis support

It's very normal to experience fear when supporting someone who is in a crisis. Crisis is uncertain, and as we have covered in this training, uncertainty is very scary. Fear can erode connection, and therefore it's essential that you get the support you need – and build the skills necessary – to be the best peer support worker possible.

When you're supporting someone through a crisis experience, remember that your role is not to fix anything or anyone. Your role is to show care and compassion towards the person you are supporting, and by doing so, you are giving someone a significant gift and will surely have an impact.



How can you support yourself to not be overwhelmed by fear?
What practices can you do to support yourself?

your own well-being

As we read in the life application story in lesson 8, Kirsty found herself feeling anxiety as she was supporting Sonia. Significantly, she acknowledged her own anxiety and discomfort and supported herself.



It's very important that we pay attention to what our own bodies are telling us when we're supporting someone in crisis. Some of our stress and anxiety can be softened through self-compassionate practices.

**However, sometimes you might find support
work too triggering and that your own past**

**trauma is resurfacing. When this is the case,
you'll need to step back.**

Speak to a supervisor or manager and let them know that you need to take a break. This is also an example of good self-care.

Doing regular self-inventories where we reflect on how we're doing emotionally and whether situations are manageable for us or not is essential in this work. Programs such as Wellness Recovery Action Plan (WRAP) can support us to develop this capacity to self-assess.

CONTINUE

questions for reflection

Answer these questions in your reflection journal.



**What are some regular practices
you can engage in that bring calm
for yourself, especially when
supporting people in crisis
situations?**



What are some warning signs that you are struggling and might need to step back from peer support work, or perhaps stop working with a specific person?

2 of 3



When you notice these warning signs, what's your plan to support yourself? What actions do you need to take in your personal and work lives? (It's a good idea to reflect on, review and upgrade this plan periodically.)

3 of 3

15. family peer support – supporting other families in crisis



We cover family peer support in greater detail in module **15. family peer support**, but it's important to acknowledge it in this module because family peer support often involves supporting someone in crisis.

A family peer support worker is someone whose loved one may be currently living with a mental health diagnosis and/or is using substances in a potentially harmful way – or has done so in the past. The loved one can be a child, spouse, parent or sibling. If that loved one is currently unwell, the family peer support worker is supporting another family while their own loved one is in a current crisis. This kind of situation can be emotionally difficult.

Family members often struggle with their own mental health as they are supporting their loved ones, and it's not uncommon for a family member to be dealing with trauma or Post-Traumatic Stress Disorder (PTSD) as a result of their loved one's struggle. For example, they may have been traumatized as a parent by seeing their child in a severe crisis, hospitalized, and possibly even restrained, and felt helpless as a result. This feeling of helplessness and loss is the central cause of trauma, as we explore in module **8. healing-centred connection:**

principles in trauma-informed care.

Families can actually feel oppressed by the very system that is supposed to be supporting their loved ones. This is because confidentiality laws do not allow families of people over 19 to be included in their loved one's recovery team. As a result, they can feel isolated and left out, often feeling ill-equipped to support the person that they love so much.

We must also accept that people may decide of their own accord not to share information with their biological or chosen families. Public health care ethics remind us that autonomy and self-determination are non-negotiable and, even when our loved ones appear to be in distress, we must honour this as we work to support them.

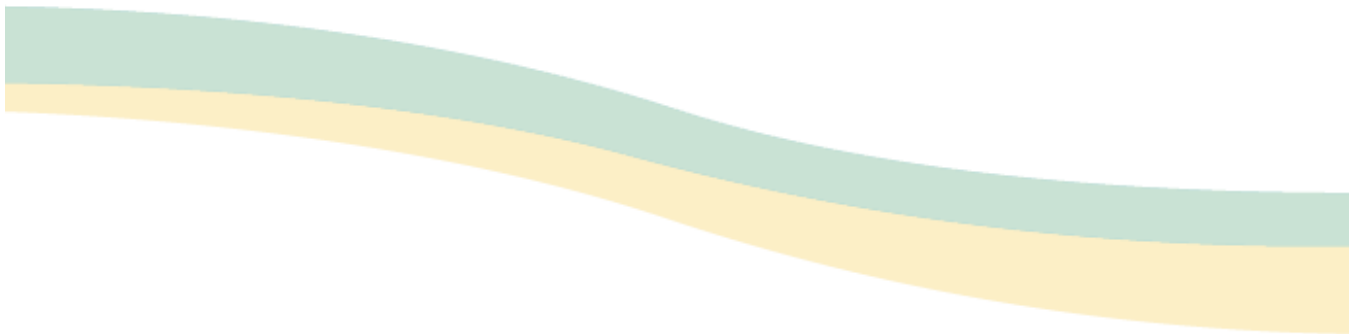
Despite these challenges, many agencies are increasingly aware of the importance of all forms of family in the recovery process and choose to centre them in the creation and implementation of care plans. There are a growing number of success stories and the courage and persistence of family peer supporters has been crucial in this.

Living with a person who has a mental health diagnosis and is using substances in a potentially harmful way can HUGELY impact the whole family system. They affect all family members. That's one of the reasons why family peer support is so needed. Families commonly deal with a lot of "shame and blame," especially since most struggle in isolation and don't always get support for themselves. They need to know that they aren't alone. Family peer support workers are able to provide emotional support in a way that no one else can, because they personally understand the struggle.



Family peer support workers must have firm boundaries around what they can and can't do within their role. A family peer support worker may be working with a family while their own loved one is in the midst of crisis, and

this could be very triggering for them. For example, a family peer support worker in the midst of supporting their loved one through a substance use crisis, that includes psychosis, might find it too much to also be working with another family that is dealing with the same exact crisis. In such a case, they must be ready to pass this family on to another worker. Clarity on boundaries is really important.



16. resilience

We can choose to see setbacks as learning opportunities rather than as something that will kick us back to square one. Taking the “shame and blame” out of setbacks supports us to hold onto hope and see experience as a teacher. Part of the healing process from setbacks is allowing ourselves to feel all our feelings – including pain – and remembering that bumps in the road are a part of the process. When we believe this, we can get back up more easily.



Resilience is the ability to bounce back after adversity. Resilience-building supports us to manage adversity. Being resilient doesn't mean that a person won't experience crisis or adversity. In fact, going through those

things can strengthen our resilience. Resiliency is not extraordinary; anyone can strengthen their resilience. It's like strengthening a muscle.

As we cultivate resilience while practicing self-compassion,* our capacity for taking personal responsibility expands. We begin to understand that imperfection is a non-negotiable piece of the human condition, and that guarantees that we'll make mistakes in life. We'll have moments when we either intentionally or unintentionally hurt people around us. However, when we're able to let go of our shame and offer kindness to ourselves, then we can own our mistakes. We can feel equipped to actively repair our damaged relationships.

Human beings are resilient. Believing that fact makes us even more resilient.

This is important to remember for ourselves, and we also might be in a position of sharing these ideas and practices with the people we support.

*You can read more about self-compassion in module **11. supporting someone who uses substances**. We also explore self-compassion and other resiliency practices in module **14. building personal resilience**.

CONTINUE

questions for reflection

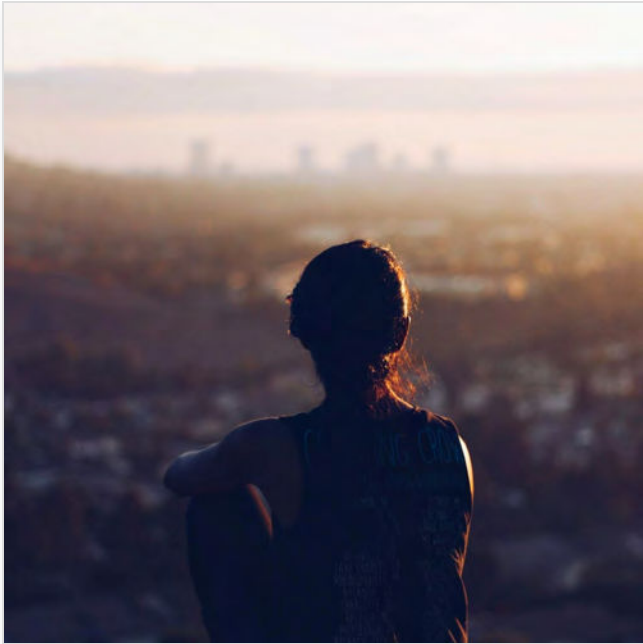
Answer these questions in your reflection journal.



What are some things you currently do that are strengthening your resilience?

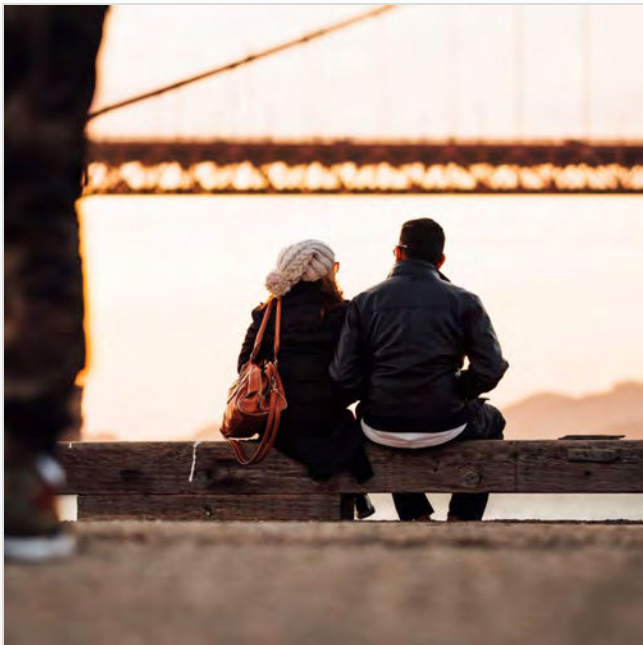


1 of 3



What would you like to try?

2 of 3



How can you share some of these ideas with the people you work with while practicing mutuality, supporting self-determination and avoiding advice-giving?

3 of 3

CONTINUE

Any time you're working with people, it's important to be aware of where you are with your own well-being. Self-awareness and self-nourishment are essential in this work. This is especially relevant if you're supporting someone who's in the midst of a crisis. There is a real risk of you experiencing retraumatization if you have been through something similar. Please support yourself and reach out when you need support. If you need to pass the baton, please do. If you need to take some time off for yourself, please advocate for that. Working when you're unwell can be potentially damaging to both you and the person you are supporting.

We cover this more in module **14. building personal resilience**.



17. when someone is in an acute crisis...

You may find yourself in a situation where someone you're working with is in a crisis. There are many different types of situations that can be labelled as a crisis.

the following are some potential crisis situations:

- ☐ Psychosis
- ☐ Panic attack
- ☐ Potential overdose
- ☐ Delusional state as a result of alcohol withdrawal
- ☐ Physical health crisis
- ☐ Retraumatization
- ☐ Suicidal ideation – in process, or in the planning stage (we'll cover this in **lesson 21**)
- ☐ Severe depressive episode
- ☐ Episode of mania



Each of these situations requires a different approach.

Being prepared for anything is important. If you're out in the community, having a phone and Naloxone is essential.

Be cautious about entering a person's home on your own. Many organizations have a policy that requires people to go into people's homes in pairs.

Be ready to call 9-1-1 if you come across anything you feel you can't handle.

talk about crisis with the people you're working with when they are well

As we've already covered in this module, setbacks are a normal part of the human experience. There's no shame in having a crisis. Part of the way we normalize this is by talking about it. When something is talked about, the shame attached to it can begin to melt away.

Consider having an open conversation about crisis with the people you work with. In the spirit of mutuality, you can also share what crisis looks like for you. As we mentioned earlier, some people actually create a crisis plan, or advance directive, when they're well. This gives them a sense of control even when things are spinning out of control. You can talk with them about this plan, as well as your own, to remove any sense of shame or fear.

You can also talk with your peer about what the signs of crisis look like. What would they like you to do as a supporter if you were to see those signs? What's worked for them in the past? What would help them to feel safe and secure when they're in a crisis? Through these conversations, you'll know first-hand what they need and you won't have to guess.



CONTINUE

psychosis

Let's look in more detail at one of the crisis situations listed above, psychosis.

You'll notice we're taking a more clinical perspective in this section since many peer support workers will be working in clinical settings. Also, one of the core values of peer support – **respect, dignity and equity** – reminds us that all perspectives need to be heard.

any of these mental health diagnoses can induce a psychotic episode (this list is not exhaustive):

- ☐ Schizophrenia
- ☐ Schizoaffective disorder
- ☐ Bipolar
- ☐ Depression
- ☐ Post-partum depression/psychosis
- ☐ Substance use
- ☐ Alcohol withdrawal

☐

Brain injury

☐

Dementia

☐

Starvation (people with eating disorders can experience psychosis)

☐

Sleep deprivation

☐

And other medical conditions

CONTINUE



Only a doctor can diagnose something like psychosis. If, for example, we don't know someone's diagnosis and see symptoms of psychosis, we shouldn't assume we know what's happening. We just need to support them

where they're at – and seek support if we need it.

Here are some facts about psychosis.

regularity varies

Psychosis can be a regular experience for some people. For others, it can be a one-time event or happen irregularly.

saving a life

Psychosis can be a symptom of a disorder like schizophrenia. Psychosis can also be a symptom of a serious medical condition. Regardless, paying attention to the signs of psychosis can perhaps save a life.

an indicator

Psychosis is a syndrome or a grouping of symptoms, not a disorder itself. It's an indicator that there's something else wrong.

disruptive experience

Psychosis is described by some as a "break from reality." It feels 100% real to the person experiencing it and can be very disruptive to their life.

affects —

Psychosis can affect perception, thoughts and behaviours.

stigma —

People who experience psychosis also experience stigma and discrimination. As peer support workers, it's very important to work at breaking down that destructive stigma.



CONTINUE



Psychosis involves a combination of symptoms. Some are behaviours that are added or expressed and some are behaviours that have gone missing.

Added/expressed behaviours include:



Hallucinations: This means someone perceives things that others around them aren't perceiving. Hallucinations can include visions, tastes, smells, sounds and sensations. Emotions

and feelings can feel mixed up, and the person experiencing hallucinations can be confused.



Delusions: A delusion is a strong and firmly held belief that other people's perceptions and experiences don't affirm. For example, a person might have a delusional belief that they hold special powers or abilities that make them more powerful than they actually are. Or someone may believe they're being unfairly targeted by a person, a group of people or perhaps a famous organization. Paranoia and elevated fear often come with delusions. These feelings seem very real to the person experiencing them.



Disorganized thinking and speech: Thoughts can move rapidly. They can be disjointed and jump all over the place. Speech can be hard to understand. Written words, such as texts, can also be confusing and hard to understand.

Missing behaviours include:



Expression and engagement: The person might lack their usual emotional expression. They might be very withdrawn and unmotivated compared to their usual behaviour. [NOTE: This could also be a sign of hypoarousal in neurodivergent people.]

Not all psychosis involves missing behaviours.



18. tips to support calm in an intense crisis

Crisis can be very intense. It may also differ from one person to the next.

For some people, a crisis can be more episodic in nature, meaning it's a one-time, intense and often aggressive situation. For others, a crisis can be less intense and last much longer, perhaps even several months or years. The way we support someone depends on what their crisis looks like.





If we're working with someone who's experiencing a more acute, intense crisis, it's important to know some ways to create a calmer environment in the moment. De-escalation is the more clinical term for this.

In a moment of intense crisis, the stress response is active and the sympathetic nervous system is engaged. (This is covered in module **8. healing-centred connection: principles in trauma-informed care**.) Stress hormones like adrenaline and cortisol are pumping through the body, which can cause a fight, flight or freeze response. This is true for both the person who's experiencing the crisis and for you, the person in the supportive role.

In such cases, you'll need to try to regulate your stress. As you're able to calm your sympathetic nervous system, you'll feel more capable to support someone else. A simple way to do this is by utilizing some breathing techniques. We cover this approach – and more – in module **14. building personal resilience**.

With regard to the person you are supporting, there are some actions you can take to de-escalate, but there is no set recipe, no one-size-fits-all approach. You might find yourself in a situation where nothing seems to help. Or perhaps, like in the life application story in lesson 8, it does.

CONTINUE

tips to remember that can de-escalate a crisis situation and support the person struggling

The tips below are not about suppressing a person, but instead, are about tapping your empathy and compassion so you can connect with and support them so they are seen and heard.

Communication is the key to managing a crisis situation. Awareness of our own communication is essential. As long as no one is in immediate danger, you have time to slow down and be deliberate. When you slow down and work on connection and communication, it could easily stop the situation from getting worse.

Remember: If at any point you are concerned about the safety of the person you're with, your own safety or that of anyone around you, consider it an emergency situation and follow your agency's emergency protocols.

Consider safety

Notice any potential safety issues for all in the vicinity. Are you in a location where someone could potentially fall or be hurt in some way?

Avoid restraining someone

Restraints can be very traumatic for people. The recovery movement is leading an initiative to stop the use of restraints and seclusion. Many recovery-oriented programs also avoid these things as much as possible.

Give space

It's best to give someone space and not crowd them. People can feel ganged up on if everyone is in their personal space. This can continue to escalate them.

Be empathetic

Accept the person's feelings exactly as they are. They're real and powerful to them in the moment. Responding to them with empathy is very validating, and it acknowledges their reality.

Be conscious of your tone

Manage your own responses in the moment. If you're very anxious, fearful and aggressive, the other person will likely respond in kind and continue to experience intense stress and fear.

Be aware of your own biases and judgements

Work to withhold them. Being judgemental and harsh with someone is never supportive, and especially to someone who's in a crisis.

Limit your words

The fewer words you use in the moment the better. When our brains are in crisis mode, our comprehension goes down. The stress response puts us into survival mode. Choose simple language and avoid too many words. This way the person is more likely to be able to take in the information.

Build connection

This is not the time to challenge someone or ask a lot of questions. Don't try to convince someone that they're wrong. Don't argue. Just be with them exactly where they are at the moment.

Focus on feelings

Rather than challenging someone, focus on the feelings they're experiencing. You don't have to validate exactly what they're saying, but validating their feelings is so important. Offer kindness, compassion and empathy for where they are. If you've been through something similar, you can share that in a way that creates connection and doesn't cause them to be overwhelmed. Saying something like, "You're not alone. I'm here with you. I have been in a similar place myself," can be comforting. If sharing appears to make the person more agitated, then hold back.

Be aware of your non-verbal communication

You can say all the right things but if your non-verbal communication or tone is aggressive or defensive, the person may end up feeling worse. Be as aware as you can be about using facial expressions that show calm, care and connection.

Offer choices and options

Rather than telling someone what to do, offer some potential options. But not too many – that can be overwhelming. Module **4. self-determination** explains that choice is always very important.

Be clear on any limitations

Don't leave room for ambiguity. It's very important to have clarity on the limits within the situation. Again, be aware of your tone and non-verbal communication. If you have to repeat yourself several times, that's okay.

Module **6. understanding boundaries & what it means to co-create them** explores this topic.

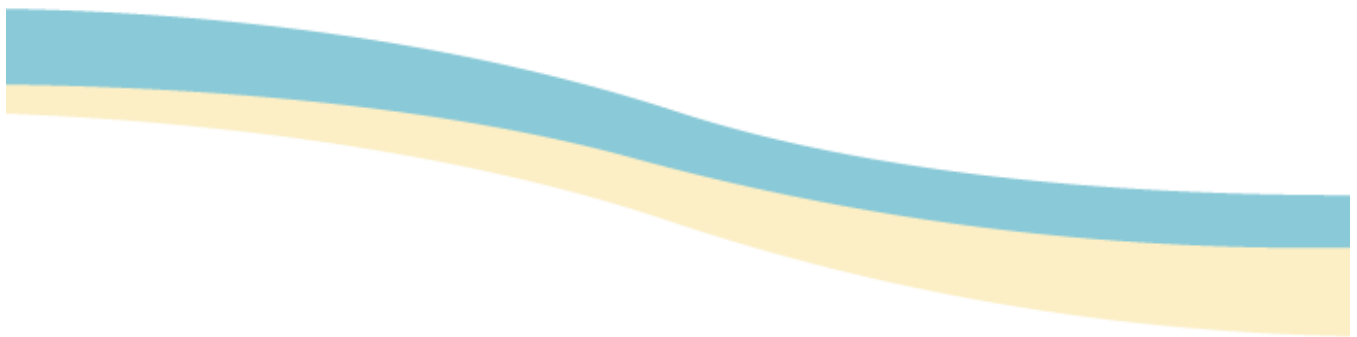
Allow time for reflection

Be okay with silence. Create opportunities for reflection. These moments allow for the person to de-escalate, breathe and begin to relax.

Try deep breathing and grounding exercises

These are scientifically proven to relax us. Some people might be agitated if you push this on them though. Ask first. Grounding and mindfulness techniques support us to connect to the room, our bodies, our senses, our breath. Sometimes if you choose to very deliberately work on your own breathing, the person might follow suit.

After we've supported someone through a crisis, we'll find that our sympathetic nervous system is engaged. Attending to our own well-being is important. We can close off the stress response by debriefing with someone, moving our bodies, journaling or meditating.



19. a note about voice-hearing

voice-hearing

When someone is hearing, seeing or sensing something that others around them aren't. These experiences can include all five senses – hearing, sight, smell, taste and touch. These experiences can occur in one sense at a time (hearing a voice, for example, or smelling something), but they can also

1 of 1

These five points are adapted from a document by local peer K.C. Pearcey about voice-hearing.



Make no assumptions: many voice hearers do not seek medical treatment, do not consider themselves ill and do not have a diagnosis.



Sometimes voice hearers are comforted by having a mental health diagnosis and by medical language such as psychosis, hallucinations or delusional thinking. But many people find this language stigmatizing. They have other beliefs about what their experiences are, such as:

- Spiritual
- Telepathic
- Ancestral
- Conspiratorial
- Technological
- Alien



Stereotypes of people being violent and dangerous to society persist, especially if they are hearing command voices. The news media sensationalizes this. Statistically, far more people with a diagnosis of schizophrenia, or who experience psychosis, are **victims** of violence rather than being **perpetrators** of violence.



Voice hearers, vision seers and people with unique belief experiences are real and most of these people are able to discern what consensus reality is. They handle life well and are able to manage their experiences and beliefs.



Voice hearers, vision seers and people with unique beliefs are experts about their experiences and have tremendous insight to share.

CONTINUE



hearing voices network

[Hearing Voices Network](#) (HVN) is a national non-profit organization. There are also a few chapters in B.C.

The following is an excerpt from the [BC Hearing Voices Network](#) website:

The Hearing Voices Movement was begun by Dr. Marius Romme, a professor of social psychiatry, science journalist Dr. Sandra Escher and voice-hearer Patsy Hage in 1987 – after Hage challenged Romme about why he couldn't accept the reality of her voice hearing experience. As voice hearer Ron Coleman has said, if someone is hearing voices, something real is happening. The movement challenges conventional wisdom in other ways also, challenging the notion that to hear voices or have other unusual sensory experiences necessarily needs to be understood as mental illness but may instead be seen as a normal part of the continuum of human experience, an experience that is sometimes even valued. Having said that, our groups sanction the right to interpret our experiences in any way, including illness.

If you are interested in joining a community, there are chapters of BC-HVN in Chilliwack, Langley, New Westminster, North Vancouver and Vancouver.

20. self-harm

self-harm

Any behaviour that inflicts a physical injury on oneself.

1 of 1

You may work with someone who uses self-harm as a coping skill. You may also have used or currently use it as a means to cope.

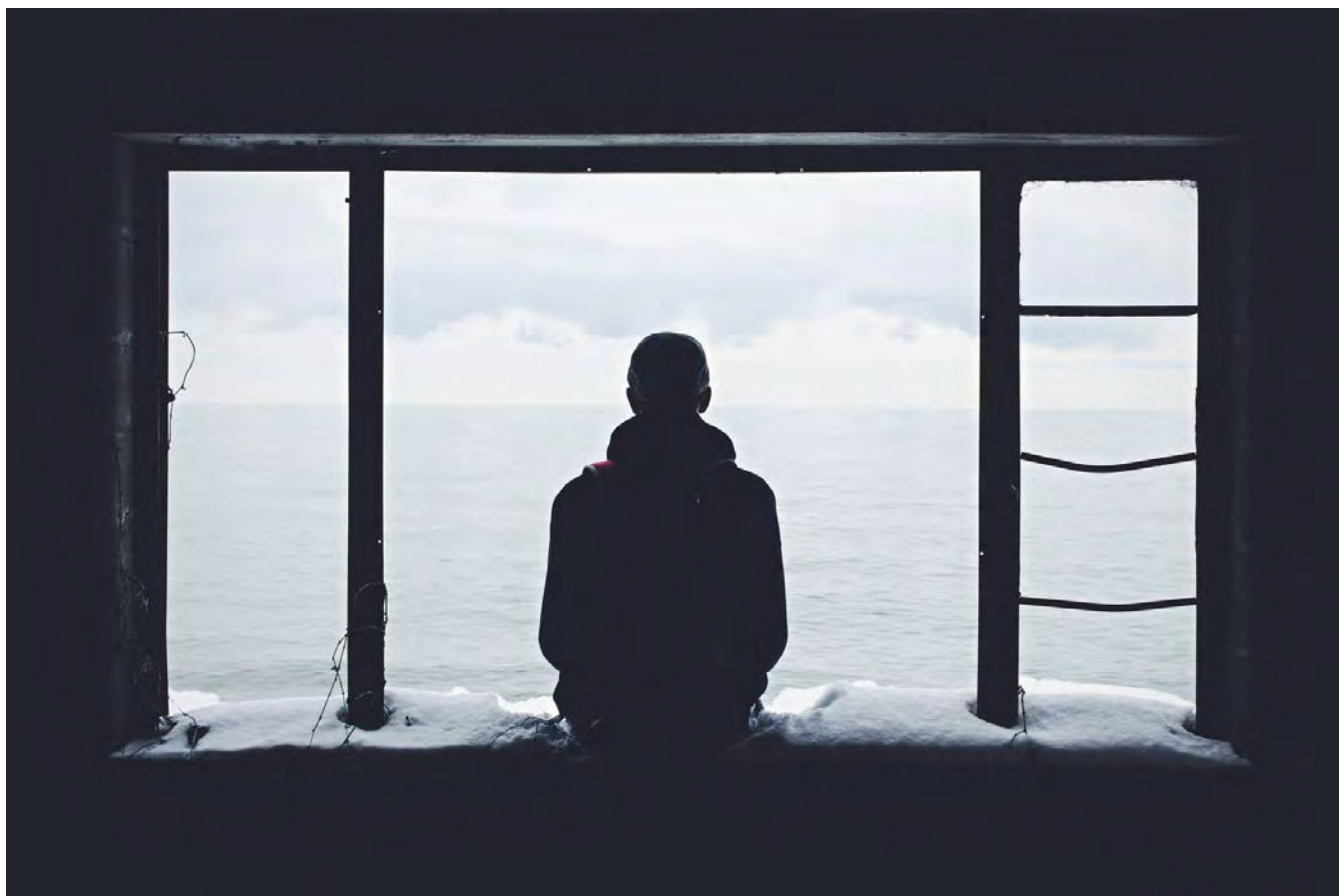
Self-harm is any behaviour that inflicts a physical injury on oneself. Self-harm is common. The [Recovery Village](#) website states that 17% of the population have self-harmed at some point in their lives. Self-harm is not equivalent to a suicide attempt. Young people are statistically more apt to self-harm, and all genders can engage in it. Self-harm is not a mental health condition but can be a way that someone copes with a mental health condition. When we support the underlying needs of a person, they'll be less likely to self-harm.

We need to understand that self-harm is a reaction to other issues in a person's life –problems such as low self-worth, trauma, loss, overwhelming emotions, extreme stress, bullying or others. Many people who self-harm have expressed feeling numb and a loss of control of their life and discuss self-harm as a coping tool to help release the pain.

People who self-harm most often keep it secret and can feel ashamed about it. A myth around self-harming is that the person wants to die. That's not the case. People tend to self-harm as a way to cope with their deep pain.

It's essential that you never take an authoritarian approach to supporting someone who self-harms. If it's something that's new to you, it can be easy to shame someone about it. Telling someone that they shouldn't self-harm will never be effective: shame and stigma are never helpful.

Extending kindness, love and compassion is an important way we can support someone who self-harms.



21. suicide



When someone tells us that they are contemplating suicide, it feels terrifying and overwhelming. It can be easy to slip into an intense panic mode, which makes us focus on the symptoms we see rather than the person as a whole.

The following chart is shared from Shery Mead's intentional peer support work. It contrasts two

possible responses to a crisis: one from a place of hope, and one from a place of fear:

Response made from a place of hope	Response made from a place of fear
Sitting with the discomfort of the situation	Trying to stabilize the situation
Staying connected to the person	Taking care of, helper/helpee
Seeing unpredictability as possibility	Going back to the way things were. Striving for predictability

Both you and the person you are supporting will benefit from calm presence rather than panicked reactions.

First thing – take a moment to calm your nervous system. Breathe a bit deeper to help regulate your body and emotions. Consider using some of the relaxation techniques we explore in this training.

As long as you are with the person, they are safe. This gives you some time to just be present with them.

Don't worry about time; take all the time needed to listen to them share about what's happening for them and how they're feeling. Human connection, empathy and shared experience – that's what it's all about.

And know that if you have exhausted all other options and support you are always able to call 9-1-1 if the situation escalates.

CONTINUE

some warning signs of suicide:

- ☐ Long-term, unrelenting anxiety or depression
- ☐ Increased agitation
- ☐ Giving away belongings – especially possessions that are meaningful to the person
- ☐ Stockpiling medications
- ☐ Previous suicide attempts
- ☐ Talking about suicide
- ☐ Reckless behaviour
- ☐ Hopelessness
- ☐ Inappropriately saying goodbye
- ☐ Increased use of drugs or alcohol
- ☐ Withdrawing more than usual from others
- ☐ Increased emotional display, such as rage or sadness
- ☐ Verbal behaviour that's ambiguous or indirect (e.g., "I'm going away on a real long trip," or "I don't want to be a burden on others")
- ☐ A sudden, unexpected state of calm



Please learn your agency's policies on suicide and suicide prevention. We encourage you to take as much training as you can. Applied Suicide Intervention Skills Training (ASIST) and Suicide Attempt Follow-up, Education & Research ([SAFER](#)) are good options.

Ask for help if you need it. It's better to err on the side of caution when you suspect someone to have a plan for suicide.

CONTINUE

language and suicide

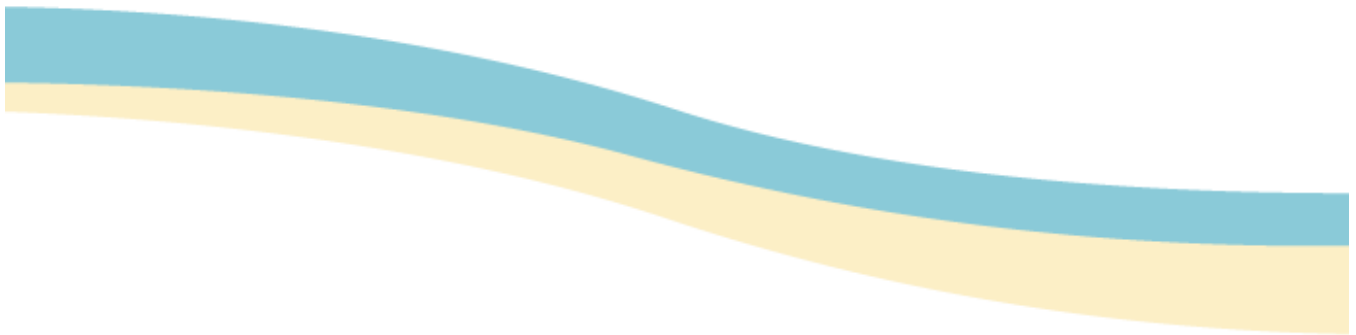
Words matter. The way we speak about suicide matters greatly. It's important to be hopeful and respectful in our language, as words have great power.

Instead of saying this...	Say this...	Why?
Commit/committed suicide	<ul style="list-style-type: none"> • Died by suicide • Death by suicide • Lost their life to suicide 	The word “commit” comes from a time when suicide was considered a crime. It reinforces a stigma around suicide being an illegal and selfish act.
Completed suicide or successful suicide	<ul style="list-style-type: none"> • Died by suicide • Death by suicide • Lost their life to suicide 	Using either the words “successful” or “completed” is inappropriate because suicide is tragic. Those two words are not congruent with suicide. It’s better to take a direct approach. Suicide is fatal, or it isn’t.
(Name) is suicidal	<ul style="list-style-type: none"> • (Name) is thinking of suicide • (Name) is or has experienced suicidal thoughts • (Name) is facing suicide 	As with all person-first language, we never want to define someone by an illness or struggle. They are more than their suicidal thoughts.

The above information was sourced from:

“Words matter. Learning how to talk about suicide in a hopeful, respectful way has the power to save lives,” from the Centre for Addiction and Mental Health (CAMH).

“Language Matters: Committed Suicide vs. Completed Suicide vs. Died by Suicide” from the [Speaking of Suicide](#) website.



22. hope

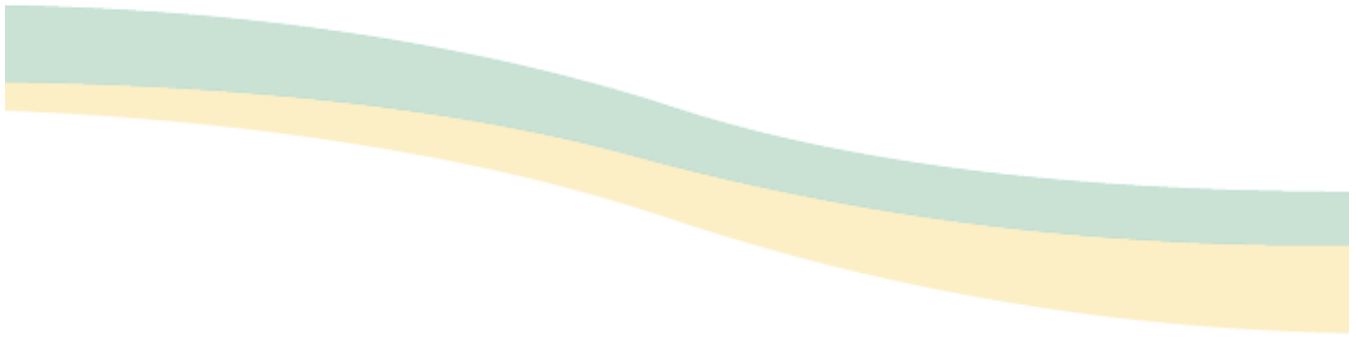


Let's look again at this quote from *Crisis and Connection* (Mead, Hilton 2002) that we referenced at the beginning of this module:

When people are willing to listen to each other's stories without providing analysis, and at the same time compare and contrast experiences, possibilities for transfiguring meaning are endless. When we become part of each other's narratives, we not only offer possibility for alternate (mutually enriching) interpretations,

our new shared story becomes a way to negotiate future challenges and crises while building real communities.

When we learn to reframe crisis – and are able to support someone through crisis with a lens of hope – we're able to create new, shared meaning. This way of being supports interconnection, hope-building and resilience. We can learn to reframe our approach and find hope and possibility in crisis.



23. core values assessment

question for reflection

Answer this question in your reflection journal.



In what ways have the core values
(see list below) intersected with the
topic of supporting those in crisis?

1 of 1

CONTINUE

core peer support values



acknowledgement —

All human beings deserve to be seen for who they are.

IN ACTION: Peer support strives to acknowledge – and deeply hear – people where they are in their journey.

PSWs SUGGEST: Asking open-ended questions and actively listening to the PSW to see if they feel comfortable sharing their experience. Ask: “What do you think about that situation?” “Is there a coping strategy that you have used in a previous similar experience that worked for you?”

mutuality —

All healthy relationships are mutual and reciprocal.

IN ACTION: Peer support relationships are co-created, with all parties participating in boundary creation.

PSWs SUGGEST: Having a conversation about what is and isn’t okay to discuss with the PSW.

“...Even though I am a PSW, it’s painful for me to make eye contact with people. Hopefully, clients will see that if I’m looking away that it actually means that I am deeply listening to them. Being vulnerable and open seems to allow the other person to do their version of the same, building trust and respect and co-creating the relationship.”

strength-based —

Every human being has strengths.

IN ACTION: Peer support intentionally builds on existing strengths. It thoughtfully and purposefully moves in the direction of flourishing, rather than only responding to pain and oppression.

PSWs SUGGEST: Finding things that the PSW feels really confident about and expanding on those areas or delving into those areas and supporting their choices.

self-determination —

Motivation works best when it's driven from within.

IN ACTION: Peer support encourages self-determination and acknowledges and holds space for resilience and inner wisdom.

PSWs SUGGEST: Support the PSW in making decisions and doing things on their own – based on their wants, needs and goals.

respect, dignity & equity —

All human beings have intrinsic value.

IN ACTION: Peer support honours human value by

- Practicing cultural humility and sensitivity
- Serving with a trauma-informed approach
- Offering generosity of assumption
- Addressing personal biases mindfully
- Meeting people where they are
- Serving with a knowledge of equity

PSWs SUGGEST: Treat PSWs as you would like to be treated and expect to be treated. Learn about them on a personal level and treat them as equals.

belonging & community —

All human beings need to belong and be a part of a community.

IN ACTION: Peer support recognizes that many people have barriers that keep them from developing community and it actively works towards deconstructing those social blockades that prevent inclusion and acceptance. Peer support encourages a social justice mindset, and intentionally promotes empathy, compassion and self-compassion.

PSWs SUGGEST: Help PSWs feel wanted and cared about. Help them find resources that foster a sense of community and belonging.

“My quality of life improves immensely when I am surrounded by one or a community of people who understand me. I don’t feel alone. I can be myself among people who I know understand me on a deeper level. When I feel like I can be myself, I feel more confident and able to take positive risks, thus improving the quality of my life. The root of this is connection and being able to be seen for who I truly am. Peers can help people be seen in a real way.”

curiosity —

Curiosity and inquiry support connection, growth, learning and engagement.

IN ACTION: Peer support

- Is continually curious
- Challenges assumptions and narratives
- Asks powerful questions
- Offers generosity of assumption to those who think differently
- Knows that listening and asking questions is more important than providing answers

PSWs SUGGEST: Ask questions and be engaged in learning about your PSWs. Find out about their culture and explore with them.



24. summary

Let's review some of the key concepts covered in this module.

☐

This module isn't meant to replace agency manuals or policies. It's only meant to offer some tips for de-escalating someone in crisis.

☐

The greatest gift you can give to someone in crisis is your presence, attention and care.

☐

A peer support worker is not a clinician, but is part of the support team. As such, understanding what you can and can't do to support someone in a crisis – and afterwards – is essential.

☐

Your role is to focus on relationship and connection. Having some background education in mental health will create a deeper understanding of how to support someone. This includes understanding mental health diagnoses, the mental health system, the laws around someone receiving mental health services, and knowing of a place outside a hospital someone can receive support.

☐

You should learn to avoid jargon and the use of illness-focused language. Instead, peer support workers should learn to use strength-based, person-first, recovery-oriented language.

☐

Everyone experiences challenges. When we shift our mindset about crisis and setbacks, we can focus on creating stronger support systems and communities with others.

☐

Peer support workers must learn to self-assess when supporting someone who is in crisis. If a situation isn't manageable, you must take action to protect yourself.

☐

A family peer support worker also needs to take care to set boundaries for their own protection.



When you cultivate resilience while practicing self-compassion your capacity for taking personal responsibility expands.



It's important to be familiar with the symptoms of psychosis and know the mental health issues that can induce it.



Communication is key to managing a crisis situation. When you're able to slow down and work on communication and connection, a crisis can often be kept from getting worse.



Voice-hearing is a real condition and voice-hearers have tremendous insight about their experiences.



People who self-harm often do so as a coping skill. Self-harm is not a mental health condition but can be the way a person copes with a mental health condition.



When supporting someone who's suicidal, it's important to know your agency's policies on suicide. In general, a peer support worker should remain calm, take the time to build connection and practice empathy, and ask for help if it's needed.



25. next steps

We want to thank you for taking the time to walk alongside peer support workers on a shared path of learning from lived experience.

You are now ready to visit another module of the Peer Support Worker training curriculum!

Please head home to <https://peerconnectbc.ca> where you will find the individual training modules and facilitation guides. You will also find a [resource page](#) at that site to continue your learning about peer support work and the issues surrounding it.

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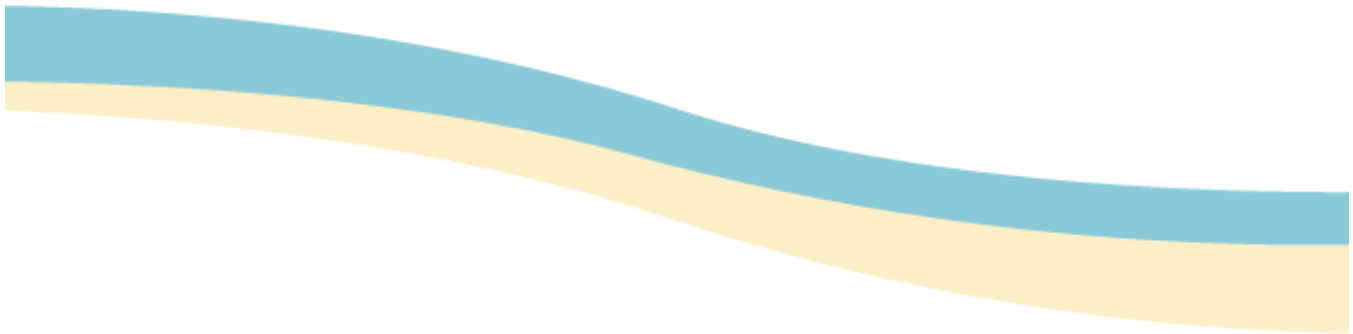
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