MyCounselor Online

FIRST RESPONDER REFERENCE GUIDE

Working together to increase access to excellent Christian counseling.

"Empowering Your Mission By Caring For Your People"

24/7 MCO HelpLine | 833-957-4357

We're here to help!
Sometimes you have questions about a situation that you could really use the input of a professional counselor on. The MCO HelpLine is a service of MyCounselor Online for our partner pastors and organizational leaders.

24/7 MCO HelpLine | 833-957-4357

You can call the HelpLine 24 hours a day / 7 days a week and a senior clinician from our team will get back with you for a consult on your situation within 24 hours.

Note: This line is not for clients or to give out to those you are referring. This phone number is only for pastors and organizational leaders seeking a consult from a senior clinician on a situation they are facing personally or within their organization. Individuals or Couples you are referring for counseling services should be directed to our website at MyCounselor.Online or to our toll-free client number: 855-55-WE-HELP / 855-593-4357

WHY, WHEN, AND HOW TO REFER TO COUNSELING

WHY

From a pastor's perspective...

> In 20 years of pastoral experience, I have learned that referring a member of my church to professional counseling is not an outsourcing of pastoral care, but rather a fulfillment of pastoral care. There are hurts, wounds, and beliefs that I simply need help speaking to by someone who is specifically trained to speak to those areas. I refer to MyCounselor because I know that my members will receive the truth of the gospel applied directly to the depth of their sin and hurt rather than simply treating the symptoms.
>
> **Joshua Hedger | Pastor of Teaching, Vision, and Family Equipping**
> Emmaus Church | 406 Armour Road 230 | North Kansas City, Mo 64116

Every Christian, with a Bible and Spirit of humility, can and should be confident to help a troubled friend with grace and truth. But, with humility, every Christian should acknowledge the limits of his or her own wisdom.

In ministry you will come across problems you've never experienced, situations you only have part of the story concerning, and relationships you don't have the depth yet to speak into. Humility is your best guard from unintentionally hurting someone when getting involved in a sensitive situation.

In humility we recognize our limitations in perspective and experience.

7 REASONS WHY PASTORS REFER

1. The Need is Beyond Your Training or Experience. Most pastors didn't receive much training in counseling during seminary and only spend a portion of their week providing counsel. So it's no surprise if you feel totally out of your element when you counsel others.

2. Concern about liabilities. Many pastors are not certain what they are required legally to report as a consequence of a counseling session. Others fear lawsuits as a result of counseling. Still others wonder about confidentiality issues and counseling.

3. Not fruitful. Some pastors do not see their counseling sessions as fruitful. They don't know if they are helping, hindering, or hurting. They don't know how to evaluate the effectiveness of their counseling. Some wonder with transparency if they are wasting their time.

4. Time consuming. Most pastors are overworked. Their workweek can be 60 or 70 hours or longer. They are on call 24/7. When they look for places to find margin, it is not uncommon to see them choose to reduce or eliminate their counseling hours by referring to professional Christian counselors.

5. Fearful of blame. Often the most-needy church members are most likely to seek counseling. Those same people are also likely to assign blame to the pastor if the counseling sessions do not meet their expectations.

6. Availability of referrals. MyCounselor Online is committed to Scriptural integrity and professional excellence in counseling. We meet with people wherever they want and with flexible scheduling options from 9 am to 9 pm. So many churches and church leaders know they can easily and confidently refer to one of our qualified counselors.

7. Opposite gender. This problem has become even more exacerbated by the #MeToo movement. Understandably, pastors are becoming more and more hesitant to counsel people of the opposite gender.

WHEN

For many situations pastoral counseling fully meets the needs of the person looking for help. So how do you know **when** it's time to refer?

- If hours of counseling keep you from meeting regular needs within the church, it may be time to seek the assistance of a Christian therapist.

- When addressing spiritual matters, a tell-tale sign that deeper troubles are looming is the person's ability to understand a spiritual truth, but their inability to accept it for themselves.When pastors find themselves frustrated or wondering what keeps the truth from becoming relevant to such an individual it is a sign that professional help may be needed.

- When family dynamics appear to be causing a level of stress that effects a person's ability to cope, family therapy may be appropriate.

- When the need exceeds the pastor's training and ability. If a pastor meets with someone several times, but notices minimal improvements, deeper issues may exist unbeknownst to either party.

- Any threat of harm to themselves or another is an urgent warning sign requiring professional oversight.

Common Referral Situations

MyCounselor specializes in Very Challenging situations.

- **Infidelity** - Infidelity in all it's forms (sexual, emotional or pornography) creates a significant wound to the individuals involved. Working through the complex emotions towards healing and reconciliation can require a lot of time and energy (easily 1-4 hours a week at the beginning).

- **Marital** - Marriage help is frequently sought from pastors. Often times, clergy are the first responders to crisis and ongoing struggles. Sometimes the couple is offered a number of book suggestions or referral to marital sermons. While these are valuable interventions, some marital struggles involve complicated relationship dynamics which need to be addressed in a dynamic, case by case basis.

- **Sexual Difficulties** - Sex doesn't always come easily for couples. Sometimes they need some coaching from a professional trained in troubleshooting sexual difficulties to overcome the challenges. Common sexual difficulties we help couples with include: Low sexual desire, pain during sex, erectile difficulties, premature ejaculation, anorgasmia (inability to orgasm).

- **Same-Sex Attraction & Gender Dysphoria** - Knowing how to help individuals and families going through same-sex attraction or gender dysphoria struggles beyond simply knowing what the Bible says can be very complicated. We know how to walk through that journey.

- **Sexual Abuse & Rape Trauma** - Even if the abuse or rape was a long time ago, if an individual has never worked through the wounds these will continue to negatively influence their life and relationships in the present.

- **Chronic Anxiety & Depression** - Everybody experiences some anxiety and depression over the course of their lifetime. Some people, however, are stuck in a chronic state of severe anxiety or depression. Sometimes this is brought on by an acute traumatic situation, natural disaster, loss of loved one suddenly, or significant illness. At other times the cause isn't exactly clear, but in spite of efforts to address the struggle the problem keeps persisting.

- **Self-Harm** - There are lots of different reasons why a person might engage self-harm (cutting, burning, suicidal thoughts, ect). The direction of helping individuals varies depending on what the self-harm is about. Professional counselors are trained to assess what is driving self-harm in each situation, tailor a treatment approach both for the individual, and to support those who love them.

- **Eating Disorders** - Anorexia, bulimia, and binge eating are common disorders that are not only difficult to identify but also complex to treat. We know how to come alongside the individual and families going through this to help them towards healing and wholeness.

- **Grief** - All of us experience grief in life. Some situations are harder to grieve than others and each person grieves differently. Sometimes people get stuck in their grief in a way that keeps them from moving forward in life. We help people who are stuck in grief from situations like the death of a child, spouse, or those suffering from a chronic or terminal illness.

- **Blended Family Struggles** - Divorce and remarriage are such a prevalent part of our society these days that close to half of families face some blended families struggles.
  These challenges have lots of moving pieces from all the people involved making them very complex and overwhelming.

- **Complex / Sensitive Situations** - Situations involving persons in leadership can be sensitive and complex in nature. We work with organizations to both assess situations, make recommendations, and help the people involved find healing. Our services are confidential and discreet.

- **Online Campus or Travelers** - Sometimes organization have people associated with them that either live remotely from their campus (like an online campus or missionaries on the field), members who travel frequently for work, or even live as expatriates in another country for work. It can be difficult to find resource for them to connect with in their area.
  Our services can be accessed anywhere there is internet.

HOW

What to Say

Navigating referral can be tricky. You don't want the person you're referring to feel rejected. This script will help you navigate the conversation in a healthy and loving way. You can, of course, modify it based on the situation and your personality.

> ***Thanks for meeting with me. I admire anyone who will admit they need help. It's a courageous step!***
>
> ***Like we talked about in the beginning of our initial meeting, there may be times when I refer people to another counselor that I trust. After our time together, I believe that there are counselors who have the skill and expertise to help you move toward healing. I want what's best for you, so I suggest that your next step is to meet with one of the counselors I recommend.***
>
> ***If you agree, I will follow through until you are connected with the best person for you and your needs. You can be confident that this church will stand behind you and support you in every way we can.***
>
> ***Let me know what you want to do. Thank you again for taking a courageous step!***

How to Connect Them

We make it easy for our partner organizations to make referrals. When you submit a referral to us we will reach out to the person you refer and walk them step-by-step through the process.

Three Easy Ways to Refer

1. Complete the referral web form on your phone or computer (takes 2 minutes): mycounselor.online/refer
2. Email our receptionist: receptionist@mycounselor.online
3. Call Us (855-55-WE-HELP / 855-593-4357)

What We Need to Know

The information we need for a referral is the same whichever method you choose.

- Contact information for the person making the referral
- Contact information for the person being referred
- What type of scholarship, if any, is being offered by the organization

Once you submit a referral we will reach out to the person to help them get scheduled.

OUR STORY

I'm Josh Spurlock, founder and director of MyCounselor.Online. God called me to the discipleship ministry of professional counseling. He charged me with both providing excellent counseling services and training up excellent Christian counselors in my generation. I've spent the last 15 years relentlessly pursuing that calling.

I share that with you because I believe referring someone to counseling is a big deal. You'll never know exactly what is said behind the closed door of the counselor's office. Being able to trust the character, calling, and commitment to Biblical, clinical, and professional excellence of the counselor is of great importance.

God called me to provide counsel that is true to the Bible and utilizes the best practices the helping professions have to offer. To prepare myself to do so I attended Bible college, studying Biblical languages (3 years of Greek, 2 years of Hebrew) followed by seminary for a Masters in Counseling. I practice as an ordained minister and licensed professional counselor (LPC).

As a team we embrace the Focus on the Family Statement of Faith and adhere to the American Association of Christian Counselors Code of Ethics.

A commitment to Biblical integrity and clinical excellence is a mandatory requirement for every counselor I hire.

At MyCounselor.Online I personally recruit every clinician on our team, hire them as employees of our practice, and oversee their training to ensure the counsel they provide will be true to the Scriptures and clinically sound.

If you have any questions about our theology, clinical orientation, or philosophy of practice – I invite you to call me personally at 720-306-8992 and I will be happy to answer any questions you have. I can also provide references from pastors who refer to us for the care of their people.

We're looking forward to the opportunity to serve you and your people.

Blessings!

Josh Spurlock, MA, LPC, CST
Founder / Director MyCounselor.Online

EMERGENCY NUMBERS

911 - Emergency
+1 (800) 273-8255 – National Suicide Prevention Lifeline
+1 (800) 799-7233 – National Domestic Violence Hotline
+1 (800) 996-6228 – Family Violence Helpline
+1 (800) 784-2433 – National Hopeline Network
+1 (800) 366-8288 – Self-Harm Hotline
+1 (800) 222-1222 – American Association of Poison Control Centers
+1 (800) 622-2255 – Alcoholism & Drug Dependency Hope Line
+1 (800) 233-4357 – National Crisis Line, Anorexia and Bulimia

LEGAL DEFINITIONS FOR ABUSE & NEGLECT (MISSOURI)

LEGAL DEFINITIONS OF CHILD ABUSE AND NEGLECT (Section 210.110, RSMo.; 13 CSR 35-31.010)

Child is defined as any person, regardless of physical or mental condition, under eighteen years of age.

Abuse is defined as any physical injury, sexual abuse, or emotional abuse inflicted on a child other than by accidental means by those responsible for the child's care, custody, and control, except that discipline including spanking, administered in a reasonable manner, shall not be construed to be abuse. Victims of abuse shall also include any victims of sex trafficking or severe forms of trafficking as those terms are defined in 22 U.S.C. 78 Section 7102(9)-(10).

Neglect is defined as the failure to provide, by those responsible for the care, custody, and control of the child, the proper or necessary support, education as required by law, nutrition or medical, surgical, or any other care necessary for the child's well-being. Victims of neglect shall also include any victims of sex trafficking or severe forms of trafficking as those terms are defined in 22 U.S.C. 78 Section 7102(9)-(10).

Those responsible for the care, custody, and control of the child includes, but is not limited to:

- The parents or legal guardians of a child;
- Other members of the child's household;
- Those exercising supervision over a child for any part of a twenty-four-hour day;
- Any person who has access to the child based on relationship to the parents of the child or members of the child's household or the family; or
- Any person who takes control of the child by deception, force, or coercion.

Emotional abuse is defined as any injury to a child's psychological capacity or emotional stability demonstrated by an observable or substantial change or impairment in the child's behavior, emotional response, or cognition, which may include, but is not limited to: anxiety, depression, withdrawal, or aggressive behavior; and which may be established by either lay or expert witnesses.

Physical injury is defined as any bruising, lacerations, hematomas, welts, permanent or temporary disfigurement; loss, or impairment of any bodily function or organ, which may be accompanied by physical pain, illness, or impairment of the child's physical condition.

Proper or necessary support includes adequate food, clothing, shelter, medical care, or other care and control necessary to provide for the child's physical, mental, or emotional health or development.

Sexual abuse is defined as any sexual or sexualized interaction with a child, except as otherwise provided in paragraph 2 below:

1. Sexual abuse shall include, but is not limited to:

(A) Any touching of the genitals, anus or buttocks of a child, or the breast of a female child, or any such touching through the clothing; any act involving the genitals of a child and the hand, mouth, tongue, or anus of another person; or any sexual act involving the penetration, however slight, of a child's mouth, penis, female genitalia, or anus by any body part of another person, or by any instrument or object;

(B) Any conduct that would constitute a violation, regardless of arrest or conviction, of Chapter 566, RSMo. if the victim is less than eighteen (18) years of age, section 567.050, RSMo if the victim is less than eighteen (18) years of age, sections 568.020, 568.060, 568.080, or 568.090, RSMo, sections 573.025, 573.035, 573.037, or 573.040, RSMo, or an attempt to commit any of the preceding crimes;

(C) Sexual exploitation of the child, which shall include:

I. Allowing, permitting, or encouraging a child to engage in prostitution, as defined by state law; or

II. Allowing, permitting, encouraging, or engaging in the obscene or pornographic photographing, filming, or depicting of a child as those acts are defined by state law. This includes the storage or transmission of any data depicting said obscene or pornographic acts, images, or recordings.

2. Any reasonable interaction with a child, including touching a child's body for the purpose of providing the proper or necessary care or support of the child, shall not be considered sexual abuse. The touching of a child's body, including a child's genitals, buttocks, anus, or breasts for reasonable, medical, child rearing, or child care purposes shall not be considered sexual abuse.

3. The division shall not be required to prove that the alleged perpetrator received sexual gratification or that there was an exchange or promise of anything of value as a result of the act of sexual abuse to establish sexual abuse under Chapter 210 or 211, RSMo.

4. The use of force or coercion is not a necessary element for a finding of sexual abuse.

5. Sexual abuse may occur over or under the child's clothes.

6. The division shall not be required to prove that the child suffered trauma or harm as a result of the act of sexual abuse.

7. A child cannot consent to a sexual or sexualized act or interaction with a person responsible for that child's care, custody, and control.

Sex trafficking is defined as the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purpose of a commercial sex act.

Severe forms of trafficking in persons is defined as:

(A) Sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or 11

(B) The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

Commercial sex act is defined as any sex act on account of which anything of value is given to, promised, or received by any person.

REPORTING PROCEDURE (MISSOURI)

Information for the Child Abuse/Neglect Hotline Unit

Reports are to be made immediately to the 24 hour, 7 day a week Child Abuse/Neglect Hotline telephone number (1-800-392-3738 or 1-844-CAN-TELL) maintained by CD.

The Hotline is staffed by trained Children's Service Workers whose responsibility is to accept the information and make the determination that the information constitutes a child abuse/neglect report. The screening will determine that:

- The alleged victim is a child (less than eighteen (18) years-old) at the time of the hotline call;
- Whether or not the person who is alleged to have abused the child was "responsible for the care, custody, and control" of the child at the time of the incident;
- The alleged abuse or neglect is having an adverse effect on the child;
- The incident occurred in Missouri;
- The report meets the definition of abuse or neglect as defined by law; and
- Identifying information is available to locate the child/family.

The following information, if available, should be provided when making a report:

- The name, address, present whereabouts, sex, race, and birth date or estimated age of the reported child or children and of any other children in the household;
- The name(s), address(es), and telephone number(s) of the child's parent(s), or other person(s) responsible for the child's care;
- The name(s), address(es), and telephone number(s) of the person(s) alleged to be responsible for the abuse or neglect, if different from the parent(s);
- Directions to the home, if available, when the child's address is general delivery, rural route, or only a town;
- Other means of locating the family;
- Parents'/alleged perpetrators' place of employment and work hours, if known;
- The full nature and extent of the child's injuries, abuse, or neglect, and any indication of prior injuries, including the reason for suspecting the child may be subjected to conditions resulting in abuse or neglect; 13
- An assessment of the risk of further harm to the child and, if a risk exists, whether it is imminent;
- Any event that precipitated the report;
- If the information was provided by a third party, or if there were witnesses, the identity of that person(s);
- The circumstances under which the reporter first became aware of the child's alleged injuries, abuse or neglect;
- The action taken, if any, to treat, shelter, or assist the child;
- Present location of the child;
- Whether the subjects of the report are aware a report is being made;
- The name, address, work, and home telephone numbers, profession, and relationship to the child of the reporter;
- When was the child last seen by the reporter;
- Whether other children are in the home.

INDICATORS OF ABUSE AND NEGLECT

Parental/Familial Characteristics:

- Seems unconcerned about the child;
- Perceives the child as “bad,” “evil,” a “monster,” a “witch,” or “different”;
- Offers an inadequate or illogical explanation or has no explanation for the child’s injury;
- Gives different or contradictory explanations for the same injury;
- Attempts to conceal the child’s injury or to protect the identity of a person the caretaker says is responsible;
- Takes an unusually long time to obtain medical care for the child;
- Takes the child to a different doctor or hospital for each injury;
- Does not visit the child in the hospital;
- Does not ask about follow-up care;
- Disciplines the child too harshly considering the child’s age, condition, or what the child did;
- Abuses alcohol or other drugs; and/or,
- Has a history of physical abuse as a child.

Sexual Abuse The presence of indicators alone does not establish that sexual abuse or exploitation has occurred. It should be noted that physical indicators are present in only a very small percentage of sexual abuse cases.

Behavioral Indicators of Child:

- Child displays bizarre, sophisticated or unusual knowledge of sex;
- Acts out sexually;
- Child displays confusions over sexual identity;
- Victim has fear of men or women;
- Extreme curiosity about sexual parts of body;
- Excessivemasturbation;
- Excessive sexual activity with other children;
- Victim affectionless or extremely affectionate;
- Role reversal with same sex parent;
- Refuses to participate in physical education activities;
- Difficulty in sitting or walking;
- Child feels destroying parents’ marriage;
- Night terrors;
- Deviantsexual activity;
- Runs away;
- Withdrawn;
- Aggressive;
- Depressed;
- Enuresis;
- Regressed;
- Retreated into fantasy world;
- Poor peer relationships;
- Sudden school problems;

- Fire setting;
- Emotional instability;
- Delinquent;
- Extreme changes in behavior such as loss of appetite;
- Child has episodes of self-mutilation;
- Cruelty to animals;
- Low self-esteem;
- Defiance;
- Lying;
- Sleep disorders;
- Speech disorders; and/or,
- Self-destruction (i.e., head banging, drug abuse, obesity, or anorexia).

Parental/Familial Characteristics:

- Authoritarian father - ineffectual mother;
- Sexual problems in marriage;
- Role reversal between mother and daughter;
- Over protection of the daughter;
- Isolation, geographic isolation, lack of social or emotional contacts with people outside family;
- Poor self-esteem in family members;
- Repression and denial as coping mechanisms;
- Alcohol/drug problems – other addictions;
- High stress – unemployment, physical disability, etc.;
- Past sexual abuse in family;
- Poor sexual boundaries;
- Extreme passivity of the father;
- Power, tries to control wife, child, etc., but has no impulse control;
- Prolonged absence (emotionally and/or physically) of one parent from the home;
- Loss of one parent through death or divorce;
- Severe overcrowding in the home, especially in sleeping arrangements;
- Marital problems causing one spouse to seek physical affection from a child rather than from the other spouse;
- Cultural standards in a family which determine the degree of acceptable bodily contact;
- Family roles are rigid;
- Family members are socially fearful, placating, or blaming;
- Family members have difficulty expressing feelings; Attitudes regarding sexuality are repressed or confused;
- Mother passive/poor self-image;
- Parents claim victim is “seductive”;
- Child may mention subtle or veiled threats;
- May be evidence of “conditioning” process – including favoritism;
- Denial of non-abusive parent; and/or,
- Perpetrator abuses victims serially and one at a time.

Child Neglect Physical Indicators:

- Consistent hunger, poor hygiene, inappropriate dress;
- Consistent lack of supervision, i.e., child participates in dangerous activities or is unsupervised for long periods of time;
- Abandonment;
- Often tired or listless;
- Lack of adequate clothing;
- Illnesses associated with excessive exposure and poor hygiene (EXAMPLE - persistent scabies, bacterial infections, persistent head lice);
- Persistent diaper rash or other skin disorder;
- Chronically dirty or unbathed;
- Developmental delays (EXAMPLE-three-year old that doesn't verbalize);
- Consistently low blood count; and/or,
- Improper growth patterns, low weight or weight loss.

Behavioral Indicators in Child:

- Child begs or steals food;
- Child assumes an excessive amount of responsibility or relies heavily on another child;
- Child attends school irregularly, including excessive tardiness;
- Child remains at home for extended hours;
- Child falls asleep, is fatigued, or listless in school;
- Child abuses drugs or alcohol;
- Child engages in delinquent or status offender behavior, or has other contact with Juvenile or other Law Enforcement authorities;
- Extended stays in school (early arrival or late departure) or other places where care is provided;
- Child states there is no caretaker;
- Child is unable to form appropriate relationships with peers and adults; and/or,
- Eating disorders (example: over-eating/hoarding food).

Parental/Familial Characteristics:

- Highly stressful family situations;
- Single parent family;
- Several children
- Recent marital problems;
- Insufficient financial and other resources for child care;
- Isolated within the neighborhood;
- Developmental delays, character disorders, emotional illness of parent(s)
- Coldness, inability to empathize with child's needs;
- Alcoholism, drug abuse;
- Loneliness
- Poor self-esteem, immaturity, dependent, unable to carry continuing responsibility, poor, or distorted judgment;
- Parental history also reflects neglect;

- Parents are indifferent, emotionally detached from each other and/or the child(ren);
- Disorganized, inconsistent family life;
- Parent(s) is unable to make decisions, passively accepts events, waits for others to solve problems/provided needs
- Parent(s) is unwilling to accept referrals for tangible services;
- Parent(s) is unable to give information on child(ren)'s immunizations, illnesses, childhood milestones;
- Parent(s) has long-term chronic illness;
- Parent(s) cannot be found;
- Parent(s) provides for self before providing for needs of child; and/or,
- Parent(s) is apathetic, feels nothing will change.

Medical Neglect Examples of medical neglect include:

- Untreated serious physical or psychological illness or injury;
- Developmental delays; and/or
- Failure to thrive.

Educational Neglect

Educational neglect must be differentiated from truancy (a status offense). When a child is continuously absent from school through intent or neglect of the parent or caretaker, there is educational neglect. When a child is absent through his/her own intent, this is truancy and not reportable as child abuse/neglect.

Home schooling does not constitute educational neglect.

Indicators / Characteristics of Educational Neglect:

- A child being held responsible for the care of other children during the school day while the parent works;
- A parent who is unable to get the child fed and dressed in time to attend school; and/or,
- Failure of parent to obtain and /or cooperate with special or remedial instruction for the child when recommended and provided by the school and the child is not succeeding in current class placement.

Factors to Consider:

- Parent has been advised by school personnel of child's excessive absenteeism/special educational needs;
- Parent is providing home schooling; and/or
- Parent's religious practices prevent child's attendance in a public school setting.

Emotional Abuse and Child Behavioral Indicators:

- Habit disorders such as sucking, biting, rocking, enuresis, soiling, or feeding disorders;
- Conduct disorders including self-destructive and antisocial behavior, such as oblivious to hazards and risks, destructiveness, cruelty to self and others, stealing, hyperactivity, and disruptiveness;
- Neurotic disorders such as sleep problems, uninhibited play, depression, anxiety, and fearfulness;
- Behavior extremes such as extremely passive or aggressive, impulsive, overly compliant, very demanding, or withdrawn; and/or,
- Overly adaptive behaviors which are either inappropriately adult (parenting other children for example) or inappropriately infantile (rocking, head-banging, or thumb-sucking). Child Physical Indicators:
- Lags in physical development;
- Failure to thrive;
- Lags in emotional development;
- Empty or blank expression;
- Speech disorders;
- Lags in intellectual development;
- Attempted suicide;
- Avoidance of eye contact; and/or,
- Stress related physical symptoms, i.e. enuresis, hair pulling, ulcers, headaches, hives.

Family/ParentalCharacteristics and Behavioral Indicators:

- Verbal scapegoating and ridicule;
- Extremely inappropriate expectations in performance and behavior, etc.;
- Substance abuse;
- Psychosis – may view child as monster;
- Withholds love, sees child as bad or evil;
- Ignoring, blaming, or rejecting, unconcerned about child, unwilling to accept help;
- Threats to health or safety, uses excessive physical punishment;
- Bizarre behavior by parent;
- Deprived of emotional support as children, lack of self-esteem;
- Family may be socially isolated with few support systems;
- Frequent marital problems and life crises, such as spouse abuse, noncommunicative marriage, loss of employment, high level of indebtedness, lack of housing, and conflicts between divorced or separated parents; and/or,
- Lack of nurturing child-rearing practices.

Emotional abuse means an injury to the intellectual or psychological capacity of a child as evidenced by an observable and substantial impairment in his/her ability to function within a normal range of performance and behavior, with due regard to his/her culture.

The results of emotional abuse cover the entire spectrum of psychological and mental dysfunction. In order for intervention to be indicated, the child's maladaptive behaviors must be clearly observable, unalterable through normal channels (such as school), circumstantially caused.

Child Trafficking Child Behavioral and Physical Indicators:

- Frequent runaway episodes;
- A heightened sense of fear or distrust of authority;
- Unable to identify where they were while they were gone;
- Has money or material goods without a clear explanation of how they were obtained;
- Physical injuries with no explanation of how they were received;
- Has a sexually transmitted infection (STI) or a history of STIs;
- Uses drugs and/or alcohol;
- Reports sexual assaults by strangers;
- Talks about a paramour, but does not provide their identity;
- Frequent unexplained absences from school; • Involved in gang activity;
- Appears fearful, anxious, depressed, tense, nervous, paranoid, or hypervigilant;
- Has multiple cell phones;
- Has hotel keys or talks about staying in hotels;
- Has suspicious tattoos or other signs of branding;
- Child has inappropriate, sexually suggestive activity on social media, the internet, or cell phone apps; • Refuses to talk about their experiences while on runaway status; and/or,
- Child associates and/or has relationships with age-inappropriate friends and/or paramours.

Identification of Child Trafficking
Identifying victims of trafficking can be challenging due to the following:

- They may not view themselves as victims;
- They may not trust adults due to trauma they have experienced;
- They may be concerned they will face legal consequences for their role in sex trafficking; and/or,
- Their trafficker may have made threats to harm the child, their family, and/or friends.

Trauma Bonding

Often referred to as Stockholm syndrome, traumatic bonding of the child to their trafficker is often an influential factor that interferes with self-identification as a victim and in severing the child's relationship to their trafficker. Traffickers use power and control tactics to make their victims increasingly reliant on them for emotional and psychological needs. Children who are emotionally vulnerable due to a history of abuse/neglect are especially vulnerable to the tactics of traffickers.

CLERGY AS MANDATED REPORTERS

Mandated reporting laws can be tricky waters for pastors and organizational leaders to navigate. This guide will outline for you the requirements of all 50 states.

STATE STATUTES
Current Through August 2015

Clergy as Mandatory Reporters of Child Abuse and Neglect

Every State, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands have statutes that identify persons who are required to report child maltreatment under specific circumstances.[1] Approximately 28 States and Guam currently include members of the clergy among those professionals specifically mandated by law to report known or suspected instances of child abuse or neglect.[2] In approximately 18 States and Puerto Rico, any person who suspects child abuse or neglect is required to report it.[3] This inclusive language appears to include clergy but may be interpreted otherwise.

[1] For more information on mandated reporters, see Child Welfare Information Gateway's *Mandatory Reporters of Child Abuse and Neglect* at https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/manda/.

[2] The word "approximately" is used to stress the fact that States frequently amend their laws. This information is current only through August 2015. States that include clergy as mandated reporters are Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Georgia, Illinois, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Mexico, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, Vermont, West Virginia, and Wisconsin.

[3] Delaware, Florida, Idaho, Indiana, Kentucky, Maryland, Mississippi, Nebraska, New Hampshire, New Jersey, New Mexico, North Carolina, Oklahoma, Rhode Island, Tennessee, Texas, Utah, and Wyoming. Three of these States (Mississippi, New Hampshire, and New Mexico) also enumerate clergy as mandated reporters.

WHAT'S INSIDE

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Children's Bureau

Privileged Communications

As a doctrine of some faiths, clergy must maintain the confidentiality of pastoral communications. This is sometimes referred to as "clergy-penitent privilege," where "penitent" refers to the person consulting the clergy. Mandatory reporting statutes in some States specify the circumstances under which a communication is "privileged" or allowed to remain confidential. Privileged communications may be exempt from the requirement to report suspected abuse or neglect. The privilege of maintaining this confidentiality under State law must be provided by statute. Most States do provide the privilege, typically in rules of evidence or civil procedure.[4] If the issue of privilege is not addressed in the reporting laws, it does not mean that privilege is not granted; it may be granted in other parts of State statutes.

This privilege, however, is not absolute. While clergy-penitent privilege is frequently recognized within the reporting laws, it is typically interpreted narrowly in the context of child abuse or neglect. The circumstances under which it is allowed vary from State to State, and in some States it is denied altogether. For example, among the States that list clergy as mandated reporters, Guam, New Hampshire, and West Virginia deny the clergy penitent privilege in cases of child abuse or neglect. Four of the States that enumerate "any person" as a mandated reporter (North Carolina, Oklahoma, Rhode Island, and Texas) also deny clergy-penitent privilege in child abuse cases.

In States where neither clergy members nor "any person" are enumerated as mandated reporters, it is less clear whether clergy are included as mandated reporters within other broad categories of professionals who work with children. For example, in Virginia and Washington, clergy are not enumerated as mandated reporters, but the clergy-penitent privilege is affirmed within the reporting laws.

Many States and territories include Christian Science practitioners or religious healers among professionals who are mandated to report suspected child maltreatment. In most instances, they appear to be regarded as a type of health-care provider. Only 10 States explicitly include Christian Science practitioners among classes of clergy required to report.[5] In those States, the clergy-penitent privilege also is extended to those practitioners by statute.

[4] The issue of clergy-penitent privilege also may be addressed in case law, which this publication does not cover.

[5] Alaska, Arizona, Arkansas, Louisiana, Massachusetts, Missouri, Montana, Nevada, South Carolina, and Vermont. American Samoa requires Christian Science practitioners to report, but it is not clear from the context whether they are considered clergy or health-care providers.

The following chart summarizes how States have or have not addressed the issue of clergy as mandated reporters (either specifically or as part of a broad category) and/or clergy penitent privilege (either limiting or denying the privilege) within their reporting laws.

	Privilege granted but limited to pastoral communications	Privilege denied in cases of suspected child abuse or neglect	Privilege not addressed in the reporting laws
Clergy enumerated as mandated reporters	Alabama, Alaska, Arizona, Arkansas, California, Colorado, Georgia, Illinois, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nevada, New Mexico, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, Vermont, Wisconsin	Guam, New Hampshire, West Virginia	Connecticut, Mississippi
Clergy not enumerated as mandated reporters but may be included with "any person" designation	Delaware, Florida, Idaho, Kentucky, Maryland, Utah, Wyoming	North Carolina, Oklahoma, Rhode Island, Texas	Indiana, Nebraska, New Jersey, Tennessee, Puerto Rico
Neither clergy nor "any person" enumerated as mandated reporters	Virginia, Washington[6]	Not applicable	American Samoa, District of Columbia, Hawaii, Iowa, Kansas, New York, Northern Mariana Islands, South Dakota, Virgin Islands

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[6] Clergy are not mandated reporters in Washington, but if they elect to report, their report and any testimony are provided statutory immunity from liability.

Alabama

Ala. Code § 26-14-3(a), (f)

Members of the clergy (as defined in Rule 505 of the Alabama Rules of Evidence) shall be required to report or cause a report to be made immediately when a child is known or suspected to be a victim of child abuse or neglect—either by telephone or direct communication, followed by a written report—to a duly constituted authority.

A member of the clergy shall not be required to report information gained solely in a confidential communication, privileged pursuant to Rule 505 of the Alabama Rules of Evidence, as such communications shall continue to be privileged as provided by law.

Alaska

Alaska Stat. § 47.17.020(d)

This section does not require a religious healing practitioner to report as neglect of a child the failure to provide medical attention to the child if the child is provided treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination by an accredited practitioner of the church or denomination.

American Samoa

Ann. Code § 45.2002(a), (b)(11)

Any mandatory reporter who has reasonable cause to know or suspect that a child has been subjected to abuse or neglect, or who has observed the child being subjected to circumstances or conditions that would reasonably result in abuse or neglect, shall immediately report or cause a report to be made of that fact to the agency, who immediately informs the department.

Persons required to report the abuse or neglect or circumstances or conditions include any Christian Science practitioner.

Arizona

Ariz. Rev. Stat. Ann. § 13-3620(A), (L)

Any member of the clergy, priest, or Christian Science practitioner who reasonably believes that a minor is or has been the victim of injury, abuse, child abuse, a reportable offense, or neglect shall immediately report or cause a report to be made.

A member of the clergy, a Christian Science practitioner, or a priest who has received a confidential communication or a confession in that person's role as a member of the clergy, a Christian Science practitioner, or a priest in the course of the discipline enjoined by the church to which the member of the clergy, Christian Science practitioner, or priest belongs may withhold reporting of the communication or confession if the member of the clergy, Christian Science practitioner, or priest determines that it is reasonable and necessary within the concepts of the religion. This exemption applies only to the communication or confession and not to the personal observations the member of the clergy, Christian Science practitioner, or priest may otherwise make of the minor.

In any civil or criminal litigation in which a child's neglect, dependency, physical injury, abuse, child abuse, or abandonment is an issue, a member of the clergy, a Christian Science practitioner, or a priest shall not, without his or her consent, be examined as a witness concerning any confession made to him or her in his or her role as a member of the clergy, a Christian Science practitioner, or a priest in the course of the discipline enjoined by the church to which he or she belongs. This subsection does not discharge a member of the clergy, a Christian Science practitioner, or a priest from the duty to report as required above.

Arkansas

Ark. Code Ann. § 12-18-402

A clergy member shall immediately notify the Child Abuse Hotline if he or she:

- Has reasonable cause to suspect that a child has been subjected to child maltreatment, died as a result of child maltreatment, or died suddenly and unexpectedly
- Observes a child being subjected to conditions or circumstances that would reasonably result in child maltreatment

A clergy member includes a minister, priest, rabbi, accredited Christian Science practitioner, or other similar functionary of a religious organization, or an individual reasonably believed to be so by the person consulting him or her. Clergy must report suspected child maltreatment except to the extent the clergy member:

- Has acquired knowledge of suspected child maltreatment through communications required to be kept confidential pursuant to the religious discipline of the relevant denomination or faith
- Received the knowledge of the suspected child maltreatment from the alleged offender in the context of a statement of admission

A privilege or contract shall not prevent a person from reporting child maltreatment when he or she is a mandated reporter and required to report under this section.

Ark. Code Ann. § 12-18-803(b)

No privilege, except that between a lawyer and client or between a minister, including a Christian Science practitioner, and a person confessing to or being counseled by the minister, shall prevent anyone from testifying concerning child maltreatment.

California

Cal. Penal Code § 11166(d)

A clergy member who acquires knowledge or reasonable suspicion of child abuse during a penitential communication is not required to make a report. For the purposes of this subdivision, 'penitential communication' means a communication intended to be in confidence—including, but not limited to, a sacramental confession—made to a clergy member who in the course of the discipline or practice of his or her church, denomination, or organization is authorized or accustomed to hear those communications and under the discipline, tenets, customs, or practices of his or her church, denomination, or organization, has a duty to keep those communications secret.

Nothing in this subdivision shall be construed to modify or limit a clergy member's duty to report known or suspected child abuse when a clergy member is acting in some other capacity that would otherwise make the clergy member a mandated reporter.

On or before January 1, 2004, a clergy member or any custodian of records for the clergy member may report to an agency specified in § 11165.9 that the clergy member or any custodian of records for the clergy member, prior to January 1, 1997, in his or her professional capacity or within the scope of his or her employment, other than during a penitential communication, acquired knowledge or had a reasonable suspicion that a child had been the victim of sexual abuse and that the clergy member or any custodian of records for the clergy member did not previously report the abuse to an agency specified in § 11165.9.

This paragraph shall apply even if the victim of the known or suspected abuse has reached the age of majority by the time the required report is made.

The local law enforcement agency shall have jurisdiction to investigate any report of child abuse made pursuant to this paragraph even if the report is made after the victim has reached the age of majority.

Cal. Penal Code § 11165.7(a)(32)-(33)

A mandated reporter is defined as any of the following:

- A clergy member, as specified in § 11166(c)
- Any custodian of records of a clergy member, as specified in this section and § 11166(c)

As used in this article, 'clergy member' means a priest, minister, rabbi, religious practitioner, or similar functionary of a church, temple, or recognized denomination or organization.

Colorado

Colo. Rev. Stat. Ann. § 13-90-107(1)(c)

A clergy member, minister, priest, or rabbi shall not be examined without both his or her consent and also the consent of the person making the confidential communication as to any confidential communication made to the clergy member, minister, priest, or rabbi in his or her professional capacity in the course of discipline expected by the religious body to which he or she belongs.

Colo. Stat. Ann. § 19-3-304(2)(aa)

Persons required to report abuse or neglect or circumstances or conditions shall include any clergy member.

The provisions of this paragraph shall not apply to a person who acquires reasonable cause to know or suspect that a child has been subjected to abuse or neglect during a communication about which the person may not be examined as a witness pursuant to § 13-90-107(1)(c), unless the person also acquires such reasonable cause from a source other than such communication.

For purposes of this paragraph, unless the context otherwise requires, 'clergy member' means a priest; rabbi; duly ordained, commissioned, or licensed minister of a church; member of a religious order; or recognized leader of any religious body.

Connecticut

Conn. Gen. Stat. Ann. § 17a-101(b)

The following persons shall be mandated reporters: members of the clergy.

Delaware

Del. Code Ann. Tit. 16, § 909

No legally recognized privilege, except that between attorney and client and that between priest and penitent in a sacramental confession, shall apply to situations involving known or suspected child abuse, neglect, exploitation, or abandonment and shall not constitute grounds for failure to report as required or to give or accept evidence in any judicial proceeding relating to child abuse or neglect.

Del. Code Ann. Tit. 16, § 903

Any person, agency, organization, or entity that knows or in good faith suspects child abuse or neglect shall make a report in accordance with § 904 of this title.

District of Columbia

This issue is not addressed in the statutes reviewed.

Florida

Fla. Stat. Ann. § 39.201(1)

Any person who knows or has reasonable cause to suspect that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible for the child's welfare, or that a child is in need of supervision and care and has no parent, legal custodian, or responsible adult relative immediately known and available to provide supervision and care, shall report such knowledge or suspicion to the department.

Fla. Stat. Ann. § 39.204

The privileged quality of communications between husband and wife and between any professional person and his or her patient or client, or any other privileged communications except that between attorney and client or the privilege provided by § 90.505 [providing for the confidentiality of communications made to a clergy member for the purpose of spiritual counsel], as such communication relates both to the competency of the witness and to the exclusion of confidential communications, shall not apply to any communication involving the perpetrator or alleged perpetrator in any situation involving known or suspected child abuse, abandonment, or neglect, and shall not constitute grounds for failure to report as required by the reporting laws regardless of the source of information requiring the report, failure to cooperate with law enforcement or the department in its activities pursuant to this chapter, or failure to give evidence in any judicial proceeding relating to child abuse, abandonment, or neglect.

Georgia

Ga. Ann. Code § 19-7-5

A member of the clergy shall not be required to report child abuse reported solely within the context of confession or other similar communication required to be kept confidential under church doctrine or practice. When a clergy member receives information about child abuse from any other source, the clergy member shall comply with the reporting requirements of this Code section, even though the clergy member may have also received a report of child abuse from the confession of the perpetrator.

The term 'clergy' includes ministers, priests, rabbis, imams, or similar functionaries, by whatever name called, of a bona fide religious organization.

Guam

Guam Ann. Code Tit. 19, § 13201

Persons required to report suspected child abuse include, but are not limited to, any clergy member of any religious faith, or other similar functionary or employee of any church, place of worship, or other religious organization whose primary duties consist of teaching, spreading the faith, church governance, supervision of a religious order, or supervision or participation in religious ritual and worship.

No person may claim 'privileged communications' as a basis for his or her refusal or failure to report suspected child abuse or neglect or to provide Child Protective Services or the Guam Police Department with required information. Such privileges are specifically abrogated with respect to reporting suspected child abuse or neglect or of providing information to the agency.

Hawaii

This issue is not addressed in the statutes reviewed.

Idaho

Idaho Code § 16-1605

Any other person having reason to believe that a child has been abused, abandoned, or neglected shall report or cause a report to be made within 24 hours.

The term 'duly ordained minister of religion' means a person who has been ordained or set apart, in accordance with the ceremony, ritual, or discipline of a church or religious organization that has been established on the basis of a community of religious faith, belief, doctrines, and practices, to hear confessions and confidential communications in accordance with the bona fide doctrines or discipline of that church or religious organization.

The notification requirements do not apply to a duly ordained minister of religion, with regard to any confession or confidential communication made to him or her in his or her ecclesiastical capacity in the course of discipline enjoined by the church to which he or she belongs if:

- The church qualifies as tax-exempt under Federal law.
- The confession or confidential communication was made directly to the duly ordained minister of religion.
- The confession or confidential communication was made in the manner and context that places the duly ordained minister specifically and strictly under a level of confidentiality that is considered inviolate by canon law or church doctrine.

A confession or confidential communication made under any other circumstances does not fall under this exemption.

Illinois

325 Ill. Comp. Stat. Ann. § 5/4

Any member of the clergy having reasonable cause to believe that a child known to that member of the clergy in his or her professional capacity may be an abused child as defined by law shall immediately report or cause a report to be made to the Department of Children and Family Services.

Whenever such person is required to report under this act in his or her capacity as a member of the clergy, he or she shall make a report immediately to the department in accordance with the provisions of this act and also may notify the person in charge of the church, synagogue, temple, mosque, or other religious institution, or his or her designated agent, that such a report has been made. Under no circumstances shall any person in charge of the church, synagogue, temple, mosque, or other religious institution, or his or her designated agent to whom such notification is made, exercise any control, restraint, modification, or other change in the report or the forwarding of such report to the department.

The privileged quality of communication between any professional person required to report and his or her patient or client shall not apply to situations involving abused or neglected children and shall not constitute grounds for failure to report.

A member of the clergy may claim the privilege under § 8-803 of the Code of Civil Procedure.

735 Ill. Comp. Stat. Ann. § 5/8-803

A member of the clergy or practitioner of any religious denomination accredited by the religious body to which he or she belongs shall not be compelled to disclose in any court, or to any administrative body or agency, or to any public officer, a confession or admission made to him or her in his or her professional character or as a spiritual advisor in the course of the discipline enjoined by the rules or practice of such religious body or of the religion that he or she professes, nor be compelled to divulge any information that has been obtained by him or her in such professional character or such spiritual advisor.

Indiana

Ind. Code Ann. § 31-33-5-1

In addition to any other duty to report arising under this article, an individual who has reason to believe that a child is a victim of child abuse or neglect shall make a report as required by this article.

Iowa

This issue is not addressed in the statutes reviewed.

Kansas

This issue is not addressed in the statutes reviewed.

Kentucky

Ky. Rev. Stat. Ann. § 620.030(1), (3)

Any person who knows or has reasonable cause to believe that a child is dependent, neglected, or abused shall immediately cause an oral or written report to be made.

Neither the husband-wife nor any professional-client/patient privilege, except the attorney-client and clergy-penitent privilege, shall be grounds for refusing to report or for excluding evidence regarding a dependent, neglected, or abused child or the cause thereof, in any judicial proceedings resulting from a report. This subsection shall also apply in any criminal proceeding in district or circuit court regarding a dependent, neglected, or abused child.

Louisiana

La. Children's Code Art. 603(17)(b)-(c)

'Mental health/social service practitioner' is any individual who provides mental health or social service diagnosis, assessment, counseling, or treatment, including a psychiatrist, psychologist, marriage or family counselor, social worker, member of the clergy, aide, or other individual who provides counseling services to a child or his or her family.

'Member of the clergy' is any priest, rabbi, duly ordained deacon or minister, Christian Science practitioner, or other similarly situated functionary of a religious organization.

A member of the clergy is not required to report a confidential communication, as defined in Code of Evidence article 511(A)(2), from a person to a member of the clergy who in the course of the discipline or practice of that church, denomination, or organization is authorized and accustomed to hearing confidential communication and, under the discipline or tenets of that church, denomination, or organization, has a duty to keep such communication confidential. In that instance, the member of the clergy shall encourage that person to report the allegations to the appropriate authorities.

Maine

Me. Rev. Stat. Ann. Tit. 22, § 4011-A(1)(A)(27)

The following adult persons shall immediately report or cause a report to be made to the department when the person knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected: clergy members acquiring the information as a result of clerical professional work, except for information received during confidential communications.

Maryland

Md. Code Ann. Fam. Law § 5-705(a)(1), (a)(3)

Except as provided below, notwithstanding any other provision of law, including a law on privileged communications, a person other than a health practitioner, police officer, or educator or human service worker who has reason to believe that a child has been subjected to abuse or neglect shall notify the local department or the appropriate law enforcement agency.

A minister of the gospel, clergy member, or priest of an established church of any denomination is not required to provide notice [when they have reason to believe that a child has been subjected to abuse or neglect] if the notice would disclose matter in relation to any communication that is protected by the clergy-penitent privilege and:

- The communication was made to the minister, clergy member, or priest in a professional character in the course of discipline enjoined by the church to which the minister, clergy member, or priest belongs.
- The minister, clergy member, or priest is bound to maintain the confidentiality of that communication under canon law, church doctrine, or practice.

Massachusetts

Mass. Gen. Laws Ann. Ch. 119, § 21

Mandatory reporters include:

- Priests, rabbis, clergy members, ordained or licensed ministers, leaders of any church or religious body, or accredited Christian Science practitioners
- Persons performing official duties on behalf of a church or religious body that are recognized as the duties of a priest, rabbi, clergy, ordained or licensed minister, leader of any church or religious body, or accredited Christian Science practitioner
- Persons employed by a church or religious body to supervise, educate, coach, train, or counsel a child on a regular basis

Mass. Gen. Laws Ann. Ch. 119, § 51A(j)

Any privilege relating to confidential communications, established by §§ 135 to 135B, inclusive, of chapter 112 [pertaining to social worker-client privilege] or by §§ 20A [clergy-penitent privilege] and 20B [psychotherapist-patient privilege] of chapter 233, shall not prohibit the filing of a report under this section or a care and protection petition under § 24, except that a priest, rabbi, clergy member, ordained or licensed minister, leader of a church or religious body, or accredited Christian Science practitioner need not report information solely gained in a confession or similarly confidential communication in other religious faiths. Nothing in the general laws shall modify or limit the duty of a priest, rabbi, clergy member, ordained or licensed minister, leader of a church or religious body, or accredited Christian Science practitioner to report suspected child abuse or neglect under this section when the priest, rabbi, clergy member, ordained or licensed minister, leader of a church or religious body, or accredited Christian Science practitioner is acting in some other capacity that would otherwise make him or her a mandated reporter.

Michigan

Mich. Comp. Laws Ann. § 722.623

A member of the clergy who has reasonable cause to suspect child abuse or neglect shall make immediately, by telephone or otherwise, an oral report, or cause on oral report to be made, of the suspected child abuse or neglect to the Department of Human Services.

Mich. Comp. Laws Ann. § 722.631

Any legally recognized privileged communication except that between attorney and client or that made to a member of the clergy in his or her professional character in a confession or similarly confidential communication is abrogated and shall not constitute grounds for excusing a report otherwise required to be made or for excluding evidence in a civil protective proceeding resulting from a report made pursuant to this act. This section does not relieve a member of the clergy from reporting suspected child abuse or child neglect if that member of the clergy receives information concerning suspected child abuse or child neglect while acting in any other capacity listed under § 722.623.

Minnesota

Minn. Stat. Ann. § 626.556, Subd. 3(a)

A person who knows or has reason to believe a child is being neglected or physically or sexually abused shall immediately report the information to the local welfare agency, agency responsible for assessing or investigating the report, police department, or the county sheriff if the person is employed as a member of the clergy and received the information while engaged in ministerial duties, provided that a member of clergy is not required to report information that is otherwise privileged under § 595.02(1)(c) [pertaining to clergy-penitent privilege].

Mississippi

Miss. Code Ann. § 43-21-353(1)

Any minister who has reasonable cause to suspect that a child is a neglected child or an abused child shall cause an oral report to be made immediately, by telephone or otherwise, to be followed as soon thereafter as possible by a report in writing to the Department of Human Services.

Missouri

Mo. Ann. Stat. § 210.140

Any legally recognized privileged communication, except that between an attorney and client or involving communications made to a minister or clergy member, shall not apply to situations involving known or suspected child abuse or neglect and shall not constitute grounds for failure to report as required or permitted, to cooperate with the division in any of its activities, or to give or accept evidence in any judicial proceeding relating to child abuse or neglect.

Mo. Ann. Stat. § 210.115

When any minister, as provided by § 352.400, has reasonable cause to suspect that a child has been or may be subjected to abuse or neglect or observes a child being subjected to conditions or circumstances that would reasonably result in abuse or neglect, that person shall immediately report or cause a report to be made to the Children's Division.

Mo. Ann. Stat. § 352.400

'Minister' means any person who while practicing as a minister of the gospel, clergy member, priest, rabbi, Christian Science practitioner, or other person serving in a similar capacity for any religious organization is responsible for or who has supervisory authority over one who is responsible for the care, custody, and control of a child or who has access to a child.

When a minister or designated agent has reasonable cause to suspect that a child has been or may be subjected to abuse or neglect under circumstances required to be reported, the minister or designated agent shall immediately report or cause a report to be made.

Notwithstanding any other provision of this section or any section of the reporting laws, a minister shall not be required to report concerning a privileged communication made to him or her in his or her professional capacity.

Montana

Mont. Code Ann. § 15-6-201(2)(b)

The term 'clergy' means:

- An ordained minister, priest, or rabbi
- A commissioned or licensed minister of a church or church denomination that ordains ministers if the person has the authority to perform substantially all the religious duties of the church or denomination
- A member of a religious order who has taken a vow of poverty
- A Christian Science practitioner

Mont. Code Ann. § 41-3-201(2)(h), (5)(b)

Professionals and officials required to report include members of the clergy.

A member of the clergy or priest is not required to report under this section if:

- The knowledge or suspicion of the abuse or neglect came from a statement or confession made to the member of the clergy or priest in that person's capacity as a member of the clergy or priest.
- The statement was intended to be a part of a confidential communication between the member of the clergy or the priest and a member of the church or congregation.
- The person who made the statement or confession does not consent to the disclosure by the member of the clergy or priest.

A member of the clergy or priest is not required to make a report under this section if the communication is required to be confidential by canon law, church doctrine, or established church practice.

Nebraska

Neb. Rev. Stat. Ann. § 28-711

When any person has reasonable cause to believe that a child has been subjected to child abuse or neglect or observes that child being subjected to conditions or circumstances that reasonably would result in child abuse or neglect, he or she shall report such incident or cause a report of child abuse or neglect to be made to the proper law enforcement agency or to the Department of Social Services.

Nevada

Nev. Rev. Stat. Ann. § 432B.220(3)(d)

A report must be made by a clergy member, practitioner of Christian Science, or religious healer, unless he or she has acquired the knowledge of the abuse or neglect from the offender during a confession.

New Hampshire

N.H. Rev. Stat. Ann. § 169-C:29

A priest, minister, or rabbi having reason to suspect that a child has been abused or neglected shall report the same in accordance with this chapter.

N.H. Rev. Stat. Ann. § 169-C:32

The privileged quality of communication between husband and wife and any professional person [including a priest, minister, or rabbi] and his or her patient or client, except that between attorney and client, shall not apply to proceedings instituted pursuant to this chapter and shall not constitute grounds for failure to report as required by this chapter.

New Jersey

N.J. Ann. Stat. § 9:6-8.10

Any person having reasonable cause to believe that a child has been subjected to child abuse or acts of child abuse shall report the same immediately to the Division of Youth and Family Services by telephone or otherwise.

New Mexico

N.M. Stat. Ann. § 32A-4-3(A)

Every person, including a member of the clergy who has information that is not privileged as a matter of law, who knows or has a reasonable suspicion that a child is an abused or a neglected child shall report the matter immediately.

New York

This issue is not addressed in the statutes reviewed.

North Carolina

N.C. Gen. Stat. § 7B-301

Any person or institution that has cause to suspect that any juvenile is abused, neglected, or dependent, or has died as the result of maltreatment, shall report the case of that juvenile to the director of the Department of Social Services in the county where the juvenile resides or is found.

N.C. Gen. Stat. § 7B-310

No privilege shall be grounds for any person or institution failing to report that a juvenile may have been abused, neglected, or dependent, even if the knowledge or suspicion is acquired in an official professional capacity, except when the knowledge is gained by an attorney from that attorney's client during representation only in the abuse, neglect, or dependency case.

No privilege, except the attorney-client privilege, shall be grounds for excluding evidence of abuse, neglect, or dependency in any judicial proceeding (civil, criminal, or juvenile) in which a juvenile's abuse, neglect, or dependency is an issue nor in any judicial proceeding resulting from a report submitted under this article, both as the privilege relates to the competency of the witness and to the exclusion of confidential communications.

North Dakota

N.D. Cent. Code § 50-25.1-03(1)

Any member of the clergy having knowledge of or reasonable cause to suspect that a child is abused or neglected or has died as a result of abuse or neglect shall report the circumstances to the department if the knowledge or suspicion is derived from information received by that person in that person's official or professional capacity. A member of the clergy, however, is not required to report such circumstances if the knowledge or suspicion is derived from information received in the capacity of a spiritual advisor.

Northern Mariana Islands

This issue is not addressed in the statutes reviewed.

Ohio

Ohio Rev. Code § 2151.421(A)(4)(b)-(d)

A cleric is not required to make a report concerning any communication the cleric receives from a penitent in a cleric-penitent relationship if, in accordance with § 2317.02(C), the cleric could not testify with respect to that communication in a civil or criminal proceeding.

The penitent in a cleric-penitent relationship is deemed to have waived any testimonial privilege with respect to any communication the cleric receives from the penitent in that cleric-penitent relationship, and the cleric shall make a report with respect to that communication if all of the following apply:

- The penitent, at the time of the communication, is either a child under age 18 or a mentally retarded, developmentally disabled, or physically impaired person under age 21.
- The cleric knows, or has reasonable cause to believe based on facts that would cause a reasonable person in a similar position to believe, as a result of the communication or any observations made during that communication, the penitent has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the penitent.

- The abuse or neglect does not arise out of the penitent's attempt to have an abortion performed upon a child under age 18 or upon a mentally retarded, developmentally disabled, or physically impaired person under age 21 without the notification of her parents, guardian, or custodian in accordance with § 2151.85.

The above sections do not apply in a cleric-penitent relationship when the disclosure of any communication the cleric receives from the penitent is in violation of the sacred trust.

Ohio Rev. Code § 2151.421(A)(4)(a)

No cleric and no person, other than a volunteer, designated by any church, religious society, or faith acting as a leader, official, or delegate on behalf of the church, religious society, or faith who is acting in an official or professional capacity who knows, or has reasonable cause to believe based on facts that would cause a reasonable person in a similar position to believe, that a child under age 18 or a mentally retarded, developmentally disabled, or physically impaired child under age 21 has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the child, and who knows, or has reasonable cause to believe based on facts that would cause a reasonable person in a similar position to believe, that another cleric or another person, other than a volunteer, designated by a church, religious society, or faith acting as a leader, official, or delegate on behalf of the church, religious society, or faith caused or poses the threat of causing the wound, injury, disability, or condition that reasonably indicates abuse or neglect shall fail to immediately report that knowledge or reasonable cause to believe to the entity or persons specified in this division.

Oklahoma

Okla. Stat. Ann. Tit. 10A, § 1-2-101

Every person having reason to believe that a child under age 18 is a victim of abuse or neglect shall report the matter promptly to the Department of Human Services.

No privilege or contract shall relieve any person from the requirement of reporting pursuant to this section.

Oregon

Or. Rev. Stat. Ann. § 419B.005(3)(h)

Public or private official [includes]: member of the clergy.

Or. Rev. Stat. Ann. § 419B.010(1)

Any public or private official having reasonable cause to believe that any child with whom the official comes in contact has suffered abuse, or that any person with whom the official comes in contact has abused a child, shall immediately report or cause a report to be made.

Nothing shall affect the duty to report imposed by the reporting laws, except that a psychiatrist, psychologist, member of clergy, or attorney shall not be required to report such information communicated by a person if such communication is privileged under §§ 40.225 to 40.295.

Pennsylvania

23 Pa. Cons. Stat. Ann. § 6311(a)

The following adults shall make a report of suspected child abuse: A clergyman, priest, rabbi, minister, Christian Science practitioner, religious healer, or spiritual leader of any regularly established church or other religious organization.

23 Pa. Cons. Stat. Ann. § 6311.1

The privileged communications between a mandated reporter and a patient or client of the mandated reporter shall not:

- Apply to a situation involving child abuse
- Relieve the mandated reporter of the duty to make a report of suspected child abuse

Confidential communications made to a member of the clergy are protected under title 42, § 5943 (relating to confidential communications to clergymen).

Puerto Rico

P.R. Laws Ann. Tit. 8, § 446(b)

Any person who has knowledge of or suspects that a minor is a victim of abuse, institutional abuse, neglect, and/or institutional neglect shall report that fact through the hotline of the department, to the Puerto Rico police, or to the local office of the department.

Rhode Island

R.I. Gen. Laws § 40-11-11

The privileged quality of communication between husband and wife and any professional and his or her patient or client, except that between attorney and client, is hereby abrogated in situations involving known or suspected child abuse or neglect and shall not constitute grounds for failure to report as required by this chapter, failure to cooperate with the department in its activities pursuant to this chapter, or failure to give or accept evidence in any judicial proceeding relating to child abuse or neglect. In any family court proceeding relating to child abuse or neglect, notwithstanding the provisions of other statutes, no privilege of confidentiality may be invoked with respect to any illness, trauma, incompetency, addiction to drugs, or alcoholism of any parent.

R.I. Gen. Laws § 40-11-3(a)

Any person who has reasonable cause to know or suspect that any child has been abused or neglected or has been a victim of sexual abuse by another child shall, within 24 hours, transfer that information to the department.

South Carolina

S.C. Code Ann. § 63-7-420

The privileged quality of communication between husband and wife and any professional person and his or her patient or client—except that between attorney and client or clergy member, including Christian Science practitioner or religious healer, and penitent—is abrogated and does not constitute grounds for failure to report or the exclusion of evidence in a civil protective proceeding resulting from a report pursuant to this article. However, a clergy member, including Christian Science practitioner or religious healer, must report in accordance with this subarticle, except when information is received from the alleged perpetrator of the abuse and neglect during a communication that is protected by the clergy and penitent privilege as defined in § 19-11-90.

S.C. Code Ann. § 63-7-310(A)

Persons required to report include members of the clergy, including Christian Science practitioners or religious healers.

South Dakota

This issue is not addressed in the statutes reviewed.

Tennessee

Tenn. Code Ann. § 37-1-403(a)

Any person who has knowledge of or is called upon to render aid to any child who is suffering from or has sustained any wound, injury, disability, or physical or mental condition shall report such harm immediately if the harm is of such a nature as to reasonably indicate that it has been caused by brutality, abuse, or neglect or that, on the basis of available information, reasonably appears to have been caused by brutality, abuse, or neglect.

Tenn. Code Ann. § 37-1-605(a)

Any person who knows or has reasonable cause to suspect that a child has been sexually abused shall report such knowledge or suspicion to the department.

Texas

Tex. Fam. Code Ann. § 261.101

A person having cause to believe that a child's physical or mental health or welfare has been adversely affected by abuse or neglect by any person shall immediately make a report as provided by this subchapter.

The requirement to report under this section applies, without exception, to an individual whose personal communications may otherwise be privileged, including an attorney, a member of the clergy, a medical practitioner, a social worker, a mental health professional, and an employee of a clinic or health-care facility that provides reproductive services.

Utah

Utah Code Ann. § 62A-4a-403

When any person has reason to believe that a child has been subjected to abuse or neglect, or who observes a child being subjected to conditions or circumstances that reasonably would result in abuse or neglect, he or she shall immediately notify the nearest peace officer, law enforcement agency, or office of the division.

The notification requirements do not apply to a clergy member or priest, without the consent of the person making the confession, with regard to any confession made to him or her in his or her professional character in the course of discipline enjoined by the church to which he or she belongs if:

- The confession was made directly to the clergy member or priest by the perpetrator.
- The clergy member or priest is, under canon law or church doctrine or practice, bound to maintain the confidentiality of that confession.

When the clergy member or priest receives information about abuse or neglect from any source other than confession of the perpetrator, he or she is required to give notification on the basis of that information, even though he or she may have also received a report of abuse or neglect from the confession of the perpetrator.

Exemption of notification requirements for a clergy member or priest does not exempt him or her from any other efforts required by law to prevent further abuse or neglect by the perpetrator.

Vermont

Vt. Stat. Ann. Tit. 33, § 4913(a), (h)-(i)

Any member of the clergy who has reasonable cause to believe that any child has been abused or neglected shall report or cause a report to be made in accordance with the reporting laws.

Except as provided below, a person may not refuse to make a report required by this section on the grounds that making the report would violate privilege or disclose a confidential communication.

A member of the clergy shall not be required to make a report under this section if the report would be based upon information revealed in a communication that is:

- Made to a member of the clergy acting in his or her capacity as spiritual advisor
- Intended by the parties to be confidential at the time the communication is made
- Intended by the communicant to be an act of contrition or a matter of conscience
- Required to be confidential by religious law, doctrine, or tenet

When a member of the clergy receives information about abuse or neglect of a child in a manner other than as described above, he or she is required to report on the basis of that information, even though he or she may have also received a report of abuse or neglect about the same person or incident in the manner described above.

Vt. Stat. Ann. Tit. 33, § 4912(12)

'Member of the clergy' means a priest; rabbi; clergy member; ordained or licensed minister; leader of any church or religious body; accredited Christian Science practitioner; or a person performing official duties on behalf of a church or religious body that are recognized as the duties of a priest, rabbi, clergy, nun, brother, ordained or licensed minister, leader of any church or religious body, or accredited Christian Science practitioner.

Virgin Islands

This issue is not addressed in the statutes reviewed.

Virginia

Va. Code Ann. § 63.2-1509

This subsection [enumerating mandated reporters] shall not apply to any regular minister, priest, rabbi, imam, or duly accredited practitioner of any religious organization or denomination usually referred to as a church as it relates to (i) information required by the doctrine of the religious organization or denomination to be kept in a confidential manner, or (ii) information that would be subject to § 8.01-400 or 19.2-271.3 if offered as evidence in court.

Washington

Wash. Rev. Code Ann. § 26.44.030(7)

Information considered privileged by statute and not directly related to reports required by this section must not be divulged without a valid written waiver of the privilege.

Wash. Rev. Code Ann. § 26.44.060(3)

Conduct conforming with reporting requirements shall not be deemed a violation of the confidential communication privilege of §§ 5.60.060 (3) and (4) [pertaining to clergy-penitent and physician-patient privilege], 18.53.200 [pertaining to optometrist-patient privilege], and 18.83.110 [pertaining to psychologist-client privilege].

West Virginia

W. Va. Code Ann. § 49-2-811

The privileged quality of communications between husband and wife and between any professional person and his or her patient or client, except that between attorney and client, is hereby abrogated in situations involving suspected or known child abuse or neglect.

W. Va. Code Ann. § 49-2-803

When any member of the clergy has reasonable cause to suspect that a child is neglected or abused, or observes the child being subjected to conditions that are likely to result in abuse or neglect, such person shall immediately, and not more than 48 hours after suspecting this abuse, report the circumstances or cause a report to be made to the Department of Health and Human Resources.

Wisconsin

Wis. Stat. Ann. § 48.981(2)(b)

Except as provided below, a member of the clergy shall report if the member of the clergy has reasonable cause to suspect that a child seen by the member of the clergy in the course of his or her professional duties:

- Has been abused
- Has been threatened with abuse, and abuse of the child will likely occur

Except as provided below, a member of the clergy shall report if the member of the clergy has reasonable cause, based on observations made or information that he or she receives, to suspect that a member of the clergy has done any of the following:

- Abused a child
- Threatened a child with abuse, and abuse of the child will likely occur

A member of the clergy is not required to report child abuse information that he or she receives solely through confidential communications made to him or her privately or in a confessional setting if he or she is authorized to hear or is accustomed to hearing such communications and under the disciplines, tenets, or traditions of his or her religion has a duty or is expected to keep those communications secret. Those disciplines, tenets, or traditions need not be in writing.

Wyoming

Wyo. Stat. Ann. § 14-3-205(a)

Any person who knows or has reasonable cause to believe or suspect that a child has been abused or neglected, or who observes any child being subjected to conditions or circumstances that would reasonably result in abuse or neglect, shall immediately report it to the child protective agency or local law enforcement agency or cause a report to be made.

Wyo. Stat. Ann. § 14-3-210

Evidence regarding a child in any judicial proceeding resulting from a report made pursuant to the reporting laws shall not be excluded on the ground it constitutes a privileged communication [and the privilege of confidential communication may not be claimed]:

- Between husband and wife
- Claimed under any provision of law other than § 1-12-101(a)(i) [regarding attorney-client or physician-patient privilege] and § 1-12-101(a)(ii) [regarding privilege of a clergy member or priest as it relates to a confession made to him or her in his or her professional character if enjoined by the church to which he or she belongs]
- Claimed pursuant to § 1-12-116 [regarding the confidential communication between a family violence and sexual assault advocate and victim]

MENTAL HEALTH FIRST AID

As a pastor or organizational leader you are often called on to be a “first responder” to the crisis in peoples lives. These First Aid Guidelines compiled by Mental Health First Aid of Australia will give you very practical direction on how to be of help in some of life’s most challenging situations.

If you need further assistance on how to be helpful in a non-emergency situation, call our 24/7 MCO HelpLine (833-957-4357). If you’re facing an emergency situation or if you are unsure if it’s an emergency or not, refer to the Emergency Numbers section of this guide for the appropriate contacts.

SUICIDE PREVENTION

In every organization there are people who are facing suicidal thoughts. The topic is scary and it’s easy to feel overwhelmed. This guide will give you practical direction on how to help.

REVISED 2014

SUICIDAL THOUGHTS & BEHAVIOURS

MENTAL HEALTH FIRST AID GUIDELINES (Revised 2014)

Suicide can be prevented. Most suicidal people do not want to die. They simply do not want to live with the pain. Openly talking about suicidal thoughts and feelings can save a life.

Do not underestimate your abilities to help a suicidal person, even to save a life.

How can I tell if someone is feeling suicidal?

It is important that you know the warning signs and risk factors for suicide, and the reasons why a person might have thoughts of suicide.

Signs a person may be suicidal:

- Threatening to hurt or kill themselves
- Looking for ways to kill themselves: seeking access to pills, weapons, or other means
- Talking or writing about death, dying or suicide
- Hopelessness
- Rage, anger, seeking revenge
- Acting recklessly or engaging in risky activities, seemingly without thinking
- Feeling trapped, like there's no way out
- Increasing alcohol and drug use
- Withdrawing from friends, family or society
- Anxiety, agitation, unable to sleep or sleeping all the time
- Dramatic changes in mood
- No reason for living, no sense of purpose in life

Adapted from Rudd et al (2006).
Warning signs for suicide: Theory, research and clinical applications. Suicide and Life-Threatening Behavior, 36:255-262.

BOX 1:

Reasons why a person might have thoughts about suicide

The main reasons people give for attempting suicide are:

1. Needing to escape or relieve unmanageable emotions and thoughts. The person wants relief from unbearable emotional pain, feels their situation is hopeless, feels worthless and believes that other people would be better off without them.
2. Desire to communicate with or influence another individual. The person wants to communicate how they feel to other people, change how other people treat them or get help.

Adapted from May & Klonsky (2013) Assessing motivations for suicide attempts: Development of psychometric properties of the inventory of motivations for suicide attempts. Suicide and Life-Threatening Behavior, 43(5), 532-546.

BOX 2:

Factors associated with a higher risk of suicide

People are at greater risk of suicide if they have:

- A mental illness
- Poor physical health and disabilities
- Attempted suicide or harmed themselves in the past
- Had bad things happen recently, particularly with relationships or their health
- Been physically or sexually abused as a child
- Been recently exposed to suicide by someone else.

Suicide is also more common in certain groups, including males, indigenous people, the unemployed, prisoners, and gay, lesbian and bisexual people.

Adapted from Hawton K, van Heeringen K. Suicide. Lancet 2009; 373: 1372-1381.

Mental Health First Aid Australia
www.mhfa.com.au

If you are concerned the person may be at risk of suicide, you need to approach them and have a conversation about your concerns.

Preparing yourself to approach the person

Be aware of your own attitudes about suicide and the impact of these on your ability to provide assistance (e.g. beliefs that suicide is wrong or that it is a rational option). If the person is from a different cultural or religious background to your own, keep in mind that they might have beliefs and attitudes about suicide which differ from your own.

Be aware that it is more important to genuinely want to help than to be of the same age, gender or cultural background as the person.

If you feel unable to ask the person about suicidal thoughts, find someone else who can.

Making the approach

Act promptly if you think someone is considering suicide. Even if you only have a mild suspicion that the person is having suicidal thoughts, you should still approach them.

Tell the person you care and want to help. Tell them your concerns about them, describing behaviours that have caused you to be concerned about suicide. However, understand that the person may not want to talk with you. In this instance, you should offer to help them find someone else to talk to. Also, if you are unable to make a connection with the person, help them to find someone else to talk to.

Asking about thoughts of suicide

Anyone could have thoughts of suicide. If you think someone might be having suicidal thoughts, you should ask that person directly. Unless someone tells you, the only way to know if they are thinking about suicide is to ask.

For example, you could ask:

- "Are you having thoughts of suicide?" or
- "Are you thinking about killing yourself?"

While it is more important to ask the question directly than to be concerned about the exact wording, you should not ask about suicide in leading or judgmental ways (e.g. 'You're not thinking of doing anything stupid, are you?').

Sometimes people are reluctant to ask directly about suicide because they think they will put the idea in the person's head. This is not true. Similarly, if a person is suicidal, asking them about suicidal thoughts will not increase the risk that they will act on these. Instead, asking the person about suicidal thoughts will allow them the chance to talk about their problems and show them that somebody cares.

Although it is common to feel panic or shock when someone discloses thoughts of suicide, it is important to avoid expressing negative reactions. Do your best to appear calm, confident and empathic in the face of the suicide crisis, as this may have a reassuring effect for the suicidal person.

How should I talk with someone who is suicidal?

It is more important to be genuinely caring than to say 'all the right things'. Be supportive and understanding of the suicidal person, and listen to them with undivided attention. Suicidal thoughts are often a plea for help and a desperate attempt to escape from problems and distressing feelings.

Ask the suicidal person what they are thinking and feeling. Reassure them that you want to hear whatever they have to say. Allow them to talk about these thoughts and feelings, and their reasons for wanting to die and acknowledge these. Let the suicidal person know it is okay to talk about things that might be painful, even if it is hard. Allow them to express their feelings (e.g. allow them to cry, express anger, or scream). A suicidal person may feel relief at being able to do so.

Remember to thank the suicidal person for sharing their feelings with you and acknowledge the courage this takes.

See Box 3 for tips on how to listen effectively and Box 4 on things not to do.

BOX 3:

Listening tips

- Be patient and calm while the suicidal person is talking about their feelings.
- Listen to the suicidal person without expressing judgment, accepting what they are saying without agreeing or disagreeing with their behaviour or point of view.
- Ask open-ended questions (i.e. questions that cannot be simply answered with 'yes' or 'no') to find out more about the suicidal thoughts and feelings and the problems behind these.
- Show you are listening by summarising what the suicidal person is saying.
- Clarify important points with the person to make sure they are fully understood.
- Express empathy for the suicidal person.

BOX 4:

What not to do.

Don't…

- … argue or debate with the person about their thoughts of suicide.
- … discuss with the person whether suicide is right or wrong.
- … use guilt or threats to prevent suicide (e.g. do not tell the person they will go to hell or ruin other people's lives if they die by suicide).
- … minimise the suicidal person's problems.
- … give glib 'reassurance' such as "don't worry", "cheer up", "you have everything going for you" or "everything will be alright".
- … interrupt with stories of your own.
- … communicate a lack of interest or negative attitude through your body language.
- … 'call their bluff' (dare or tell the suicidal person to 'just do it').
- … attempt to give the suicidal person a diagnosis of a mental illness.

Do not avoid using the word 'suicide'. It is important to discuss the issue directly without dread or expressing negative judgement. Demonstrate appropriate language when referring to suicide by using the terms 'suicide' or 'die by suicide', and avoiding the use of terms to describe suicide that promote stigmatising attitudes, e.g. 'commit suicide' (implying it is a crime or sin) or referring to past suicide attempts as having 'failed' or been 'unsuccessful', implying death would have been a favourable outcome.

How can I tell how urgent the situation is?

Take all thoughts of suicide seriously and take action. Do not dismiss the person's thoughts as 'attention seeking' or a 'cry for help'. Determine the urgency of taking action based on recognition of suicide warning signs.

Ask the suicidal person about issues that affect their immediate safety:

- Whether they have a plan for suicide.
- How they intend to suicide, i.e. ask them direct questions about how and where they intend to suicide.
- Whether they have decided when they will carry out their plan.
- Whether they have already taken steps to secure the means to end their life.
- Whether they have been using drugs or alcohol. Intoxication can increase the risk of a person acting on suicidal thoughts.
- Whether they have ever attempted or planned suicide in the past.

If the suicidal person says they are hearing voices, ask what the voices are telling them. This is important in case the voices are relevant to their current suicidal thoughts.

It is also useful to find out what supports are available to the person:

- Whether they have told anyone about how they are feeling.
- Whether there have been changes in their employment, social life, or family.
- Whether they have received treatment for mental health problems or are taking any medication.

Be aware that those at the highest risk for acting on thoughts of suicide in the near future are those who have a specific suicide plan, the means to carry out the plan, a time set for doing it, and an intention to do it. However, the lack of a plan for suicide is not sufficient to ensure safety.

How can I keep the person safe?

Once you have established that a suicide risk is present, you need to take action to keep the person safe. A person who is suicidal should not be left on their own. If you suspect there is an immediate risk of the person acting on suicidal thoughts, act quickly, even if you are unsure. Work collaboratively with the suicidal person to ensure their safety, rather than acting alone to prevent suicide.

Remind the suicidal person that suicidal thoughts need not be acted on. Reassure the suicidal person that there are solutions to problems or ways of coping other than suicide.

When talking to the suicidal person, focus on the things that will keep them safe for now, rather than the things that put them at risk. To help keep the suicidal person safe, develop a safety plan with them (See Box 5). Engage the suicidal person to the fullest extent possible in decisions about a safety plan. However, do not assume that a safety plan by itself is adequate to keep the suicidal person safe.

BOX 5:

Safety plan

A safety plan is an agreement between the suicidal person and the first aider that involves actions to keep the person safe. The safety plan should:

- Focus on what the suicidal person should do rather than what they shouldn't.
- Be clear, outlining what will be done, who will be doing it, and when it will be carried out.
- Be for a length of time which will be easy for the suicidal person to cope with, so that they can feel able to fulfil the agreement and have a sense of achievement.
- Include contact numbers that the person agrees to call if they are feeling suicidal, e.g. the person's doctor or mental health care professional, a suicide helpline or 24 hour crisis line, friends and family members who will help in an emergency.

Find out who or what has supported the person in the past and whether these supports are still available. Ask them how they would like to be supported and if there is anything you can do to help, but do not try to take on their responsibilities.

Although you can offer support, you are not responsible for the actions or behaviours of someone else, and cannot control what they might decide to do.

What about professional help?

Encourage the person to get appropriate professional help as soon as possible. Find out information about the resources and services available for a person who is considering suicide, including local services that can assist in response to people at risk of suicide such as hospitals, mental health clinics, mobile outreach crisis teams, suicide prevention helplines and local emergency services. Provide this information to the suicidal person and discuss help-seeking options with them. If they don't want to talk to someone face-to-face, encourage them to contact a suicide helpline.

Don't assume that the person will get better without help or that they will seek help on their own. People who are feeling suicidal often don't ask for help for many reasons, including stigma, shame and a belief that their situation is hopeless and that nothing can help.

If the suicidal person is reluctant to seek help, keep encouraging them to see a mental health professional and contact a suicide prevention hotline for guidance on how to help them. **If the suicidal person refuses professional help,** call a mental health centre or crisis telephone line and ask for advice on the situation.

If the suicidal person is an adolescent, a more directive approach may be needed. If an adolescent is reluctant to seek help, make sure someone close to them is aware of the situation (i.e. a close friend or family member). If the adolescent refuses professional help, also get assistance from a mental health professional.

For people at more urgent risk, additional action may be needed to facilitate professional help seeking. **If you believe the suicidal person will not stay safe or if they are not willing to hand over the stated means for suicide,** seek their permission to contact their regular doctor or mental health professional about your concerns. If possible, the health professional contacted should be a professional the suicidal person already knows and trusts. **If the person has a specific plan for suicide, or if they have the means to carry out their suicide plan,** call a mental health centre or crisis telephone line and ask for advice on the situation.

If the suicidal person has a weapon, contact the police. When contacting the police, inform them that the person is suicidal to help them respond appropriately. Make sure you do not put yourself in any danger while offering support to the suicidal person.

Be prepared for the suicidal person to possibly express anger and feel betrayed by your attempt to prevent their suicide or help them get professional help. Try not to take personally any hurtful actions or words of the suicidal person.

What if the person wants me to promise not to tell anyone else?

You must never agree to keep a plan for suicide or risk of suicide a secret. If the person doesn't want you to tell anyone about their suicidal thoughts, you should not agree but give an explanation why (for example, "I care about you too much to keep a secret like this. You need help and I am here to help you get it"). Treat the person with respect and involve them in decisions about who else knows about the suicidal crisis.

If the person refuses to give permission to disclose information about their suicidal thoughts, then you may need to breach their confidentiality in order to ensure their safety. In doing so, you need to be honest and tell the person who you will be notifying.

Keep in mind that it is much better to have the person angry at you for sharing their suicidal thoughts without their permission, in order to obtain help, than to lose the person to suicide.

What should I do if the person has acted on suicidal thoughts?

If the suicidal person has already harmed themselves, administer first aid and call emergency services, asking for an ambulance.

Keep in mind that despite our best efforts, we may not be successful in preventing suicide.

The person I am trying to help has injured themselves, but insists they are not suicidal. What should I do?

Some people injure themselves for reasons other than suicide. This may be to relieve unbearable anguish, to stop feeling numb, or other reasons. This can be distressing to see. There are guidelines in this series entitled *First aid guidelines for non-suicidal self-injury* which can help you to understand and assist if this is occurring.

Take care of yourself

After helping someone who is suicidal, make sure you take appropriate self-care. Providing support and assistance to a suicidal person is exhausting and it is therefore important to take care of yourself.

An important note:

Self-injury can indicate a number of different things. Someone who is hurting themselves may be at risk of suicide. Others engage in a pattern of self-injury over weeks, months or years and are not necessarily suicidal. These guidelines are to assist you if the person you are helping is suicidal. If the person you are assisting is injuring themselves, but is not suicidal, please refer to the guidelines entitled *Non-suicidal self-injury: first aid guidelines.*

Purpose of these Guidelines

These guidelines are designed to help members of the public to provide first aid to someone who is at risk of suicide. The role of the first aider is to assist the person until appropriate professional help is received or the crisis resolves.

Development of these Guidelines

The following guidelines are based on the expert opinions of a panel of mental health consumers and professionals from Australia, New Zealand, the UK, the USA and Canada about how to help someone who may be at risk of suicide. Details of the methodology can be found in: Ross AM, Kelly CM, Jorm AF. Re-development of mental health first aid guidelines for suicidal ideation and behaviour: a Delphi study. *BMC Psychiatry 2014; 14:241.*

How to use these Guidelines

These guidelines are a general set of recommendations about how you can help someone who may be at risk of suicide. Each individual is unique and it is important to tailor your support to that person's needs. These recommendations therefore may not be appropriate for every person who may be at risk of suicide.

Also, the guidelines are designed to be suitable for providing first aid in developed English-speaking countries. They may not be suitable for other cultural groups or for countries with different health systems.

Please cite the guidelines as follows:
Mental Health First Aid Australia. *Suicidal Thoughts and Behaviours: First Aid Guidelines* (Revised 2014). Melbourne: Mental Health First Aid Australia; 2014.

Enquiries should be sent to:

Mental Health First Aid Australia
email: mhfa@mhfa.com.au

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SUICIDE PREVENTION

MOST SUICIDAL PEOPLE DON'T WANT TO DIE. RATHER, THEY DON'T WANT TO LIVE WITH THE PAIN THAT THEY'RE EXPERIENCING. YOU CAN HELP SAVE LIVES BY KNOWING WHAT TO WATCH FOR, AND HOW TO HELP.

A SUICIDAL PERSON MAY NOT ASK FOR HELP. HOWEVER, THERE ARE SIGNS YOU CAN WATCH OUT FOR. IF YOU THINK SOMEONE IS SUICIDAL, ACT QUICKLY, EVEN IF YOU ONLY HAVE A MILD SUSPISCION. TALK TO THEM IN A PRIVATE PLACE.

WARNING SIGNS

- WITHDRAWING FROM THE PEOPLE IN THEIR LIFE.
- **FEELINGS OF HOPELESSNESS.**
- HAVING NO PURPOSE IN LIFE, OR REASON TO LIVE.
- **STRONG FEELING OF LONELINESS, EVEN IF THEY ARE SURROUNDED BY LOVED ONES.**
- FEELING THAT DEATH IS AN HONORABLE SOLUTION, TO THEIR SITUATION.
- **NO INTEREST IN OR PLANS FOR THE FUTURE.**
- FEELINGS OF GUILT OR SHAME, OR THE BELIEF THAT THEY ARE A BURDEN TO OTHERS.
- **FEELING TRAPPED, LIKE THERE IS NO WAY OUT.**
- BELIEVE THAT THEIR LIFE IS A FAILURE
- **DISTRESS ABOUT INTRUSIVE MEMORIES OF PAST TRAMAUTIC EVENTS**
- WISHES OR THREATS TO HURT OR KILL THEMSELVES
- **BEHAVING IN WAYS THAT ARE LIFE THREATENING OR DANGEROUS**
- TRYING TO SET AFFAIRS AND RELATIONSHIPS IN ORDER.

HOW TO HELP

- **CAREFULLY ASK THEM IF THEY ARE HAVING THOUGHTS OF SUICIDE. THIS SHOWS THEM THAT SOMEONE CARES, AND GIVES THEM AN OPPORTUNITY TO TALK ABOUT WHAT THEY'RE FACING.**
- GIVE THEM YOUR FULL ATTENTION, SHOWING SUPPORT AND UNDERSTANDING AS YOU LISTEN TO THEM. ENCOURAGING THEM TO DO MOST OF THE TALKING.
- **DON'T LET FEAR OF SAYING THE WRONG THING STOP YOU FROM ENCOURAGING THEM TO TALK ABOUT THEIR STRUGGLES.**
- WHEN THEY CONFIRM A SUICIDE RISK, YOU NEED TO TAKE ACTION TO KEEP THEM SAFE. THEY SHOULD NOT BE LEFT ALONE, OR WITH POTENTIALLY HARMFUL ITEMS.
- **REMIND THEM THAT SUICIDAL THOUGHTS DO NOT HAVE TO BE ACTED ON, AND ARE USUALLY TEMPORARY, EVEN THOUGH THEY DON'T FEEL TEMPORARY.**
- ASSURE THEM THAT HELP IS AVAILABLE. HELP CONNECT THEM WITH A LOVED ONE OR LEADER IN THEIR LIFE IF THEY WOULD LIKE YOU TO.
- **ENCOURAGE THEM TO GET PROFESSIONAL HELP AS SOON AS POSSIBLE.**

TAKE ALL SUICIDE THOUGHTS SERIOUSLY & TAKE ACTION!

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DEPRESSION

Almost everyone experiences some level of depression at one point in their life or another. This guide will help you identify what it looks like when someone is struggling and how to be helpful to them.

DEPRESSION
FIRST AID GUIDELINES

- How do I know if someone is experiencing depression?
- What are the signs and symptoms of depression?
- How should I approach someone who may be experiencing depression?
- How can I be supportive?
- What doesn't help?
- Should I encourage the person to seek professional help?
- What about self-help strategies?
- What if the person doesn't want help?
- What if the person is suicidal or is harming themselves?

How do I know if someone is experiencing depression?

Only a trained professional can diagnose someone with depression. However, if you notice changes in the person's mood, their behaviour, energy levels, habits or personality, you should consider depression as a possible reason for these changes.

It is important to learn about depression so that you are able to recognise these symptoms and help someone who may be developing a depressive episode. Take the time to find out information about depression such as its causes, its symptoms, how it can be treated, and what services are available in your local area.

It is important that you do not ignore the symptoms you have noticed or assume that they will just go away. It is also important that you do not lie or make excuses for the person's behaviour as this may delay getting assistance.

You should, however, remain aware that each individual is different and not everyone who is experiencing depression will show the typical signs or symptoms of depression.

What are the signs and symptoms of depression?

For a person to be diagnosed with clinical depression, they would have to have five or more of the following symptoms, including at least one of the first two, for at least two weeks:

- an unusually sad or irritable mood that does not go away;
- loss of enjoyment and interest in activities that used to be enjoyable;
- lack of energy and tiredness;
- feeling worthless or feeling guilty when they are not really at fault;
- thinking about death a lot or wishing they were dead;
- difficulty concentrating or making decisions;
- moving more slowly or, sometimes, becoming agitated and unable to settle;
- having sleeping difficulties or, sometimes, sleeping too much;
- loss of interest in food or, sometimes, eating too much. Changes in eating habits may lead to either loss of weight or putting on weight.

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DEPRESSION
FIRST AID GUIDELINES

How should I approach someone who may be experiencing depression?

Contrary to myth, talking about depression makes things better, not worse. If you think that someone you know may be depressed and needs help, give the person appropriate opportunities to talk. It can be helpful to let the person choose the moment to open up. However, if the person does not initiate a conversation with you about how they are feeling, you should say something to them.

It is important to choose a suitable time when both you and the person are available to talk, as well as a space where you both feel comfortable. Let the person know that you are concerned about them and are willing to help. If the person says that they are feeling sad or down, you should ask them how long they have been feeling that way.

Don't assume that the person knows nothing about depression as they, or someone else close to them, may have experienced depression before. At this point, you should ask the person if they would like some information about depression. If they do want some information, it is important that you give them resources that are accurate and appropriate to their situation.

You should respect how the person interprets their symptoms. If the person doesn't feel comfortable talking to you, encourage them to discuss how they are feeling with someone else.

How can I be supportive?

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

Do not blame the person for their illness Depression is a medical illness and the person cannot help being affected by depression. It is important to remind the person that they have an illness and that they are not to blame for feeling "down."

Have realistic expectations for the person You should accept the person as they are and have realistic expectations for them. You should let them know that they are not weak or a failure because they have depression, and that you don't think less of them as a person. Everyday activities like cleaning the house, paying bills, or feeding the dog may seem overwhelming to the person. You should acknowledge that the person is not "faking", "lazy", "weak" or "selfish." Ask the person if they would like any practical assistance with tasks but be careful not to take over or encourage dependency.

Offer consistent emotional support and understanding It is more important for you to be genuinely caring than for you to say all the "right things". The person genuinely needs additional love and understanding to help them through their illness so you should be empathetic, compassionate and patient. People with depression are often overwhelmed by irrational fears; you need to be gently understanding of someone in this state. It is important to be patient, persistent and encouraging when supporting someone with depression. You should also offer the person kindness and attention, even if it is not reciprocated. Let the person know that they will not be abandoned. You should be consistent and predictable in your interactions with the person.

Encourage the person to talk to you
Don't be afraid to encourage the person to talk about their feelings, symptoms and what is going on in their mind. Let the person know that you are available to talk when they are ready; do not put pressure on the person to talk right away.

Be a good listener You can help someone with depression by listening to them without expressing judgement. Be an active listener; reflect back what the person has said to you before responding with your own thoughts. It is important to listen carefully to the person even if what they tell you is obviously not true or is misguided. Although the person may not be communicating well, and may be speaking slower and less clearly than usual, you must be patient and must not interrupt. If the person is repetitive try not to get impatient, but rather keep trying to be as supportive as possible.

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

What doesn't help?

- There's no point in just telling someone with depression to get better as they cannot "snap out of it" or "get over it."
- You should not be hostile or sarcastic when the person attempts to be responsive but rather accept these responses as the best the person has to offer at that time.
- Do not adopt an over-involved or over-protective attitude towards someone who is depressed.
- Do not nag the person to try to get them to do what they normally would.
- Do not trivialise the person's experiences by pressuring them to "put a smile on their face," to "get their act together," or to "lighten up".
- Do not belittle or dismiss the person's feelings by attempting to say something positive like, "You don't seem that bad to me."
- Avoid speaking to the person with a patronising tone of voice and do not use overly-compassionate looks of concern.
- Resist the urge to try to cure the person's depression or to come up with answers to their problems.

Should I encourage the person to seek professional help?

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

Professional help is warranted when depression lasts for weeks and affects a person's functioning in daily life.

You should ask the person if they need help to manage how they are feeling. If they feel they do need help, discuss the options that they have for seeking help and encourage them to use these options. If the person does not know where to get help, offer to help them seek assistance.

It is important to encourage the person to get appropriate professional help and effective treatment as early as possible. If the person would like you to support them by accompanying them to a doctor's appointment, you must not take over completely; a person with depression needs to make their own decisions as much as possible.

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

What about self-help strategies?

People who are depressed frequently use self-help strategies. Some of these are supported by scientific evidence as effective, such as regular physical activity. The person's ability and desire to use self-help strategies will depend on their interests and the severity of their depression. Therefore you should not be too forceful when trying to encourage the person to use self-help strategies.

What if the person doesn't want help?

The person may not want to seek professional help. You should find out if there are specific reasons why this is the case. For example, the person might be concerned about finances, or about not having a doctor they like, or they might be worried they will be sent to hospital. These reasons may be based on mistaken beliefs, or you may be able to help the person overcome their worry about seeking help. If the person still doesn't want help after you have explored their reasons with them, let them know that if they change their mind in the future about seeking help they can contact you. You must respect the person's right not to seek help at all times unless you believe that they are at risk of harming themselves or others.

What if the person is suicidal or has injured themselves?

There are separate first aid guidelines about how to help someone who is suicidal or who has injured themselves. Please see the *First aid guidelines for suicidal thoughts and behaviours* and *First aid guidelines for non-suicidal self-injury.*

Purpose of these guidelines

These guidelines are designed to help members of the public to provide first aid to someone who may be experiencing depression. The role of the first aider is to assist the person until appropriate professional help is received or the crisis resolves.

Development of these Guidelines

The following guidelines are based on the expert opinions of a panel of mental health consumers, carers and clinicians from Australia, New Zealand, the UK, the USA and Canada about how to help someone who may be developing depression.

Details of the methodology can be found in: Langlands RL, Jorm AF, Kelly CM, Kitchener BA. First aid for depression: A Delphi consensus study with consumers, carers and clinicians. *Journal of Affective Disorders* 2008; 105:157-165

How to use these Guidelines

These guidelines are a general set of recommendations about how you can help someone who may be depressed. Each individual is unique and it is important to tailor your support to that person's needs. These recommendations therefore will not be appropriate for every person who may have depression.

Also, the guidelines are designed to be suitable for providing first aid in developed English-speaking countries. They may not be suitable for other cultural groups or for countries with different health systems.

Please cite these guidelines as follows: Mental Health First Aid Australia. *Depression: first aid guidelines.* Melbourne: Mental Health First Aid Australia; 2008.

Enquiries should be sent to:

Mental Health First Aid Australia
email: mhfa@mhfa.com.au

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SELF-INJURY (NON-SUICIDAL)

If you've never struggled with self-injury it can be completing confusing. Why would someone hurt themselves? This guid will help you gain a basic understanding and have clear direction on how to help.

REVISED 2014

NON-SUICIDAL SELF-INJURY

FIRST AID GUIDELINES

This document includes advice on assisting a person who is injuring themselves, but is not suicidal. It also includes advice on when you should seek professional medical help for a person who has severely injured themselves and is at risk of more serious harm or accidental death, regardless of intent.

Remember that accidental death can occur.

What is non-suicidal self-injury?

The term non-suicidal self-injury is used to refer to situations where self-injury is not intended to result in death.

What are the signs that indicate a person may have been self-injuring?

The most common methods of self-injury are[1]:

- Cutting (41%)
- Scratching (40%)
- Deliberately hitting body on hard surface (37%)
- Punching, hitting or slapping self (34%)
- Biting (15%)
- Burning (15%).

Frequent, unexplained injuries of the types described above, or concealing skin that is injured, may indicate that self-injury has been occurring. However, some people will go to great lengths to conceal their injuries, and it might be hard to pick up on some of these signs.

Take all self-injuring behaviour seriously, regardless of severity of the injuries or the intent.

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How common is non-suicidal self-injury?

An Australian national survey in 2008[1] found that 2.6% of people aged 10 or over had engaged in non-suicidal self-injury in the past year, and 8.1% had done so at some point in their life. Although it can occur at any age, self-injury is most common in adolescents and young adults. About 5% of 10-17 year olds and 7% of 18-24 year olds have deliberately injured themselves in the past year. The median age of onset of self-injury is 17 years. Self-injury is slightly more common in women than in men.

Why do people engage in non-suicidal self-injury?

People self-injure for many reasons. These include[1]:

- To manage painful feelings (57%)
- To punish oneself (25%)
- To communicate with others (6%)
- Other reasons (58%).

Less than 3% cited their reason as combating suicidal thoughts, seeking a rush or high, or to deliberately scar themselves. Self-injury is rarely used as a means of seeking attention due to the intense shame most people feel about their wounds and scars.

What is the relationship between non-suicidal self-injury and suicide?

People who engage in non-suicidal self-injury are at higher risk of a suicide attempt. About 10% of people who had injured themselves in the last four weeks had made a suicide attempt in the last year, and about 60% had had thoughts of suicide. This shows that people who engage in non-suicidal self-injury may at other times engage in self-injury with the intention of dying.

It is not always easy to tell the difference between non-suicidal self-injury and a suicide attempt. Do not assume that people who self-harm are suicidal. The only way to know is to ask the person directly if they are suicidal. If they say yes, you should refer to "Suicidal thoughts and behaviours: first aid guidelines[2]".

What types of professional help are available for non-suicidal self-injury?

Mental healthcare professionals, such as a GP, psychologist, psychiatrist, school counsellor, are all able to provide appropriate assistance to help someone who is engaging in self-injury. Mental health services, including suicide helplines, and other mental health community groups are also able to provide support and assistance.

What are the physical and mental health risks of self-injury?

Injuries to the skin often go untreated (e.g., people may be unwilling to seek sutures for wounds or may not undertake good wound care to keep injuries from becoming infected), meaning they can take a long time to heal, and there may be complications from infection. Hitting body parts against hard surfaces may result in small fractures which may become complicated if untreated.

Over time, self-injury can become the central strategy for coping with problems, making it very hard to use more adaptive ways of coping. For some people, self-injury can be a very difficult habit to break.

What should I do if I suspect someone is self-injuring?

If you suspect that someone you care about is deliberately injuring themselves, you need to discuss it with them. Before talking to the person, acknowledge and deal with your own feelings about self-injuring behaviours. If you feel you are unable to talk to the person who is self-injuring, try to find someone else who can talk to them.

Choose a private place for the conversation. Directly express your concerns that the person may be injuring themselves. Ask about self-injury in a way that makes it clear to the person that you understand a bit about self-injury, e.g. "Sometimes, when people are in a lot of emotional pain, they injure themselves on purpose. Is that how your injury happened?".

Self-injury is a very private thing and is hard to talk about. Do not demand to talk about things the person is not ready to discuss. You should avoid expressing a strong emotional response of anger, fear, revulsion or frustration.

If the person is receiving psychiatric care, ask if their treating professional knows about the injuries.

What should I do if I find someone injuring themselves?

If you have interrupted someone who is in the act of deliberate self-injury, intervene in a supportive and non-judgmental way. Although it is natural to feel upset, helpless and even angry upon finding out someone self-injures, try to remain calm and avoid expressions of shock or anger. Tell the person that you are concerned about them and ask whether you can do anything to alleviate the distress. Ask if medical attention is needed.

How should I talk with someone who is deliberately injuring themselves?

Keep in mind that 'stopping self-injury' should not be the focus of the conversation. Instead, look at what can be done to make the person's life more manageable, or their environment less distressing. Understand that self-injury cannot be stopped overnight, and people will need time to recover and learn healthy coping mechanisms.

Behave in a supportive and non-judgmental way. Understand that self-injury makes the person's life easier and accept their reasons for doing it. Be supportive without being permissive of the behaviour. Be aware of what your body language is communicating about your attitudes.

Use a calm voice when talking to the person. Avoid expressing anger or a desire to punish the person for self-injuring. Be comfortable with silence, allowing the person time to process what has been talked about. Be prepared for the expression of intense emotions.

What should I say?

Express concern & actively listen

Use 'I' statements instead of 'you' statements (e.g. "I feel worried/angry/frustrated when you…" instead of "You make me feel worried/angry/frustrated…") when talking with the person. Ask the person questions about their self-injury, but avoid pressuring them to talk about it. Reflect what the person is saying by acknowledging their experience as they are describing it.

Give support & reassurance

Express empathy for how the person is feeling. Validate the person's emotions by explaining that these emotions are appropriate and valid.

Let them know they are not alone and that you are there to support them. Work

collaboratively with the person in finding solutions (i.e. by finding out what they want to happen, and discussing any possible actions with them).

Reassure the person that there are sources of help and support available. Tell the person that you want to help, and let them know the ways in which you are willing to help them.

Don't promise the person that you will keep their self-injury a secret. If you need to tell somebody about the person's self-injury to keep them safe, speak to them about this first. Avoid gossiping or talking to others about it without their permission.

BOX A:

Things to avoid when talking with someone about deliberate self-injury

Don't…

- … minimise the person's feelings or problems.
- … use statements that don't take the person's pain seriously (such as "but you've got a great life" or "things aren't that bad").
- … try to solve the person's problems for them.
- … touch (e.g. hug or hold hands with) the person without their permission.
- ... use terms such as 'self-mutilator', 'self-injurer', or a 'cutter' to refer to the person.
- ... accuse the person of attention seeking.
- ... make the person feel guilty about the effect their self-injuring is having on others
- ... set goals or pacts, such as "If you promise not to hurt yourself between now and next week, you're doing really well", unless the person asks you to do this.
- ... try to make the person stop self-injuring (e.g. by removing self-injury tools) or giving them ultimatums (i.e. "If you don't stop self-injuring, you have to move out").
- … offer drugs, prescription pills or alcohol to the person.

What do I do if the person is not ready to talk?

Respect the person's right not to talk about their self-injuring. If the person doesn't want to talk right away, let them know that you want to listen to them when they are ready. Ask the person what would make them feel safe enough to be able to discuss their feelings. Do not force the issue unless the injury is severe. If the person still doesn't want to talk, ask a health professional for advice on what to do.

How can I help the person engaging in non-suicidal self-injury?

Seeking professional help

Self-injury is often a symptom of a mental health problem that can be treated. Encourage the person to seek professional help. Let them remain in control over seeking help as much as possible. Suggest and discuss options for getting help rather than directing the person what to do. Help the person map out a plan of action for seeking help. Talk about how you can help them to seek treatment and who they can talk to, e.g. a mental health service or a mental health professional.

Provide praise for any steps the person takes towards getting professional help. Follow-up with the person to check whether they have found professional help that is suitable for them.

You should seek mental health assistance on the person's behalf if:

- The person asks you to
- The injury is severe or getting more severe, such as cuts getting deeper or bones being broken
- The self-injurious behaviour is interfering with daily life
- The person has injured their eyes
- The person has injured their genitals
- The person has expressed a desire to die.

Keep in mind that not all people who self-injure want to change their behaviour. Even though you can offer support, you are not responsible for the actions or behaviour of someone else, and cannot control what they do.

If the person is an adolescent, a more directive approach may be needed. Help the adolescent map out a plan of action for seeking help and offer to go along with them to an appointment.

When is emergency medical attention necessary?

Avoid over-reacting; medical attention is only required if the injury is severe. Contact emergency services if a wound or injury is serious. Any cut which is gaping requires medical attention, as it may need stitches. Any burn which is two centimetres or larger in diameter, and any burn on the hands, feet or face requires medical attention.

If the person has harmed themselves by taking an overdose of medication or consuming poison, call an ambulance, as the risk of death or permanent harm is high. Deliberate overdose is more frequently intended to result in death, but is sometimes a form of self-injury. Regardless of a person's intentions, emergency help must be sought.

Encouraging alternatives to self-injury

Encourage the person to seek other ways to relieve their distress. Help the person to use their coping strategies that do not involve self-injuring, and help them to make a plan about what to do when they feel like self-injuring. Suggest some coping strategies and discuss with the person what might be helpful for them.

Encourage the use of any positive coping strategy which helps them to get through the urge to self-injure. Encourage the person to share their feelings with other people, such as a close friend or family member, when they are feeling distressed or have the urge to self-injure. Help the person think of ways to reduce their distress, for example, having a hot bath, listening to loud music, or doing something kind for themselves. Offer the person information materials (e.g. a website or factsheet) about alternatives to self-injury.

An important note:

Self-injury can indicate a number of different things. Someone who is hurting themselves may be at risk of suicide. Others engage in a pattern of self-injury over weeks, months or years and are not necessarily suicidal. These guidelines are to assist you if the person you are helping is not suicidal, but is injuring themselves for other reasons. If the person you are assisting is suicidal, please refer to the guidelines entitled *First aid for Suicidal thoughts and behaviours*.

Purpose of these Guidelines

These guidelines are designed to help members of the public to provide first aid to someone who is deliberately injuring themselves, but is not suicidal. The role of the first aider is to assist the person until appropriate professional help is received or the crisis resolves.

Development of these Guidelines

The following guidelines are based on the expert opinions of a panel of mental health consumers and professionals from Australia, New Zealand, the UK, the USA and Canada about how to help someone who may be deliberately injuring themselves. Details of the methodology can be found in: Ross AM, Jorm AF, Kelly CM. Re-development of mental health first aid guidelines for deliberate non-suicidal self-injury: A Delphi study. *BMC Psychiatry* 2014; 14:236.

How to use these Guidelines

These guidelines are a general set of recommendations about how you can help someone who may be deliberately injuring themselves. Each individual is unique and it is important to tailor your support to that person's needs. These recommendations therefore may not be appropriate for every person who is deliberately injuring themselves.

Also, the guidelines are designed to be suitable for providing first aid in developed English-speaking countries. They may not be suitable for other cultural groups or for countries with different health systems.

Please cite the guidelines as follows:

Mental Health First Aid Australia. *Non-suicidal self-injury: first aid guidelines* (Revised 2014). Melbourne: Mental Health First Aid Australia; 2014.

Enquiries should be sent to:
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email: mhfa@mhfa.com.au

References

1. Martin, G., Swannell, S., Harrison, J., Hazell, P., & Taylor, A. (2010). *The Australian National Epidemiological Study of Self-Injury (ANESSI)*. Centre for Suicide Prevention Studies: Brisbane, Australia.
2. *Mental Health First Aid guidelines for suicidal thoughts and behaviours*. Available from: www.mhfa.com.au/cms/mental-health-first-aid-guidelines-project/

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EATING DISORDERS

Eating disorders are a common occurrence in our culture today, but they can be hard to spot. This guide will help to clear up some of the myths, tune you into identifying those who may be struggling, and give you practical direction on how to help.

EATING DISORDERS

FIRST AID GUIDELINES

What are eating disorders?

A person has an eating disorder when their attitudes to food, weight, body size or shape lead to marked changes in their eating or exercise behaviours, which interfere with their life and relationships. Eating and exercise behaviours that people with eating disorders may engage in include: dieting, fasting, over-exercising, using slimming pills, diuretics, laxatives, vomiting, or binge eating (consumption of an unusually large amount of food accompanied by a sense of loss of control).

Eating disorders are not just about food and weight. They are also not about vanity or will-power. Eating disorders are serious and potentially life threatening mental illnesses, in which a person experiences severe disturbances in eating and exercise behaviours because of distortions in thoughts and emotions, especially those relating to body image or feelings of self-worth. People in all age groups, genders and socio-economic and cultural backgrounds can be affected by eating disorders. A person with an eating disorder can be underweight, within a healthy weight range, or overweight.

There are three main different types of eating disorders: anorexia nervosa, bulimia nervosa and binge eating disorder. If the person you are helping is underweight and using extreme weight-loss strategies, they may have anorexia. If the person is engaging in binge eating followed by extreme weight-loss strategies, they may have bulimia. Although by definition, a person with anorexia is underweight, a person with bulimia can be slightly underweight, within a healthy weight range, or overweight.

If the person regularly eats an unusually large amount of food in a short period of time, accompanied by a sense of loss of control over their eating, but does not use extreme weight-loss strategies to compensate, they may have binge eating disorder. People with binge eating disorder may be within a healthy weight range or overweight.

How can I tell if someone has an eating disorder?

You may not be able to tell if the person has an eating disorder based simply on their appearance. So it is important to know the warning signs, which include behavioural, physical and psychological signs.

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EATING DISORDERS

FIRST AID GUIDELINES

Warning signs of a developing eating disorder

Behavioural warning signs

- Dieting behaviours (e.g. fasting, counting calories/kilojoules, avoidance of food groups or types)
- Evidence of binge eating (e.g. disappearance or hoarding of food)
- Evidence of vomiting or laxative use (e.g. taking trips to the bathroom during or immediately after meals)
- Excessive, obsessive or ritualistic exercise patterns (e.g. exercising when injured or in bad weather, feeling compelled to perform a certain number of repetitions of exercises or experiencing distress if unable to exercise)
- Changes in food preferences (e.g. refusing to eat certain 'fatty' or 'bad' foods, cutting out whole food groups such as meat or dairy, claiming to dislike foods previously enjoyed, a sudden concern with 'healthy eating', or replacing meals with fluids)
- Development of rigid patterns around food selection, preparation and eating (e.g. cutting food into small pieces or eating very slowly)
- Avoidance of eating meals, especially when in a social setting (e.g. skipping meals by claiming they have already eaten or have an intolerance/allergy to particular foods)
- Lying about amount or type of food consumed or evading questions about eating and weight
- Behaviours focused on food (e.g. planning, buying, preparing and cooking meals for others but not actually consuming; interest in cookbooks, recipes and nutrition)
- Behaviours focused on body shape and weight (e.g. interest in weight-loss websites, books and magazines, or images of thin people)
- Development of repetitive or obsessive behaviours relating to body shape and weight (e.g. body-checking such as pinching waist or wrists, repeated weighing of self, excessive time spent looking in mirrors)
- Social withdrawal or avoidance of previously enjoyed activities

Physical warning signs

- Weight loss or weight fluctuations
- Sensitivity to the cold or feeling cold most of the time, even in warm temperatures
- Changes in or loss of menstrual patterns
- Swelling around the cheeks or jaw, calluses on knuckles, or damage to teeth from vomiting
- Fainting

Psychological warning signs

- Pre-occupation with food, body shape and weight
- Extreme body dissatisfaction
- Distorted body image (e.g. complaining of being/feeling/looking fat when a healthy weight or underweight)
- Sensitivity to comments or criticism about exercise, food, body shape or weight
- Heightened anxiety around meal times
- Depression, anxiety or irritability
- Low self-esteem (e.g. negative opinions of self, feelings of shame, guilt or self-loathing)
- Rigid 'black and white' thinking (e.g. labelling of food as either 'good' or 'bad')

Some warning signs may be difficult to detect

This is because the person:

- may feel shame, guilt and distress about their eating or exercise behaviours and therefore these will often occur in secret
- may actively conceal their eating and exercise behaviours
- may deny having a problem
- can find it difficult to ask for help from family and friends.

What are the risks associated with eating disorders?

A person with an eating disorder can experience a wide range of physical and mental health problems. Although rapid weight loss or being very underweight are known to bring about these problems, a person does not need to be underweight for these to occur.

Some serious health consequences associated with eating disorders include severe malnutrition, brain dysfunction and heart or kidney failure, which may lead to loss of consciousness or death. Heart failure and death can occur in both anorexia or bulimia.

It is common for a person with an eating disorder to experience another mental illness, such as depression, and to be at risk of becoming suicidal. For more information on assisting someone who is suicidal, please see the other guidelines in this series *Suicidal thoughts and behaviours: first aid guidelines.*

The need for early intervention

Because eating disorders are complex mental illnesses, people experiencing them will benefit from professional help. For most people, the earlier help is sought for their unhealthy eating and exercise behaviours, the easier it will be to overcome the problem. A delay in seeking treatment can lead to serious long-term consequences for the person's physical and mental health. So, the earlier the person gets help, the more likely they are to make a full recovery. Therefore, the sooner you discuss your concerns with the person the better.

Approaching someone who may have an eating disorder

Your aim should be to provide support for the person so that they feel safe and secure enough to seek treatment or to find someone else they can trust to talk to openly, such as a family member, friend, teacher or co-worker.

Before you approach the person, learn as much as you can about eating disorders. Do this by reading books, articles and brochures, or gathering information from a reliable source, such as an eating disorder support organisation or a health professional experienced in treating them.

EATING DISORDERS

FIRST AID GUIDELINES

How should I approach the person?

Make a plan before approaching the person; choose a place to meet that is private, quiet and comfortable. Avoid approaching the person in situations that may lead them to become sensitive or defensive, such as when either you or they are feeling angry, emotional, tired, or frustrated, are drinking, having a meal, or in a place surrounded by food.

It is better to approach the person alone, because having the whole family or a number of people confront the person at the same time could be overwhelming. Be aware that the person may respond negatively no matter how sensitively you approach them.

What if I don't feel comfortable talking to the person?

It is common to feel nervous when approaching a person about their unhealthy eating and exercise behaviours. Do not avoid talking to the person because you fear it might make them angry or upset, or make their problem worse. When you speak to the person, they might feel relief at having someone acknowledge their problems, or they may find it helpful to know that someone cares about them and has noticed that they are not coping.

What should I say?

The way you discuss the person's problem will depend on the age of the person and the degree to which their problem has developed.

Initially, focus on conveying empathy and not on changing the person or their perspective. When talking with them, you need to be non-judgmental, respectful and kind. This means you should not blame the person or their loved ones for the person's problems and avoid speculating about the cause. Be aware that you may find it tough to listen to what they have to say, especially if you do not agree with what they are saying about themselves, food or exercise. It is important that you try to stay calm.

Discuss your concerns with the person in an open and honest way. Try to use 'I' statements that are not accusing, such as "I am worried about you", rather than 'you' statements such as "You are making me worried". Try not to just focus on weight or food. Instead, allow the person to discuss other concerns that are not about food, weight or exercise. Make sure you give the person plenty of time to discuss their feelings and reassure them that it is safe to be open and honest.

Explain to the person that you think their behaviours may indicate there is a problem that needs professional attention. Offer to assist them in getting the help they need, but be careful not to overwhelm the person with information and suggestions.

Remember that you don't have to know all the answers. There will be times when you don't know what to say. In this instance, just be there for the person by letting them know you care and are committed to supporting them. Reassure the person that they are deserving of your love and concern, and let them know you want them to be healthy and happy.

What if the person reacts negatively?

The person may react negatively because they:

- are not ready to make a change
- do not know how to change without losing their coping strategies
- have difficulty trusting others
- think you are being pushy, nosey, coercive or bullying
- do not see their eating and exercise behaviours as a problem

If the person reacts negatively, it is important not to take their reaction personally. Avoid arguing or being confrontational and do not express disappointment or shock. Resist the temptation to respond angrily, as this may escalate the situation. Do not speak harshly to the person. Instead, be willing to repeat your concerns. Assure the person that even if they don't agree with you, your support is still offered and they can talk with you again in the future if they want to.

Things to avoid

In order to be supportive, it is important to avoid doing or saying things that might make the person feel ashamed or guilty. For instance, you should avoid:

- Being critical of the person
- Giving simple solutions to overcoming the person's problems, such as saying things like "all you have to do is eat"
- Making generalisations such as 'never' and 'always' (e.g. "you're always moody" or "you never do anything but exercise")
- Saying or implying that what the person is doing is 'disgusting', 'stupid' or 'self-destructive'
- Making promises to the person that you cannot keep
- Trying to solve the person's problems for them

How will the person react?

The person may react in a variety of different ways. They might react positively, for instance by being receptive to your concerns, admitting that they have a problem, or being relieved that someone has noticed their problem. The person might react negatively, for instance by being defensive, tearful, angry or aggressive, by denying they have a problem or seeking to re-assure you that they are fine. It is also possible that the person may want time to absorb your comments and concerns. However the person might react, be aware that you are unlikely to resolve the problem in the first conversation and do not expect that the person will immediately follow your advice, even if they asked for it.

Getting professional help

Eating disorders are long-term problems that are not easily overcome. Although there is no quick and easy solution, effective treatments are available. The most effective treatment involves receiving help from a number of different types of professionals.

You should suggest to the person that they may benefit from seeking professional help. It is best to encourage the person to seek help from a professional with specific training in eating disorders. Some general practitioners (GPs) or family doctors may not be able to recognise an eating disorder because they are not formally trained in detecting and

treating them. In some countries, however, a referral from a GP/family doctor is needed to see another trained professional such as a psychiatrist, psychologist, dietician or family therapist.

If the person is very underweight, they may not be able to take responsibility for seeking professional help and may therefore need your assistance to do so. This is because the symptoms of an eating disorder can affect the person's ability to think clearly.

What if the person doesn't want help?

Some people with an eating disorder may refuse professional help. The person may do this for a number of reasons. For instance, they may:

- feel ashamed of their eating and exercise behaviours
- fear gaining weight or losing control over their weight
- be afraid of acknowledging that they are unwell
- do not think that they are unwell
- believe that there are benefits to their eating or exercise behaviours (e.g. controlling their weight may make the person feel better about themselves, or give them a sense of accomplishment).

It is important to know that an adult has a right to refuse treatment, except under specific circumstances described in relevant local legislation (e.g. if the person's life is in danger). Although you may feel frustrated by the person's behaviours, it is important that you do not try to force them to change, or threaten to end your relationship with them. Instead, encourage the person's interests that are unrelated to food or physical appearance. Acknowledge their positive attributes, successes and accomplishments, and try to view them as an individual rather than just someone who has an eating disorder. You cannot force the person to change their attitudes or behaviours, or to seek help, but you can support them until they feel safe and secure enough to seek treatment.

Rather than giving up, continue to be supportive, positive and encouraging, while you are waiting for them to accept their need to change. Continue to suggest the person seek professional help, while being sensitive towards their fears about the process of seeking help. If you would like further support, seek advice from an organisation that specialises in eating disorders.

In an emergency

A person does not have to be underweight to require emergency medical assistance for an eating disorder. Symptoms that indicate a crisis or advanced disorder, for which you should always seek emergency medical help, include when the person:

- has accidentally or deliberately caused themselves a physical injury
- has become suicidal
- has confused thinking and is not making any sense
- has delusions (false beliefs) or hallucinations (experiencing things that aren't there)
- is disoriented; doesn't know what day it is, where they are or who they are
- is vomiting several times a day
- is experiencing fainting spells
- is too weak to walk or collapses
- has painful muscle spasms
- is complaining of chest pain or having trouble breathing
- has blood in their bowel movements, urine or vomit
- has a body mass index (BMI) of less than 16
- has an irregular heart beat or very low heart beat (less than 50 beats per minute)
- has cold or clammy skin indicating a low body temperature or has a body temperature of less than 35 degrees Celsius/95 degrees Fahrenheit

If the person is admitted to hospital for any reason, you should tell the medical staff that you suspect they have an eating disorder.

How can I continue to be supportive?

Offer ongoing support to the person

To help the person feel secure, reassure them that you are not going to take control over their life, but rather will assist them to get help. Explain that even if there are limits to what you can do for them, you are still going to try and help, and you will be there to listen if they want to talk. Suggest that the person surround themselves with people who are supportive.

Give the person hope for recovery

Reassure the person that people with eating disorders can get better and that past unsuccessful attempts do not mean that they cannot get better in the future. Encourage the person to be proud of any positive steps they have taken, such as acknowledging that their eating or exercise behaviours are a problem or agreeing to professional help.

What isn't helpful?

It is especially important that you do not let issues of food dominate your relationship with the person. Try to avoid conflict or arguments over food. Do not give advice about weight loss or exercise and avoid reinforcing the idea that physical appearance is critically important to happiness or success. Also, do not comment positively or negatively on the person's weight or appearance, for instance by saying "you're too thin", "you look well" or "good, you have gained weight."

If you become aware that the person is visiting pro-ana or pro-mia websites (websites that promote eating disorder behaviour) you should discourage further visits, as the websites can encourage destructive behaviour. However, do not mention these sites if the person is not already aware of them.

Eating disorders in children and young people

If you suspect that a child or young person is developing an eating disorder, you should follow the advice above, but also consider the following additional guidelines.

The negative consequences of eating disorders on physical health are much stronger in children than in adults because the eating and exercise behaviours can disrupt normal physical development. A child does not need to have all the symptoms of an eating disorder to suffer from long-term negative effects.

It is important not to accept any symptoms of eating disorders as 'normal adolescent behaviour'. Even if you think that the child's problem is not serious, you should not delay taking action. If left untreated, these behaviours can quickly develop into serious disorders that are difficult to overcome.

EATING DISORDERS

FIRST AID GUIDELINES

If you are a parent concerned about your child

If you are worried that your child may be developing an eating disorder, you should observe their behaviour for any warning signs. If concerned about intruding on your child's privacy, remember that it is your right to ensure that they are safe and healthy.

Seek advice from a professional or organisation specialising in eating disorders. Do not let the child's refusal, tears or tantrums stop you from getting help. Be prepared to take responsibility for getting professional help for your child. If they are underage, you can legally make them attend an appointment with a GP or family doctor, psychiatrist or other appropriate professional.

When initiating discussion about professional help with your child, it is important to stress how much they are loved and that your concerns for them stem from that love. Maintain a caring and supportive home environment. This means expressing your love and support for your child no matter how upsetting their behaviour is.

Understand that any resistance to eating, seeking treatment or gaining weight is motivated by fear and anxiety rather than a desire to be difficult. Always be clear and honest with your child about what to expect from any professional treatment you seek for them.

Do not let empathy for your child inadvertently lead you to support their disorder. For instance, you should not let your child always be the one to decide when, what and where the family will eat, as this may make their problem worse. Also, if your child's behaviour becomes harmful to themselves or others, you must be prepared to move them to a safe environment, such as a hospital.

If you attend an appointment and are worried that the professional is ignoring your child's condition, or has not correctly diagnosed the eating disorder, then you should seek a second opinion.

If you are an adult concerned about a child

If you are an adult who suspects that a child is developing or experiencing an eating disorder, you should first approach the parents, a family member or loved one of the child, before approaching the child directly.

If you are a young person concerned about a friend

If you are a young person who thinks a friend might be developing an eating disorder, there are some things you can do to help. If your friend is hiding their behaviours from their family or loved ones, you should encourage your friend to tell them, or to find a responsible adult they can trust and talk to about what's going on. The adult could be a parent, teacher, coach, pastor, school nurse, school counsellor, GP/family doctor, psychologist or nutritionist.

If your friend refuses to tell, you should then tell a responsible and trusted adult yourself, even if your friend does not want you to. Remember that, because eating disorders are serious illnesses, they should not be kept secret.

Although telling an adult may make your friend angry, it may also save their life. If you feel worried about talking to an adult who is close to your friend, ask your own parents or loved ones for help.

If you or your friend has told an adult about the eating and exercise behaviours, and the adult has not helped your friend, try talking to another responsible and trusted adult, or a professional who is trained in assessing and treating eating disorders.

Purpose of these Guidelines

These guidelines are designed to help members of the public to provide first aid to someone who is developing or experiencing an eating disorder. The role of the first aider is to assist the person until appropriate professional help is received.

Development of these Guidelines

The following guidelines are based on the expert opinions of a panel of mental health consumers, carers and clinicians from Australia, New Zealand, the UK, the USA and Canada about how to help someone who is developing or experiencing an eating disorder. Details of the methodology can be found in: Hart, Jorm, Paxton, Kelly & Kitchener. First Aid for Eating Disorders. *Eating Disorders:* The Journal of Treatment & Prevention. 2009;17(5):357 - 84.

How to use these Guidelines

These guidelines are a general set of recommendations about how you can help someone who is developing or experiencing an eating disorder. Each individual is unique and it is important to tailor your support to that person's needs. These recommendations therefore may not be appropriate for every person who is developing or experiencing an eating disorder.

Also, the guidelines are designed to be suitable for providing first aid in developed English speaking countries. They may not be suitable for other cultural groups or for countries with different health systems.

Please cite these guidelines as follows:

Mental Health First Aid Australia *Eating disorders: first aid guidelines.* Melbourne: Mental Health First Aid Australia; 2008.

Enquiries should be sent to:

Mental Health First Aid Australia

email: mhfa@mhfa.com.au

TRAUMA - ADULTS

How do you support an adult in the minutes, hours, days, weeks, and months following a traumatic experience? This guide will give you practical direction on how to help.

TRAUMATIC EVENTS

FIRST AID GUIDELINES FOR ASSISTING ADULTS

What are the first priorities for helping someone after a traumatic event?

A 'traumatic event' is any incident experienced by the person that is perceived to be traumatic. Common examples of traumas that affect individuals include accidents (such as traffic, car or physical accidents), assault (including physical or sexual assault, mugging or robbery, or family violence), and witnessing something terrible happen. Mass traumatic events include terrorist attacks, mass shootings, and severe weather events (hurricane, tsunami, forest and bush fire).

Please note there are separate guidelines for assisting children who have experienced traumatic events

Mental health first aid might not always occur immediately after the traumatic event.

For instance, there are other sorts of traumas that are not single discrete incidents:

- Common examples of recurring trauma include sexual, physical or emotional abuse, torture, and bullying in the schoolyard or workplace. In these cases, mental health first aid guidelines will be used when the first aider becomes aware of what has been happening.
- Sometimes the memories of a traumatic event suddenly or unexpectedly return, weeks, months or even years afterwards. Again, mental health first aid guidelines will be used when the first aider becomes aware of this.

It is important to know that people can differ a lot in how they react to traumatic events:

- One person may perceive an event as deeply traumatic, while another does not.
- Particular types of traumas may affect some individuals more than others.
- A history of trauma may make some people more susceptible to later traumatic events, while others become more resilient as a result.

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MENTAL HEALTH FIRST AID

TRAUMATIC EVENTS

FIRST AID GUIDELINES FOR ASSISTING ADULTS

What are the first priorities for helping someone after a traumatic event?

You need to ensure your own safety before offering help to anyone. Check for potential dangers, such as fire, weapons, debris, or other people who may become aggressive, before deciding to approach a person to offer your help.

If you are helping someone who you do not know, introduce yourself and explain what your role is. Find out the person's name and use it when talking to them. Remain calm, and do what you can to create a safe environment, by taking the person to a safer location or removing any immediate dangers.

If the person is injured, it is important that their injuries are attended to. If you are able to, offer the person first aid for their injuries, and seek medical assistance. If the person seems physically unhurt, you need to watch for signs that their physical or mental state is declining, and be prepared to seek emergency medical assistance for them. Be aware that a person may suddenly become disoriented, or an apparently uninjured person may have internal injuries that reveal themselves more slowly.

Try to determine what the person's immediate needs are for food, water, shelter or clothing. However, if there are professional helpers nearby (police, ambulance, or others) who are better able to meet those needs, don't take over their role.

If the person has been a victim of assault, you need to consider the possibility that forensic evidence may need to be collected (e.g. cheek swabs, evidence on clothing or skin). Work with the person in preserving such evidence, where possible. For example, they may want to change their clothes and shower, which may destroy forensic evidence. It may be helpful to put clothing in a bag for police to take as evidence and suggest to the person that they wait to shower until after a forensic exam. Although collecting evidence is important, you should not force the person to do anything that they don't want to do.

Do not make any promises you may not be able to keep. For example, don't tell someone that you will get them home soon, if this may not be the case.

What are the priorities if I am helping after a mass traumatic event?

Mass traumatic events are those that affect large numbers of people. They include severe environmental events (such as fires and floods), acts of war and terrorism, and mass shootings. In addition to the general principles outlined above, there are a number of things you need to do.

Find out what emergency help is available. If there are professional helpers at the scene, you should follow their directions.

Be aware of and responsive to the comfort and dignity of the person you are helping, e.g., by offering the person something to cover themselves with (such as a blanket) and asking bystanders or media to go away. Try not to appear rushed or impatient.

Give the person truthful information and admit that you lack information when this is the case. Tell the person about any available sources of information which are offered to survivors (for example, information sessions, fact sheets and phone numbers for information lines) as they become available. Do not try to give the person any information they do not want to hear, as this can be traumatic in itself.

How do I talk to someone who has just experienced a traumatic event?

When talking to a person who has experienced a traumatic event, it is more important to be genuinely caring than to say all the "right things". Show the person that you understand and care, and ask them how they would like to be helped. Speak clearly and avoid clinical and technical language, and communicate with the person as an equal, rather than as a superior or expert. If the person seems unable to understand what is said, you may need to repeat yourself several times. Be aware that providing support doesn't have to be complicated; it can involve small things like spending time with the person, having a cup of tea or coffee, chatting about day-to-day life or giving them a hug.

Behaviour such as withdrawal, irritability and bad temper may be a response to the trauma, so try not to take such behaviour personally. Try to be friendly, even if the person is being difficult.

The person may not be as distressed about what has happened as you might expect them to be, and this is fine. Don't tell the person how they should be feeling. Tell them that everyone deals with trauma at their own pace. Be aware that cultural differences may influence the way some people respond to a traumatic event; for example, in some cultures, expressing vulnerability or grief around strangers is not considered appropriate.

Should we talk about what happened? How can I support someone in doing so?

It is very important that you do not force the person to tell their story. Remember that you are not the person's therapist.

Only encourage the person to talk about their reactions if they feel ready and want to do so. If the person does want to talk, don't interrupt to share your own feelings, experiences or opinions. Be aware that the person may need to talk repetitively about the trauma, so you may need to be willing to listen on more than one occasion.

Avoid saying anything that might trivialise the person's feelings, such as "don't cry" or "calm down", or anything that might trivialise their experience, such as "you should just be glad you're alive."

Be aware that the person may experience survivors' guilt; the feeling that it is unfair that others died, or were injured, while they were not.

How can I help the person to cope over the next few weeks or months?

If you are helping someone you know after a traumatic event, you can help them to cope with their reactions over the next few weeks or months. You may be helping a family member, perhaps a spouse, sibling or parent who you are living with. If you are helping someone you don't know, unless you are responsible for them in some professional capacity, it is not expected that you will have further contact with them.

Encourage the person to tell others when they need or want something, rather than assume others will know what they want. Also encourage them to identify sources of support, including loved ones and friends, but remember that it is important to respect the person's need to be alone at times.

TRAUMATIC EVENTS

FIRST AID GUIDELINES FOR ASSISTING ADULTS

Encourage the person to take care of themselves; to get plenty of rest if they feel tired, to do things that feel good to them (e.g., take baths, read, exercise, watch television), and to think about any coping strategies they have successfully used in the past and use them again. Encourage them to spend time somewhere they feel safe and comfortable.

Be aware that the person may suddenly or unexpectedly remember details of the event, and may or may not wish to discuss these details. If this happens, the general principles outlined above can help you to assist the person.

Discourage the person from using negative coping strategies such as working too hard, using alcohol and other drugs, or engaging in self-destructive behaviour.

When should the person seek professional help?

Not everyone will need professional help to recover from a traumatic event. If the person wants to seek help, you should support them to do so. Be aware of the sorts of professional help that are available locally, and if the person does not like the first professional they speak to, you should tell them that it is okay to try a different one. If the person hasn't indicated that they want professional help, the following guidelines can help you to determine whether help is needed.

If at any time the person becomes suicidal, you should seek professional help. The companion guidelines entitled First aid for suicidal thoughts and feelings may be useful in helping you to do this. Also, if at any time the person abuses alcohol or other drugs to deal with the trauma, you should encourage them to seek professional help.

After 4 weeks, some return to normal functioning is expected. You should encourage the person to seek professional help if, for 4 weeks or more, after the trauma:

- **They still feel very upset or fearful.**
- **They are unable to escape intense, ongoing distressing feelings.**
- **Their important relationships are suffering as a result of the trauma (e.g., if they withdraw from their family or friends).**
- **They feel jumpy or have nightmares because of or about the trauma.**
- **They can't stop thinking about the trauma.**
- **They are unable to enjoy life at all as a result of the trauma**
- **Their post-trauma symptoms are interfering with their usual activities.**

Purpose of these Guidelines

These guidelines are designed to help members of the public to provide first aid to someone who has experienced a traumatic event. The role of the first aider is to assist the person until appropriate professional help is received or the crisis resolves

Development of these Guidelines

The following guidelines are based on the expert opinions of a panel of mental health consumers, carers and clinicians from Australia, New Zealand, the UK, the USA and Canada about how to help someone who has experienced a traumatic event. Details of the methodology can be found in: Kelly CM, Jorm AF, Kitchener BA (2010) Development of mental health first aid guidelines on how a member of the public can support a person affected by a traumatic event: A Delphi study. BMC Psychiatry 10: 49 www.biomedcentral.com/1471-244X/10/49

How to use these Guidelines

These guidelines are a general set of recommendations about how you can help someone who has experienced a traumatic event. Each individual is unique and it is important to tailor your support to that person's needs. These recommendations therefore may not be appropriate for every person who has experienced a traumatic event.

Also, the guidelines are designed to be suitable for providing first aid in developed English-speaking countries. They may not be suitable for other cultural groups or for countries with different health systems.

Please cite these guidelines as follows:
Mental Health First Aid Australia. *Traumatic events: first aid guidelines for assisting adults.* Melbourne: Mental Health First Aid Australia; 2008.

Enquiries should be sent to: Mental Health First Aid Australia **email:** mhfa@mhfa.com.au

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TRAUMA - KIDS

Kids respond to traumatic events different than adults. This guide will help you know just what to do (and not do) when helping a child navigate a traumatic event in their life.

TRAUMATIC EVENTS

FIRST AID GUIDELINES FOR ASSISTING CHILDREN

What is a traumatic event?

A 'traumatic event' is any incident experienced by the person that is perceived to be traumatic. Common examples of traumas that affect individuals include accidents (such as traffic, car or physical accidents), assault (including physical or sexual assault, mugging or robbery, or family violence), and witnessing something terrible happen. Mass traumatic events include terrorist attacks, mass shootings, and severe weather events (hurricane, tsunami, forest and bush fire).

If mental heath first aid is being provided by a parent, the parental role takes precedence over the first aid role.

Please note there are separate guidelines for assisting adults who have experienced traumatic events

Mental health first aid might not always occur immediately after the traumatic event.

For instance, there are other sorts of traumas that are not single discrete incidents:

- Common examples of recurring trauma include sexual, physical or emotional abuse, torture, and bullying in the schoolyard or workplace. In these cases, mental health first aid guidelines will be used when the first aider becomes aware of what has been happening.
- Sometimes the memories of a traumatic event suddenly or unexpectedly return, weeks, months or even years afterwards. Again, mental health first aid guidelines will be used when the first aider becomes aware of this.

It is important to know that people can differ a lot in how they react to traumatic events:

- One person may perceive an event as deeply traumatic, while another does not.
- Particular types of traumas may affect some individuals more than others.
- A history of trauma may make some people more susceptible to later traumatic events, while others become more resilient as a result.

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TRAUMATIC EVENTS

FIRST AID GUIDELINES FOR ASSISTING CHILDREN

What are the first priorities for helping a child after a traumatic event?

You need to ensure your own safety before offering help to anyone. Determine whether it is safe to approach the child. Before deciding to approach a child to offer your help, check for potential dangers (for example, from fire, weapons, or debris), including any person who may become aggressive.

If you are helping a child who you do not know, introduce yourself and explain that you are there to help. Find out the child's name and use it when talking to them. Remain calm. Do what you can to protect the child (whether by taking them to a safer location or removing any immediate dangers). Reassure the child that they won't be left alone, so far as this is possible, and ensure that you, or another adult (such as a professional helper), are available to take care of the child. If you have to leave the child alone for a few minutes to attend to others, reassure the child that you will back soon. However, try not to behave towards the child in such a way that they feel they are still in danger.

If the child is injured, it is important that their injuries are attended to. If you are able to, give the child first aid for their injuries, and seek medical assistance. If the child seems physically unhurt, you need to watch for signs that their physical or mental state is declining, and be prepared to seek emergency medical assistance for them. Be aware that a child may suddenly become disoriented, or an apparently uninjured child may have internal injuries that reveal themselves more slowly.

Try to determine what the child's immediate needs are for food, water, shelter or clothing. However, if there are professional helpers nearby (police, ambulance, or others) who are better able to meet those needs, don't take over their role.

Don't make any promises you may not be able to keep. For example, don't promise the child that you will get them home soon, when this may not be the case.

What are the priorities if I am helping after a mass traumatic event?

Mass traumatic events are those which affect large numbers of people. They include severe environmental events (such as fires and floods), acts of war and terrorism, and mass shootings. In addition to the more general guidelines in the previous section, there are a number of things you need to do.

Try to keep the child together with any loved ones and carers who are present. If they are not present, or have been separated from the child in the course of the event, ensure that the child is re-connected with them as soon as possible.

Ask the child what would make them feel better or safer. Direct the child away from traumatic sights and sounds (including media images), people who are injured, and very distressed people (e.g., anyone who is screaming, agitated or aggressive). Ask bystanders and the media to stay away from the child.

How do I talk to a child who has experienced a traumatic event?

This section of the guidelines may be used to help you support a child after they have experienced a traumatic event. If you know the child, then you can use these guidelines to offer the child ongoing support. If you don't know the child, then you can use these as a guide for talking to the child at anytime that you come into contact with them following their traumatic experience, e.g. at the scene of a trauma, or later on, at home, in a classroom, or elsewhere.

Remember, when talking to a child who has experienced a traumatic event, that it is more important to be genuinely caring than to say all the "right things". Show the child that you understand and care, be patient, and tell the child you will do your best to keep them safe.

Talk to the child using age-appropriate language and explanations. Allow the child to ask questions and answer them as truthfully as possible. Be patient if the child asks the same question many times, and try to be consistent with answers and information. If you can't answer a question, admit to the child that you don't know the answer.

If the child knows accurate, upsetting details, don't deny these. When someone has died, it can be tempting to soften this news by telling a child that the person has "gone to sleep", but this is best avoided, as it may result in the child becoming fearful of sleep.

A child may stop talking altogether after a trauma, and if this happens, you should not try to force or coerce the child to speak. Equally, you should never coerce a child to talk about their feelings or memories of the trauma before they are ready to do so.

If the child wants to talk about their feelings, you should allow them to. Some children prefer to express their feelings through writing, drawing, or playing with toys.

Never tell the child how they should or shouldn't be feeling. Don't tell the child to be brave, or not to cry, and don't make judgements about their feelings. Don't get angry if the child expresses strong emotions; instead tell them it is okay to feel upset when something bad or scary happens

A child has told me that they are being abused. What should I do?

Remain calm and reassure the child that they have done the right thing by telling you, and that what happened was not their fault. Tell the child that you believe them.

You need to know the local laws or regulations about reporting suspected child abuse and follow these. Contact the appropriate authorities and work with them to ensure the child's safety. Do not confront the perpetrator

I am a parent/guardian and the child I am helping lives with me. How should I behave at home?

Try to keep your behaviour as predictable as possible, and tell the child that you (and their other loved ones) love and support them. Encourage the child to do things they enjoy, such as playing with toys or reading books. You can help the child to feel in control by letting them make some decisions (e.g. about meals, or what to wear).

Dealing with temper tantrums and avoidance behaviours

Be aware that the child may avoid things that remind them of the trauma (such as specific places, driving in the car, certain people, or separation from their parents or guardians). Try to figure out what triggers sudden fearfulness or regression in the child. If the child has temper tantrums or becomes fearful, crying and clingy in order to avoid something that reminds them of the trauma, ask them what they are afraid of. Don't get angry or call the child 'babyish' if they appear to regress, for example by bedwetting, misbehaving, or sucking their thumb.

If the child avoids things which remind them of the trauma, but does not appear very distressed, ask what they are afraid of and assure them that they are safe.

The symptoms associated with trauma may suddenly or unexpectedly appear months or years after the event. If this occurs, professional help may need to be sought.

TRAUMATIC EVENTS

FIRST AID GUIDELINES FOR ASSISTING CHILDREN

Should the child receive professional help?

Not all children will need professional help to recover from a traumatic event.
The following guidelines can help you to determine whether help is needed.

If at any time the child becomes suicidal, you should seek immediate professional help.

You should seek professional help for the child if, for 2 weeks or more after the trauma:

- The child is unable to enjoy life at all.
- The child displays sudden severe or delayed reactions to trauma.
- The child is unable to escape intense ongoing distressing feelings.
- The child's post-trauma symptoms are interfering with their usual activities.
- The child's important relationships are suffering (e.g. if they withdraw from their carers or friends).

You should seek professional help for the child if, for 4 weeks or more after the trauma:

- The child has temper tantrums or becomes fearful, crying and clingy in order to avoid something which reminds them of what happened.
- The child still feels very upset or fearful.
- The child acts very differently compared to before the trauma.
- The child feels jumpy or has nightmares because of or about the trauma.
- The child can't stop thinking about the trauma.

You should be aware of the types of professional help which are available locally for children. Clinical child psychologists, psychiatrists, pediatricians and family doctors can all be helpful. If you are not the child's parent or guardian, do not seek professional help for them unless it is an emergency; instead assist the child's parent or guardian to seek professional help for them.

Purpose of these Guidelines

These guidelines are designed to help members of the public to provide first aid to a child who has experienced a traumatic event. The role of the first aider is to assist the person until appropriate professional help is received or the crisis resolves.

Development of these Guidelines

The following guidelines are based on the expert opinions of a panel of mental health consumers, carers and clinicians from Australia, New Zealand, the UK, the USA and Canada about how to help someone who has experienced a traumatic event. Details of the methodology can be found in: Kelly CM, Jorm AF, Kitchener BA (2010) Development of mental health first aid guidelines on how a member of the public can support a person affected by a traumatic event: a Delphi study.

How to use these Guidelines

These guidelines are a general set of recommendations about how you can help a child who has experienced a traumatic event. Each child is unique and it is important to tailor your support to that child's needs. These recommendations therefore may not be appropriate for every child who has experienced a traumatic event.

Also, the guidelines are designed to be suitable for providing first aid in developed English-speaking countries. They may not be suitable for other cultural groups or for countries with different health systems.

Please cite these guidelines as follows:
Mental Health First Aid Australia. *Traumatic events: first aid guidelines for assisting children.* Melbourne: Mental Health First Aid Australia; 2008.

Enquiries should be sent to:

Mental Health First Aid Australia
email: mhfa@mhfa.com.au

8186_08_ORYGENKJ

PANIC ATTACK

Panic attacks are terrifying for those experiencing them and those around them. It's hard to know if the person is dying or not at times. Knowing how to recognize a panic attack and support a person who is experiencing one is what this guide will help you with.

MENTAL HEALTH FIRST AID

PANIC ATTACKS

FIRST AID GUIDELINES

What is a panic attack?

A panic attack is a distinct episode of high anxiety, with fear or discomfort, which develops abruptly and has its peak within 10 minutes. During the attack, several of the following symptoms are present.

- Palpitations, pounding heart, or rapid heart rate
- Sweating
- Trembling and shaking
- Shortness of breath, sensations of choking or smothering
- Chest pain or discomfort
- Abdominal distress or nausea
- Dizziness, light-headedness, feeling faint or unsteady
- Feelings of unreality (derealisation), or being detached from oneself
- Fears of losing control or going crazy
- Fear of dying
- Numbness or tingling
- Chills or hot flushes

Adapted from DSM-IV-TR, APA 2000

PANIC ATTACKS

FIRST AID GUIDELINES

What should I do if I think someone is having a panic attack?

If someone is experiencing the above symptoms and you suspect that they are having a panic attack, you should first ask them if they know what is happening and whether they have ever had a panic attack before. If they say that they have had panic attacks before, and believe that they are having one now, ask them if they need any kind of help, and give it to them. If you are helping someone you do not know, introduce yourself.

What if I am uncertain whether the person is really having a panic attack, and not something more serious like a heart attack?

The symptoms of a panic sometimes resemble the symptoms of a heart attack or other medical problem. It is not possible to be totally sure that a person is having a panic attack. Only a medical professional can tell if it is something more serious. If the person has not had a panic attack before, and doesn't think they are having one now, you should follow physical first aid guidelines.

Ask the person, or check to see, if they are wearing a medical alert bracelet or necklace. If they are, follow the instructions on the alert or seek medical assistance.

If the person loses consciousness, apply physical first aid principles. Check for breathing and pulse, and call an ambulance.

What should I say and do if I know the person is having a panic attack?

Reassure the person that they are experiencing a panic attack. It is important that you remain calm and that you do not start to panic yourself. Speak to the person in a reassuring but firm manner, and be patient. Speak clearly and slowly and use short, clear sentences.

Rather than making assumptions about what the person needs, ask them directly what they think might help.

Do not belittle the person's experience. Acknowledge that the terror feels very real, but reassure them that a panic attack, while very frightening, is not life threatening or dangerous. Reassure them that they are safe and that the symptoms will pass.

What should I say and do when the panic attack has ended?

After the panic attack has subsided, ask the person if they know where they can get information about panic attacks. If they don't know, offer some suggestions.

Tell the person that if the panic attacks recur, and are causing them distress, they should speak to an appropriate health professional. You should be aware of the range of professional help available for panic attacks in your community. Reassure the person that there are effective treatments available for panic attacks and panic disorder.

Panic attacks, panic disorder and agoraphobia

A panic attack is not a mental disorder. In fact, more than one in five people experience one or more panic attacks in their lifetime[1], but few go on to develop panic disorder or agoraphobia (anxiety disorders related to panic attacks).

Criteria for panic disorder[2]

- Recurrent, unexpected panic attacks

AND, for at least one month:

- worry or concern about possible future panic attacks;
- worry or concern about the possible consequences of panic attacks, such as a fear of losing control or having a heart attack;
- or a significant change in behaviour related to the panic attacks.

Criteria for agoraphobia[2]

- Anxiety about places or situations where the individual fears they may have a panic attack. The focus of the anxiety is that it will be difficult or embarrassing to get away from the place if a panic attack occurs, or that there will be no one present who can help.

AND:

- Avoidance of the places or situations which are the focus of the anxiety.

Some individuals avoid only a few places or situations (such as shopping centres, driving, or crowded places) and others may find it difficult to leave their homes.

Some people may develop panic disorder or agoraphobia after only a few panic attacks, while others may experience many panic attacks without developing either of these disorders.

1. Kessler RC et. al. *Arch Gen Psychiatry 2006, 63:415-424*

2. Adapted from DSM-IV-TR, APA 2000

MENTAL HEALTH FIRST AID

PANIC ATTACKS

FIRST AID GUIDELINES

Purpose of these Guidelines

These guidelines are designed to help members of the public to provide first aid to someone who is having a panic attack. The role of the first aider is to assist the person until appropriate professional help is received or the crisis resolves.

Development of these Guidelines

The following guidelines are based on the expert opinions of a panel of mental health consumers and clinicians from Australia, New Zealand, the UK, the USA and Canada about how to help someone who is having a panic attack. Details of the methodology can be found in: Kelly CM, Jorm AF, Kitchener BA (2009) Development of mental health first aid guidelines for panic attacks: A Delphi study. BMC Psychiatry, 9:49 doi:10.1186/1471-244X-9-49

How to use these Guidelines

These guidelines are a general set of recommendations about how you can help someone who is having a panic attack. Each individual is unique and it is important to tailor your support to that person's needs. These recommendations therefore may not be appropriate for every person who experiences a panic attack.

Also, the guidelines are designed to be suitable for providing first aid in developed English-speaking countries. They may not be suitable for other cultural groups or for countries with different health systems.

Please cite these guidelines as follows:
Mental Health First Aid Australia. *Panic attacks: first aid guidelines.* Melbourne: Mental Health First Aid Australia; 2008.

Enquiries should be sent to:

Mental Health First Aid Australia
email: mhfa@mhfa.com.au

All MHFA guidelines can be downloaded from **www.mhfa.com.au**

8185_08 ORYGENKJ

PSYCHOSIS (LOST CONNECTION W/ REALITY)

Sometimes we find ourself in contact with someone that seems to have lost connection with reality in a significant way. They maybe hallucinating and or talking nonsense. This guide will help you have a framework for understanding what's happening and how to help.

PSYCHOSIS
FIRST AID GUIDELINES

- How do I know if someone is experiencing psychosis?
- Common symptoms when psychosis is developing
- How should I approach someone who may be experiencing psychotic symptoms?
- How can I be supportive?
- How do I deal with delusions and hallucinations?
- How do I deal with communication difficulties?
- What if the person doesn't want help?
- What should I do in a crisis situation?
- What if the person becomes aggressive?
- How to de-escalate the situation.

How do I know if someone is experiencing psychosis?

It is important to learn about the early warning signs of psychosis (see box) so that you can recognise when someone may be developing psychosis. Although these signs may not be very dramatic on their own, when you consider them together, they may suggest that something is not quite right. It is important not to ignore or dismiss such warning signs, even if they appear gradually and are unclear. Do not assume that the person is just going through a phase or misusing alcohol or other drugs, or that the symptoms will go away on their own.

Common symptoms when psychosis is developing[1]

Changes in emotion and motivation:

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

Changes in thinking and perception:

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

Changes in behaviour:

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

[1]Adapted from: Edwards, J & McGorry, PD (2002). *Implementing Early Intervention in Psychosis.* Martin Dunitz, London.

You should be aware that the signs and/or symptoms of psychosis may vary from person to person and can change over time. You should also consider the spiritual and cultural context of the person's behaviours, as what is considered to be a symptom of psychosis in one culture may be considered normal in another.

PSYCHOSIS
FIRST AID GUIDELINES

How should I approach someone who may be experiencing psychotic symptoms?

People developing a psychotic disorder will often not reach out for help. Someone who is experiencing profound and frightening changes such as psychotic symptoms will often try to keep them a secret. If you are concerned about someone, approach the person in a caring and non-judgemental manner to discuss your concerns. The person you are trying to help might not trust you or might be afraid of being perceived as "different", and therefore may not be open with you. If possible, you should approach the person privately about their experiences in a place that is free of distractions.

Try to tailor your approach and interaction to the way the person is behaving (e.g. if the person is suspicious and is avoiding eye contact, be sensitive to this and give them the space they need). Do not touch the person without their permission. You should state the specific behaviours you are concerned about and should not speculate about the person's diagnosis. It is important to allow the person to talk about their experiences and beliefs if they want to. As far as possible, let the person set the pace and style of the interaction. You should recognise that they may be frightened by their thoughts and feelings. Ask the person about what will help them to feel safe and in control. Reassure them that you are there to help and support them, and that you want to keep them safe. If possible, offer the person choices of how you can help them so that they are in control. Convey a message of hope by assuring them that help is available and things can get better.

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

How can I be supportive?

Treat the person with respect. You should try to empathise with how the person feels about their beliefs and experiences, without stating any judgments about the content of those beliefs and experiences. The person may be behaving and talking differently due to psychotic symptoms.

They may also find it difficult to tell what is real from what is not real.

You should avoid confronting the person and should not criticise or blame them. Understand the symptoms for what they are and try not to take them personally. Do not use sarcasm and try to avoid using patronising statements.

It is important that you are honest when interacting with the person. Do not make any promises that you cannot keep.

How do I deal with delusions (false beliefs) and hallucinations (perceiving things that are not real)?

It is important to recognise that the delusions and hallucinations are very real to the person. You should not dismiss, minimise or argue with the person about their delusions or hallucinations. Similarly, do not act alarmed, horrified or embarrassed by the person's delusions or hallucinations. You should not laugh at the person's symptoms of psychosis. If the person exhibits paranoid behaviour, do not encourage or inflame the person's paranoia.

How do I deal with communication difficulties?

People experiencing symptoms of psychosis are often unable to think clearly. You should respond to disorganised speech by communicating in an uncomplicated and succinct manner, and should repeat things if necessary. After you say something, you should be patient and allow plenty of time for the person to process the information and respond. If the person is showing a limited range of feelings, you should be aware that it does not mean that the person is not feeling anything. Likewise, you should not assume the person cannot understand what you are saying, even if their response is limited.

Should I encourage the person to seek professional help?

You should ask the person if they have felt this way before and if so, what they have done in the past that has been helpful. Try to find out what type of assistance they believe will help them. Also, try to determine whether the person has a supportive social network and if they do, encourage them to utilise these supports.

If the person decides to seek professional help, you should make sure that they are supported both emotionally and practically in accessing services. If the person does seek help, and either they or you lack confidence in the medical advice they have received, they should seek a second opinion from another medical or mental health professional.

What if the person doesn't want help?

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

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

What should I do in a crisis situation when the person has become acutely unwell?

In a crisis situation, you should try to remain as calm as possible. Evaluate the situation by assessing the risks involved (e.g. whether there is any risk that the person will harm themselves or others). It is important to assess whether the person is at risk of suicide [please see the MHFA Guidelines for Suicidal Behaviour. These can be downloaded from www.mhfa.com.au.]. If the person has an advance directive or relapse prevention plan, you should follow those instructions. Try to find out if the person has anyone s/he trusts (e.g. close friends, family) and try to enlist their help. You should also assess whether it is safe for the person to be alone and, if not, should ensure that someone stays with them.

It is important to communicate to the person in a clear and concise manner and use short, simple sentences. Speak quietly in a non-threatening tone of voice at a moderate pace. If the person asks you questions, answer them calmly. You should comply with requests unless they are unsafe or unreasonable. This gives the person the opportunity to feel somewhat in control.

You should be aware that the person might act upon a delusion or hallucination. Remember that your primary task is to de-escalate the situation and therefore you should not do anything to further agitate the person. Try to maintain safety and protect the person, yourself and others around you from harm. Make sure that you have access to an exit.

You must remain aware that you may not be able to de-escalate the situation and if this is the case, you should be prepared to call for assistance. If the person is at risk of harming themselves or others, you should make sure they are evaluated by a medical or mental health professional immediately. If crisis staff arrive, you should convey specific, concise observations about the severity of the person's behaviour and symptoms to the crisis staff. You should explain to the person you are helping who any unfamiliar people are, that they are there to help and how they are going to help. However, if your concerns about the person are dismissed by the services you contact, you should persevere in trying to seek support for them.

PSYCHOSIS
FIRST AID GUIDELINES

What if the person becomes aggressive?

People with psychosis are not usually aggressive and are at a much higher risk of harming themselves than others. However, certain symptoms of psychosis (e.g. delusions or hallucinations) can cause people to become aggressive. You should know how to de-escalate the situation if the person you are trying to help becomes aggressive.

How to de-escalate the situation:

- Do not respond in a hostile, disciplinary or challenging manner to the person;
- Do not threaten them as this may increase fear or prompt aggressive behaviour;
- Avoid raising your voice or talking too fast;
- Stay calm and avoid nervous behaviour (e.g. shuffling your feet, fidgeting, making abrupt movements);
- Do not to restrict the person's movement (e.g. if he or she wants to pace up and down the room);
- Remain aware that the person's symptoms or fear causing their aggression might be exacerbated if you take certain steps (e.g. involve the police).

Take any threats or warnings seriously, particularly if the person believes they are being persecuted. If you are frightened, seek outside help immediately. You should never put yourself at risk. Similarly, if the person's aggression escalates out of control at any time, you should remove yourself from the situation and call the crisis team. When contacting the appropriate mental health service, you should not assume the person is experiencing a psychotic episode but should rather outline any symptoms and immediate concerns.

If the situation becomes unsafe, it may be necessary to involve the police. To assist the police in their response, you should tell them that you suspect the person is experiencing a psychotic episode and that you need their help to obtain medical treatment and to control the person's aggressive behaviour. You should tell the police whether or not the person is armed.

Purpose of these guidelines

These guidelines are designed to help members of the public to provide first aid to someone who may be experiencing psychosis. The role of the first aider is to assist the person until appropriate professional help is received or the crisis resolves.

Development of these Guidelines

The following guidelines are based on the expert opinions of a panel of mental health consumers, carers and clinicians from Australia, New Zealand, the UK, Ireland, the USA and Canada about how to help someone who may be experiencing a psychotic episode. Details of the methodology can be found in: Langlands RL, Jorm AF, Kelly CM, Kitchener BA. First aid recommendations for psychosis: Using the Delphi method to gain consensus between mental health consumers, carers and clinicians. *Schizophrenia Bulletin* 2008; 34:435-443

How to use these Guidelines

These guidelines are a general set of recommendations about how you can help someone who may be experiencing psychosis. Each individual is unique and it is important to tailor your support to that person's needs. These recommendations therefore will not be appropriate for every person who may have psychosis.

Also, the guidelines are designed to be suitable for providing first aid in developed English-speaking countries. They may not be suitable for other cultural groups or for countries with different health systems.

Please cite these guidelines as follows:

Mental Health First Aid Australia. Psychosis: first aid guidelines. Melbourne: Mental Health First Aid Australia; 2008.

Enquiries should be sent to:

Mental Health First Aid Australia
email: mhfa@mhfa.com.au

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DISORIENTED / CONFUSED ELDERLY

As the body ages so does the brain. This can lead to dementia and other mental struggles. This guide will help you to recognize when an elderly person is experiencing related confusion/ disorientation and know how to help.

GUIDELINES FOR HELPING THE CONFUSED OLDER PERSON

Confusion and dementia in older people

Confusion and dementia can occur in adults of any age, but are much more likely in older people. However, they are not a normal part of ageing.

Topics covered:

- **Signs of dementia**
- **What to do if you are concerned that a person may be developing dementia**
- **Supporting the person with dementia**
- **Communicating with the confused person**
- **Discussing sensitive issues**
- **Discussions and decisions about driving**
- **Discussions and decisions about care**
- **Behaviours that you may find challenging**
- **Assisting the confused person who is wandering**
- **Delirium.**

What is confusion?

'Confusion' is a broad term that refers to a decline in normal cognitive ability, which may vary from mild to severe. The cognitive changes may be associated with dementia, delirium or other medical conditions. It may include a number of the following signs and symptoms: lack of alertness, poor attention span, disorientation to time and place, trouble following a conversation, unclear or illogical speech, impaired short-term memory, difficulty in planning and carrying out tasks, inappropriate behaviour, disconnection from reality or delusional beliefs.

What is dementia?

'Dementia' is a condition involving progressive decline of cognitive abilities such as short-term memory, language and the ability to plan and carry out tasks. Dementia is an umbrella term for a large group of illnesses that cause this progressive decline. The early signs of dementia are subtle and can differ from person to person. However, the symptoms appear over months and years and tend to get worse over time.

Because of the progressive nature of dementia you may find that some of the strategies suggested in these guidelines are more applicable at the earlier stages, while others will be applicable at later stages.

Mental Health First Aid Australia
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MENTAL HEALTH FIRST AID

GUIDELINES FOR HELPING THE CONFUSED OLDER PERSON

Signs of dementia

The following signs may indicate a person is developing dementia.

Cognitive signs

- **Memory loss, e.g.:**
  - Forgetting things more often, and not remembering them later
  - Repeatedly misplacing items by putting them in inappropriate places
  - Forgetting the first part of an explanation by the time the explanation finishes
  - Difficulty remembering much, or any, new information.
- **Difficulty communicating or finding words, e.g.:**
  - Forgetting simple words
  - Substituting inappropriate words.
- **Difficulty with complex tasks or abstract thinking, e.g. forgetting completely what numbers are and what needs to be done with them**
- **Difficulty with planning and organizing, e.g.:**
  - Trouble following a familiar recipe or keeping track of monthly bills
  - Difficulty concentrating and taking much longer to do things than before.
- **Poor or decreased judgement, e.g.:**
  - Giving large amounts to telemarketers
  - Paying less attention to grooming or not keeping clean.
- **Inability to reason**
- **Difficulty with coordination and motor function**
- **Problems with disorientation, e.g.:**
  - Becoming lost on a familiar street
  - Not knowing where they are, how they got there or how to get back home
  - Losing track of dates, seasons and the passage of time.
- **Loss of ability to do everyday tasks**
- **Hallucinations and delusions.**

Emotional signs

- **Apathy, withdrawal and loss of initiative, e.g.:**
  - Uncommunicative
  - Passive and requiring prompts to become involved.
- **Personality changes, e.g.:**
  - Suspicious, fearful, paranoid
  - Disinhibited or behaving inappropriately
  - Agitated.
- **Mood swings, e.g. rapid changes from calm to tears to anger, for no apparent reason.**

It is important to note that changes in memory or other signs above do not necessarily indicate that the person has dementia, but may be related to other health problems.

This list is adapted from lists from Alzheimer's Australia (fightdementia.org.au), Alzheimer's Association USA (alz.org), and the Mayo Clinic (mayoclinic.org)

What to do if you are concerned that a person may be developing dementia

Early detection of dementia may have benefits for the person, their family's acceptance and the long-term management of the condition.

Talking to the person about your concerns

If you are talking to the person about your concerns about their memory and functioning, you should:

- Ask the person how they are feeling about their memory.
- Try to keep the conversation positive by focusing on the benefits of early treatment for retaining skills and strengths.
- Explain that you are concerned because you care.
- Try to make the person feel at ease and reassure them that their memory problems are not their fault.
- Reassure them that you care for or love them regardless of their memory and functioning, as this will provide a sense of security for the person.
- Try not to be upset if the person refuses to accept what you are saying.

Seeking professional help

You should encourage the person to see a doctor if:

- The person shows signs of dementia.
- Others in the person's life are worried about changes in the person's memory and functioning.
- The person is worried that there have been changes in their memory and functioning.

Note that if there is a sudden cognitive deterioration in the person, **immediate** medical attention is required. In some cases it may be a result of a reversible illness. (See the section entitled Delirium on page 10.)

Before the person attends an initial appointment with a doctor, you can help them to prepare for the appointment by thinking about and recording what information would be useful at the appointment, e.g. medical and family history, a list of behavioural or memory changes you have noticed in the person, questions for the doctor. Consider going to the doctor's appointment with the person, so that you

can act as an advocate for them. If you attend the doctor's appointment, ask the person's permission to be given confidential information from the doctor.

If the person is reluctant to get help

The person may be reluctant to visit a doctor because they may not have the insight to realise something is wrong or, if they do, they may be afraid of having their fears confirmed. They may also be embarrassed or upset about their memory loss.

If the person is reluctant to get help, you should:

- Discuss the matter with them and try to identify the reason behind their reluctance.
- Acknowledge any fears or worries the person expresses and help them overcome these by providing care and reassurance.
- Tell them that a doctor's visit will help to rule out any physical or temporary conditions causing their signs or symptoms.
- Suggest that the person go for a general medical check-up.

If the person remains reluctant to get help, identify another individual who has a good relationship with the person to support them to seek help. If the person refuses to seek help and their health or safety is at risk, get aged care assessment services involved.

Supporting the person with dementia

Seeing the person behind the dementia

You should think of the person as a 'person with dementia' and not a 'demented person'. Even though the person has failing memory or reduced understanding, it does not mean that they do not have a sense of self, personality, or thoughts and feelings. Do not assume that the person cannot learn and enjoy new things. In the earlier stages, the person may still retain much of their intellectual capacity and may still have the desire to be a contributing member of society.

Helping the person with their memory problems

If the person complains about memory loss, acknowledge it rather than dismiss it, e.g. say "It must be frustrating." Let them talk about it, unless it seems to upset them more than help them.

You should also be aware of a range of memory strategies that you can use to assist the person. If the person has forgotten that they have done something and keeps asking to do it (e.g. attending a doctor's appointment), consider using the following strategies:

- Repeat the answer, in a kind and reassuring tone of voice.
- Acknowledge the emotions behind the person's concerns.
- Patiently accept the repetition, if the above strategies do not help.

If the person does not recognise what an object is for, consider using the following strategies:

- Explain what it is for in a sensitive manner to avoid the person feeling a sense of failure.
- Demonstrate the use of the item.
- Use step-by-step prompts.
- Acknowledge any frustration the person may be experiencing.

Help the person's memory by providing appropriate information for a situation, e.g. when introducing people, you might say, "Here's your nephew John and his wife Sharon." Avoid quizzing the person, e.g. asking "Do you remember everyone's name?" Also avoid asking questions such as, "Do you remember?", "Don't you remember?" and "Have you forgotten?", because it may upset the person and is unlikely to be helpful. It is best to avoid pointing out any errors the person makes, as this can be discouraging for someone with memory loss.

Helping the person to complete tasks

Use strategies that will help the person maintain as much of their independence as possible and reduce the possibility that the person feels they are being treated like a child or as incapable. You should not blame the person for mistakes that arise from their lack of ability or their misunderstanding of what is needed of them.

If the person is struggling with a task (e.g. dressing), consider using the following strategies:

- Acknowledge the person's frustration.
- Offer help, or do the task with them, rather than just doing the task for them.
- Explain how to do the task in a sensitive manner to avoid the person feeling a sense of failure.
- Explain to them each step of the way what you are doing in a soft, reassuring way, e.g. "I am going to help you sit down now. Then we can tie your shoes."
- Allow plenty of time for the person to complete a task, because they may take longer than they used to.
- Break down tasks into small, simple, concrete steps.
- Use step-by-step prompts.
- Help the person at the point at which they have become stuck.
- Avoid interrupting the person in the middle of a task unless necessary.
- Do not give the person too many things to do at once, as this may increase their level of anxiety.
- Attempt to reduce any stress on the person because stress can increase confusion.

Helping the person who is disoriented

Do not assume the person knows who you are. It may take time for the person to sense that you are friendly or to recognise you as someone they already know and trust. You many need to introduce yourself to the person each time you talk to them. You should use orienting names whenever possible, e.g. "Your son Jack."

If the person is not oriented to time, adjust your communication to refer to daily events rather than dates or times, e.g. instead of saying, "John will be here at two o'clock", say "John will be here after lunch."

If the person is going to be in an unfamiliar place, try to ensure that they have some familiar people with them.

Helping the person who has regressed into the past

As the person's memory fails, they may be more likely to live in the moment. However, they may also regress into the past. Regressions into the past are felt as actual current experiences for the person. If the person has regressed into the past, do not dismiss their resultant feelings and thoughts.

If the person talks about deceased people as though they are alive (e.g. a parent who has died long ago), try to understand why they are talking about the person, in case it references a need that can be addressed.

GUIDELINES FOR HELPING THE CONFUSED OLDER PERSON

Communicating with the confused person

Try to connect with the person by drawing upon their remaining social skills, e.g. "Hello, how are you?" and "Pleased to see you today." Continue sharing your day-to-day thoughts and feelings with the person, using a warm, easy going and pleasant manner, as it lets them know that they are valued. Encourage the person to continue to express themselves, even if they are having trouble making themselves understood. When assisting the person, treat them with respect by trying to be patient and not talking down to them.

If the person does not talk much, this does not mean that their thoughts and feelings are absent. Pauses in the conversation do not need to be filled with words. Silence is not necessarily a negative thing – it can be a way to connect with the person. Be aware that you may have more of a problem with silence than the person does. Do not automatically interpret the person's silence as anger or depression.

Gaining and keeping the person's attention

Your best chance of getting and maintaining the person's attention is to have a one-on-one conversation with the person in a quiet setting. Eliminate or reduce distracting noises, such as television, music or other people's voices. Avoid startling the person by approaching them slowly and from the front, without sudden movements, so that they have time to focus.

If the person does not respond, or if it looks like they are not paying attention, try again after a break when the person may be more focused. Be aware that the person may not be able to attend to a discussion or task for very long. Therefore, look for signs of frustration. If the person does not want to talk, turns away, or says or gestures "No!", do not force them to talk.

Being understood during a conversation

Look for signs of understanding, e.g. the person's body language and facial expression. However, do not assume that the person understands you because they are nodding or giving a superficial response. In order to increase the likelihood that the person will understand you when talking to them, you should:

- Be prepared to give the person your full attention.
- Establish friendly eye contact when speaking to the person to assure them that they have your full attention.
- Position yourself so that you are at the same eye level as the person, or lower.
- Stay still and ensure that the person can see your face and gestures. This may make it easier for them to follow the conversation and stay attentive.
- Use concrete words (words you can picture), rather than abstract words, idioms, metaphors or slang.
- Avoid expressions that can be taken too literally, e.g. 'shake a leg'.
- Avoid using pronouns, including third person pronouns, e.g. instead of saying, "Here it is," say, "Here is your hat." Or instead of saying 'he' or 'she', identify people by their actual name.
- Focus on one main idea at a time and avoid discussing too many things at once.
- Use short sentences and pause between them to allow time for the information to be understood.
- Try to use positively framed instructions, and limit the number of negative words, such as 'don't'. For example, say "Stay here", rather than, "Don't go away."
- Adjust the pace of your speech depending on how well the person appears to be understanding you.
- If you have repeated a sentence or question using exactly the same words and the person still does not seem to understand or does not respond, try repeating it in a different way.

It is also important for you to understand the person. Keep in mind that the person's words and answers to questions may not reflect what they meant to say. Let the person know if you have understood them by providing validation and acknowledgement to the person. You can do this by:

- Listening with interest
- Nodding your head appropriately
- Reflecting back what they have said.

Communicating in a group situation

If others are present in the conversation, you can include the person by:

- Addressing the person directly
- Using appropriate body language, e.g. facing the person
- Trying to ensure that only one person speaks at a time
- Avoiding interrupting the person in the middle of a conversation, unless necessary
- Letting the person respond for themselves and not answering questions for them.

The person's feelings and behaviours may be affected by the negative actions of others (e.g. patronising or angry behaviour). Even though the person has failing memory or reduced understanding of a conversation, the person still has resultant feelings and emotions, which may last for many hours. Help others communicate with the person by modelling appropriate communication and letting them know what to expect when talking with the person. If you observe someone using baby-talk with the person, take them aside and tell them they need to talk with the person in an adult manner.

Asking the person questions

Adjust the way you ask questions using either open- or closed-ended questions depending on the purpose of the conversation with the person, e.g. closed-ended questions may be useful for helping the person in an everyday task, whereas open-ended questions may encourage conversation with the person about feelings. Questions that call for short answers may make the person feel successful instead of embarrassed and frustrated over their inability to form and keep in mind a lengthy answer.

Ask one question at a time and avoid questions that require a lot of thought or memory, e.g. don't ask "What did you do today?" Instead, shape the question to address current feelings, e.g. "Are you having a good day?".

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Offering the person options

Offer options instead of commands, in order to give the person a greater sense of control over their life. However, be aware that the person may become more confused if they are offered too many options at once. When offering the person a choice, list the available options so that the person can use the information to answer, e.g. "Would you like tea or coffee?" rather than "What would you like to drink?"

Non-verbal communication

Non-verbal communication, including body language and tone of voice, may be more effective than spoken words when communicating with the person. Gestures, facial expressions, props, and non-verbal and visual cues may be helpful in reinforcing your verbal messages. Be aware of your non-verbal cues, such as behaviour, facial expressions, tone of voice and eye contact, making sure they match what you are saying. Your behaviour may send a message to the person, e.g. non-threatening tone of voice and body language may help to gain the person's confidence in your ability to assist. Conversely, your tone of voice may indicate frustration, and talking loudly or looming over the person may indicate hostility or a threat. Also, your tone of voice or display of emotion may be mirrored by the person, e.g. an anxious tone may trigger anxiety in the person.

A gentle touch of the arm or hand can communicate to the person that you are interested and really care. If you have a close relationship with the person, touch can be a powerful way of connecting with the person and can show you are interested in them and care. However, pay attention to non-verbal cues that may indicate that the person does not want to be touched.

Look for and respond to the physical and non-verbal cues that may indicate the person's needs or feelings, e.g. the person who appears anxious or agitated may be in pain, need to go to the toilet or be troubled by something going on around them.

Challenges experienced during communication

When communication is difficult, try to be patient and do not give up trying to understand the person. There are some things you can do to help overcome communication difficulties.

To encourage the person to continue communicating you can show them you are listening by maintaining eye contact, smiling and talking in a gentle tone.

If the person is having trouble expressing themselves, or their words are mixed up and seem nonsensical:

- Listen to the person, because these may have meaning for them.
- Avoid expressing annoyance.
- Let the person know it is all right and encourage them to continue to explain their thoughts without interrupting, speaking for them or 'filling in the blanks' too quickly.
- Smile and say, "I am having a problem understanding." This implies that the person is not the problem.
- Focus on and acknowledge the emotion that the person is trying to convey, because this will help the person feel understood even if they cannot find the appropriate words.
- If you think you understand what they are trying to say, clarify this them.

If the person repeats questions or statements over and over again:

- Listen to the person and try to guess what their underlying concern is and reassure them about this, e.g. a repeated question about the time might be because they are worried they will miss an event.
- Avoid expressing annoyance.

If the person begins rambling:

- Avoid looking away or acting distracted because the person will sense the lack of interest and this may close down communication.

If you suspect the person is in pain:

- Point to or touch the area you think might be hurting and ask the person to nod if it hurts there.

Sometimes, the best thing to do is remain silent and let the person find their own way to cope with difficulties in conversation, e.g. 'talk around the topic' before finding the right word or phrase.

Factors in the person's environment may make communication more difficult. A busy, cluttered, noisy or unfamiliar environment may cause distress or confusion for the person. Furthermore, the person may misunderstand aspects of their environment, which may increase confusion or frustration, e.g. mirrors might make the person think there is somebody else in the room. If the person is having communication problems, check that they are not being affected by something unrelated, e.g. their hearing aid may not be working or they are wearing the wrong glasses.

Talking with a confused person may require skilled communication and you may make mistakes. If you feel you have done something wrong when communicating with the person (e.g. acted impatiently), apologise to demonstrate your respect.

Discussing sensitive issues

Please note that the guidelines in this section are likely to be most helpful and appropriate for a family caregiver.

Because dementia is progressive, there will be times when discussions will be needed about major changes in the person's life. If possible, wait until the person is relaxed and focused before trying to discuss a sensitive issue with them, e.g. the person may be more tired or confused in the evening and more responsive after they have rested. When discussing a sensitive issue, such as diagnosis, planning for the future, stopping driving or deciding when to move to a higher level of care, you can use the communication strategies above. In addition, you should:

- Choose a place familiar to the person as a setting for such a conversation, because this is likely to help facilitate communication and minimise anxiety.
- Approach the person in a calm, gentle, non-judgemental manner, because this sets the mood for the subsequent conversation.
- Begin the conversation with neutral topics to help build trust and help the person feel relaxed, e.g. talking about the weather or family.
- Consider enlisting the help of another person who can remain calm and objective.

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When discussing topics that evoke a strong emotional response from the person, do not reject or dismiss what the person says about their feelings, e.g. "Oh, you don't need to worry about that." Rather, validate and acknowledge how the person is feeling, e.g. "I can see this is upsetting, that's very understandable." If the person shows negative emotions (e.g. tearful, angry), take them somewhere private where they can express this without feeling embarrassed.

Discussing the diagnosis

In preparing to talk with the person about their diagnosis, learn as much as possible about their particular type of dementia. Find out about organisations that provide resources or services to people with dementia and their carers.

Keep in mind that discussions at diagnosis can provide a basis for more detailed discussions later on, e.g. discussions about dementia progression or advice on topics that may be discussed later. When discussing the person's diagnosis:

- Choose how you explain to the person what is happening based on their ability to understand, e.g. a straightforward explanation ("You have dementia") versus a more gentle approach ("You have a memory problem").
- Reassure the person and let them know that they will be supported and helped.
- Let them know that there are things they can do themselves that can support their memory and maintain their independence.
- Remain open to the person's need to talk about their diagnosis, increased limitations and negative feelings as their dementia progresses.
- Give the person the opportunity to talk about their experiences and how they see themselves as they lose some of their functioning and capabilities.

The person may not acknowledge their diagnosis. This could be due to an inability to understand or a self-protective mechanism to help them cope. If the person does not acknowledge their diagnosis, do not try to force them to recognise it. If needed, get advice from the person's healthcare professionals on how to talk to the person about their diagnosis.

Making decisions and planning for the future

Arrange times to meet with the person to discuss their wishes, concerns and any preferences for the future. Allow the person to make whatever decisions they are capable of making, as long as these do not involve danger to the person or to others. Let the person know that any decisions made about the future can be revisited if they wish to do so.

If the person has concerns about facing the future, reassure the person about the advantages of planning, e.g. "Don't be scared of planning ahead. It will make life much easier in the future." It may be helpful for both you and the person to share any sadness and concern about the future.

If the person does not have a Power of Attorney or an Advance Care Directive on relevant topics (e.g. care preferences, management of finances and arrangements after death), encourage or assist them to make an appointment with an appropriate professional to develop these. (See Box for more information on Advance Care Directives and Power of Attorney.)

What is an Advance Care Directive?

An Advance Care Directive is a document describing how the person wants to be treated when they are unable to make their own decisions due to their present state of illness. In most countries, this is not a legal document; it is an agreement made between the person, their family, and hopefully their usual healthcare professional.

What is a Power of Attorney?

A Power of Attorney is a legal document where the person appoints someone of their choice to manage their legal and financial affairs. In some countries this includes making decisions about health care.

Discussions and decisions about driving

A diagnosis of dementia is not automatically a reason to take away the right to drive. However, while the person might be driving safely early on, their progressive decline in cognitive abilities means a time will come when they will be at high risk of causing an accident.

While the person may appear to be driving safely, they may:

- Be relying entirely on the habits of driving and may be unable to respond appropriately to a new situation
- Not be capable of reacting quickly to an unexpected problem or making a decision needed to avoid an accident
- Forget unsafe driving incidents and therefore have a false sense of confidence about their driving ability.

Even if the person is currently safe to drive, they can become disoriented and lost, even on familiar roads. Discuss ways that they can communicate with someone should they become lost. Make sure they have appropriate identification in case they need to ask someone for help.

Do not try to keep the person driving longer by acting as a 'co-pilot' (e.g. by giving instruction and directions to the person when they drive), because in an emergency situation there is rarely enough time for instructions to be given and acted upon to avoid an accident.

You should be aware that no examination or single indicator exists to determine when the person poses a danger to themselves or others by driving. However, the following may indicate that the person should stop driving:

- You would not want a child or grandchild to be driven by the person.
- The person has been involved in recent accidents while driving.
- The person is more frequently becoming lost while driving.
- The person modifies their driving behaviour to accommodate changes in skill, e.g. driving shorter distances, driving only on familiar roads, avoiding night driving.

Talking with the person about driving

It is important to talk to the person about driving issues (e.g. safety and liability), being aware that stopping driving can be a sensitive issue because it may be linked to independence for the person. You should communicate with the person about their driving early, because this can help the person decide on a course of action before an accident occurs. Find out about relevant local laws regarding driving after a diagnosis

of dementia. Encourage the person to begin to plan for when they stop driving, e.g. what transport they will use, setting up automatic bill payment online and delivery services.

If the person has had an increase in frequency of unsafe driving incidents, have a discussion with them about restricting their driving. Initiate the discussion about driving in a way that is less likely to lead the person to be defensive about their abilities, e.g. rather than saying, "Your driving is terrible, you are getting lost, and you're just not safe", you can say "I am concerned about your safety, how are you feeling about your driving?" Include the person, as far as possible, in decision-making regarding any driving restrictions.

If you are going to have a frank discussion with the person about concerns over their driving ability, be prepared for a wide range of reactions, e.g. sadness, relief, anger, defensiveness. When discussing driving restrictions, you should:

- Acknowledge how difficult it may be for the person to give up driving.
- Look for ways to help the person save face and maintain their self-esteem, because giving up driving can mean the person admitting their increasing limitations.
- Listen to the concerns of the person, because it will be helpful for them to feel as if their concerns and feelings are being recognised and heard.

If the person refuses to talk about driving or is not convinced they should stop

If the discussion with the person does not go well, do not blame yourself. Remember that the person's impaired insight may be making it difficult to understand that their driving is no longer safe. Try to remain patient, firm and empathetic.

Share observations of the person's unsafe driving with family members and healthcare professionals. Ask the person's healthcare professionals to raise questions about driving safety with the person. A healthcare professional may recommend a driving assessment, e.g. by an occupational therapist. If there has been a driving assessment, you should both agree to abide by the results.

If it is clear that the person can no longer drive safely, do not delay in taking the necessary steps to stop the person driving. If the person is insistent on driving, and you decide to find ways to make driving impossible for the person (e.g. disabling the car in some way or hiding the keys), be prepared for angry or aggressive behaviour from the person and take steps to minimise any possible risk to safety.

Once the decision is made to stop driving

Once the decision is made that the person should stop driving, stand by the decision and be consistent and vigilant in ensuring that the person adheres to any driving restrictions. You may need to remind the person that they should not be driving, because they may forget or decide to continue.

You can help minimise the impact of giving up driving by:

- Being available to drive the person, if possible
- Arranging for home deliveries of medication and groceries, and automatic bill payment
- Asking the person's family members, friends and neighbours to support the person emotionally, socially and practically, e.g. by visiting the person and helping with transportation
- If the person is able, encouraging them to take charge of their new transport arrangements, e.g. by getting details of local transport services and arranging transport with friends or family
- If the person uses their driver's licence as a form of identification, arrange for them to get an alternative form.

If you require further assistance in dealing with the person's driving, call a dementia or Alzheimer's helpline for assistance.

Discussions and decisions about care

A diagnosis of dementia does not automatically mean the person's level of care must change, e.g. they can no longer live alone or that they must leave the family care and move into residential care. However, you should encourage the person who has received a diagnosis of dementia to make decisions in advance about their future care, e.g. what they want to happen if their current living arrangements become too difficult. In planning for future care decisions with the person, consider and discuss with them the range of factors that may impact upon care and living arrangements during the course of the disease, e.g. the health of family members, financial matters and the different stages of the illness.

Find out about the range of care services offered in the person's community that may be useful at different stages of the person's dementia, e.g. respite, day centres and supported residential care. You can do this by making early contact with any local aged care assessment services to learn about what levels of care may be available to the person in the future.

As the dementia progresses, monitor the person's living situation carefully for risks to safety. Identify any risks in the person's living arrangement and work with the person's health care professionals to lessen them where possible, e.g. using meal delivery services if cooking becomes unsafe. Be aware that the person needs to live in an environment that best supports both their safety and quality of life, and this may mean living at home with support services, even if there is some risk.

There may be times when, because of your own health or the needs of other family members, you are temporarily unable to provide the person with the care they need. Find out about what respite options are available in the event that the person needs to temporarily get care elsewhere.

You should also have a plan in case the time comes when the person's illness advances to the point where it is no longer possible for you to provide the level of care they need, or something happens to you which prevents you from being able to provide adequate care.

Deciding whether to change to a higher level of care

There is no single indicator to determine when a person should move to a higher level of care and it varies between individuals and families. Remember that your physical and emotional health is as important as that of the person.

Include other key people (e.g. the person's family and healthcare professional) in open and honest discussions concerning the person's care and living arrangements, so they can help and support the decision to make a change, when the time comes. A health care professional can give advice on the type of care that the person needs.

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A move to a higher level of care may improve your relationship with the person, because time together may be less stressful and free from the worries of practical care. See the box below for considerations for when deciding whether it is time to change the level of care. Keep in mind that it is best practice to move the person's place of living as infrequently as possible.

If you are considering a move to residential care

A move to residential care may not mean less time devoted to caring for the person or that you must completely give up any caring role you have. You may still need to be involved in their care, e.g. checking medications are correct and that daily needs are being met. Remember that moving the person to residential care is not a failure on anyone's part, nor are you betraying the person. It is necessitated by a need for greater care due to the disease.

Reactions to the decision to move to a higher level of care

If you find it difficult to tell the person that they need to change their current living situation, enlist someone to help you, e.g. the person's healthcare professional or someone else they respect.

Be prepared for a range of reactions to the decision, e.g. anger, bitterness, sadness and accusations. The person may not realise the impact that their care needs have on others, or they may be concerned that a move away from home would mean a loss of independence and control in their daily lives.

If the person attempts to get out of newly made arrangements, validate any distress they are feeling, but reinforce the non-negotiable nature of the decision, e.g. "I realise it is upsetting that you can't live at home, but it is no longer safe for you to do so".

If you are distressed about having made the decision to change the person's living situation, seek counselling support.

Considerations for when deciding whether it is time to change to a higher level of care or a more supported living arrangement.*

- There are signs in the person's house that show they are not managing, e.g. unclean clothing lying around, electrical appliances left on.
- There are changes in the person's appearance, e.g. unexplained weight change, altered grooming standards or poor hygiene.
- The person is not getting an adequate diet.
- The person cannot manage their medication.
- There have been particular incidents or problems, e.g. robbery because a stranger was let in or a door was left unlocked.
- There is risk to the safety of the person or others, e.g. because the person is forgetting to turn off the stove, falling on stairs or unresponsive to emergencies.
- There are challenging behaviours that require greater supervision, e.g. wandering or aggression.
- The person is no longer able to recognise or interact with their environment.
- The risks of the current living arrangement (e.g. safety issues) outweigh the benefits e.g. independence and familiar location.
- There are suitable alternative forms of care available for the person.
- There are others who can help with caregiving in the person's current living situation.
- The strain on caregivers or family has become too great, e.g. night time restlessness is keeping others from getting a good night's sleep, or around-the-clock care is too stressful or overwhelming.
- The person's values, views, history or preferences would be consistent with the proposed change.

**Some of the items in this list may only be appropriate when considering a move into residential care, while others may apply when considering any change to the level of support a person is receiving.*

Behaviours that you may find challenging

If the person shows challenging behaviours, remember that it is no one's fault and that they are not behaving this way on purpose to annoy or irritate. It is likely that their illness is causing the behaviour. They may also be frustrated by a loss of skills and an increasing dependence on others.

Challenging behaviour may not be meaningless or random. The person may have a need that they cannot communicate, or there may be an underlying psychological issue, such as anxiety or depression. Try to identify any needs underlying the behaviour and help the person to meet those needs.

When you are feeling challenged by the person's behaviour, do not argue or try to reason with them if they no longer have the ability to do so. In an emotionally charged situation, where you think you might lose control, remove yourself, if possible, and return when you feel calmer.

Resistance

Rather than asking questions that are likely to trigger immediate resistance (e.g. "Do you want to take a shower?"), break the task down into steps and use statements rather than questions, e.g. 1. "I will walk you to the bathroom", 2. "Put your hand under the water and tell me if it is the right temperature", etc.

Arguments

Arguments may develop from the person's frustration and are not necessarily a reflection on you. Avoid arguing with the person, because this is likely to cause the person to become angry, anxious, frustrated or more confused. If an argument develops, acknowledge the person's feelings and frustrations, and change the topic of conversation or begin a new activity.

Agitation

Agitation can occur every day at around the same time for some people (e.g. around sunset) and will eventually pass. Loud noises, an over-stimulating environment, or physical clutter may also cause agitated behaviour.

If the person becomes agitated, you should react calmly and reassure the person that they are safe and that everything is under control. If the person is pacing and it is safe to do so, let them pace. Be careful about touching the person who is agitated or

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frightened, because they might interpret the touch as a form of restraint and become angry.

Anger and aggression

There are some common reasons for anger or aggression in a person with dementia, e.g. situations where the person feels trapped, controlled, fearful, humiliated or helpless, or where there are changes in surroundings or routine. If the person is angry or upset, do not argue with them, try to explain away the anger, or restrain them, as this might make things worse. Remain calm and, if possible, move the person elsewhere in a quiet, unhurried way.

If you are concerned about the person becoming aggressive, remove potentially dangerous objects from the environment. If the person becomes aggressive, leave the room, if it is safe to do so, and give the person the time and space to calm down. If anyone is at risk of harm, contact emergency help.

Avoid physically restraining the person, as this may make them feel fenced in and they may become more aggressive. However, if nothing else works, and there is risk of harm to the person or others, physical restraint may be necessary.

Disinhibited and inappropriate sexual behaviour

If the person engages in disinhibited or inappropriate sexual behaviour, do not show shock or disapproval, or make fun of the behaviour. React with patience and gentleness, even though the behaviour may be embarrassing, and guide the person to a private place.

Consider ways to modify the environment to reduce the triggers for this behaviour, e.g. not going out in public or having visitors at times of the day when the problem behaviour is more likely to occur, or having a different person help with showering.

Delusions and hallucinations

Delusions *are false beliefs, for example of persecution, guilt, having a special mission or being under outside control. Although the delusions may seem bizarre to others, they are very real to the person experiencing them. Be aware that the person may appear to have a delusion because they misidentify people or misinterpret situations and feel threatened. Similarly, they may have gaps in their memory, which they compensate for by creating a false story, which they believe to be true.*

Hallucinations *are false perceptions. Hallucinations most commonly are auditory, such as hearing voices, but can also involve seeing, feeling, tasting or smelling things. These are perceived as very real by the person, but are not actually there.*

If you think the person is experiencing delusions or hallucinations, you should:

- Approach them cautiously, trying not to startle or frighten them.
- Acknowledge any fear they may have.
- Comfort the person in the same way you would if their experience was real, by responding to the person's emotional tone, e.g. remind the person that you are with them, tell them they are safe, or say something like "I didn't hear anything, but I know you are frightened. I'll look around to make sure everything is okay".
- Respond in a calm, supportive manner and offer reassurance.
- Try to reduce factors that may be contributing to the delusions or hallucinations, e.g. unclear background noises, darkness or being alone.
- Check if the person has had enough to eat and drink, and had enough sleep.

Do **not:**

- Try to reason with the person about their delusions or hallucinations
- Agree with the delusions or hallucinations
- Argue or confront the person about whether the delusions or hallucinations are real.

Delusions and hallucinations can be a sign of delirium, which is a medical emergency. (See section on Delirium.)

Assisting the confused person who is wandering

Wandering *is a dementia-related behaviour that sees a disoriented individual move about, sometimes with repetitive pacing or lapping in one area, and at other times leaving their usual environment. A wandering person may become lost, leave a safe environment or intrude in inappropriate places.*

How to tell if a person is wandering

A person who wanders may do so for a variety of reasons, e.g. they have set off to go somewhere and forgotten where it was they were going, are searching for a place from their past, believe that they have a job to do, or are bored. There are signs that can help you recognise that a person is wandering and needs help, these include:

- Wearing inappropriate clothing
- Having an unsteady gait
- Behaving in an unsafe or inappropriate way
- Appearing restless
- Pacing
- Displaying repetitive movements.

This list is adapted from a list from Alzheimer's Association USA (alz.org)

Do not assume that a person who appears to be wandering is necessarily confused, e.g. the person may want exercise.

What to do if you encounter someone who is wandering

If you encounter a person who is wandering, be aware that they may have impaired judgement regarding their own safety and that they may have health problems affecting their movement and orientation, e.g. moving is painful or their eyesight is poor. You should:

- Introduce yourself to the person and offer help.
- Adopt a caring attitude and an approach that communicates warmth and respect, because this will confirm that you are not a threat and that you have the person's best interests at heart.
- Try to understand the person's perspective about why they are wandering, because this may assist you to respond in an appropriate way.
- Ask the person if you can contact a family member or friend.
- See if the person has any needs that you could help them meet, e.g. they may be thirsty, hungry or need to go to the toilet.
- Check whether the person is injured because they may be unable to communicate that information effectively.
- Try any approach that may help you connect with the person and gain their trust.

The person who is wandering may become frightened, which could further reduce their ability to cope. If you encounter a person who is wandering and they look scared or anxious, engage them in conversation and attempt to calm them down and gain their trust.

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If you know the person who is wandering and know where they live, quietly join the person and, in a friendly calm manner, engage in light conversation, e.g. asking the person, "Where are you going?" or "How is your day going?" After a short while, suggest something to change the direction of the walk, either sitting down for a moment or making a turn.

Don't leave the person who is wandering alone, especially if they are distressed, and even if they decline your help. However, only attempt to provide assistance if you can do so without putting yourself in danger.

Ways of identifying people who wander

There may be a local ID system for identifying and helping people who are confused and lost, or there may be a local organisation that provides identification cards or bracelets for people who wander. Check if the person has any identification or a tracking device on them that will provide you with useful information to be able to contact the person's home or carer.

Contacting emergency services

If you cannot find out any of the person's emergency contact information, suggest that they sit and have a chat with you, while you quietly call emergency services. You should also call emergency services if you are very worried about the person's health or safety. When emergency services arrive, sit down with them and talk quietly with the person to see how you can help.

Delirium

Delirium *is a condition where a sudden and obvious worsening of a person's usual level of functioning appears over hours or days. Delirium can involve problems with attention, awareness, orientation to environment and other areas of cognitive functioning. It is caused by an underlying disease or environmental factors, such as medication or infection. Delirium more commonly occurs in an older person, however, it can occur in a younger person as well. People with dementia are also more likely to develop delirium.*

Delirium is a medical emergency

Delirium is a medical emergency requiring immediate medical help. If you suspect the person is experiencing delirium, contact a doctor immediately and inform them of the sudden changes in the person, and arrange an appointment. Be prepared to provide information about the person's changes in behaviour or physical function, past medical history and current medications, noting any new medications or changes in dosage. You can do this by writing down your observations about the sudden changes in behaviour and physical function, e.g. when the confusion or other problems began.

If you are caring for a person with delirium

It can be comforting for the person experiencing delirium to see familiar faces and friends, especially if the person is in hospital. However, you should inform any visitors of what to expect of the person.

Being in a delirious state may reawaken past distressing or frightening experiences for the person, and these may be experienced as reality or as part of a dreamlike state. If you know that the person experiencing delirium has had previous experiences of trauma that may be affecting their current emotional state (e.g. being trapped, frightened or very ill), tell the health professional caring for the person. Let staff know if there is anything they could say or do that will make the person feel more at ease or reassured.

If you are caring for a person with delirium, you should:

- Talk clearly and slowly.
- Ensure the person gets adequate food and fluids.
- Orientate the person to their environment, i.e. remind them where they are, what time of day it is and who you are.
- Reduce distracting noises, such as radio and television.
- Ensure there is adequate lighting.
- Ensure the person has their comfort items, e.g. familiar blankets, photos, favourite music or clothing.
- Check that the person is wearing their hearing aids or glasses.
- Monitor the person to protect them from falls and dangerous objects.
- Introduce yourself each time you see the person, if necessary, and do not take it personally if they fail to recognise you.
- Use nicknames or other familiar phrases that are likely to be reassuring.
- Avoid sudden movements that may frighten the person.
- Try not to over-excite the person with too much activity.

GUIDELINES FOR HELPING THE CONFUSED OLDER PERSON

Purpose of these guidelines

These guidelines are designed to help a family member, friend, neighbour, concerned community member or a paid carer without specialist qualifications to provide assistance to an older person experiencing confusion or cognitive changes associated with dementia, delirium or another condition. The role of the helper is to assist a person who may be developing dementia or delirium, is experiencing a worsening of existing dementia symptoms or is in a crisis due to their confusion. Older person refers to those aged 65 or older. However, it is expected that the resulting guidelines may also be relevant to assisting adults with confusion who are younger.

Development of these guidelines

These guidelines were developed using the Delphi research method, which involves systematically determining the expert consensus of panels of people with expertise in dementia and delirium, either as a carer or professional. The experts were from Australia, New Zealand, Ireland, the UK, and the USA.

How to use these guidelines

These guidelines are a general set of recommendations about how you can help an older person who is experiencing confusion or cognitive changes associated with dementia, delirium or another condition. Each individual is unique and it is important to tailor your support to that person's needs. These recommendations therefore, may not be appropriate for every older person who is confused. Also, the guidelines are designed to be suitable for providing assistance in developed English-speaking countries. They may not be suitable for other cultural groups or for countries with significantly different health systems.

These guidelines have been developed as part of a suite of guidelines about how to best assist a person with mental health problems. These other guidelines can be downloaded at: mhfa.com.au/resources/mental-health-first-aid-guidelines

These guidelines have been used to inform the curriculum of the Mental Health First Aid for the Older Person Manual and 12-hour course.

Mental Health First Aid Australia. Guidelines for helping the confused older person. Melbourne: Mental Health First Aid Australia; 2015.

Enquiries should be sent to:
Mental Health First Aid Australia
email: mhfa@mhfa.com.au

We're looking forward to serving your people!

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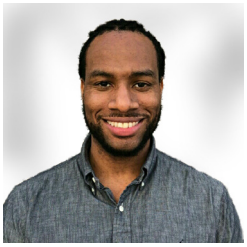

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