Coping with Mental Illness

A Regional Family Guide
Coping with Mental Illness: A Regional Family Guide

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This guide is an initiative of Friends for Mental Health, offering families in the West Island community a better understanding of mental illness and the resources available to them.

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# TABLE OF CONTENTS

**INTRODUCTION** ................................................................. 01

**CHAPTER 1: FRIENDS FOR MENTAL HEALTH** ............................. 02
   WHO WE ARE AND WHAT WE DO

**CHAPTER 2: UNDERSTANDING MENTAL ILLNESS** ......................... 03
   POSSIBLE SIGNS OF MENTAL ILLNESS ................................. 03
   FIRST PSYCHOTIC EPISODE .............................................. 04
   TYPES OF MENTAL ILLNESS ............................................. 04
      Schizophrenia ......................................................... 04
      Mood Disorders ...................................................... 05
      Anxiety Disorders ................................................... 06
      Personality Disorders .............................................. 08
   SUBSTANCE ABUSE ....................................................... 09

**CHAPTER 3: CRISIS SITUATIONS** ........................................... 10
   COPING WITH PSYCHOSIS ................................................ 10
   COPING WITH AGGRESSION ............................................. 10
   SUICIDE ........................................................................... 11
   PLANNING FOR EMERGENCIES ....................................... 11

**CHAPTER 4: SEEKING AID AND HOSPITAL ADMISSIONS** ................. 12
   VOLUNTARY HOSPITAL ADMISSION .................................. 12
   INVOLUNTARY HOSPITAL ADMISSION ................................ 13
   COURT ORDERS ............................................................. 14

**CHAPTER 5: ACCEPTING THE ILLNESS** .................................... 15
   PHASES OF ACCEPTANCE ................................................ 15
      Confusion/shock/panic ................................................ 15
      Denial .......................................................................... 15
      Sorrow/grief .................................................................. 15
      Guilt .............................................................................. 16
      Frustration/anger/resentment ...................................... 16
      Shame ............................................................................ 17

**CHAPTER 6: CARING FOR A LOVED ONE** .................................. 18
   EFFECTIVE COMMUNICATION AND INTERACTION ................... 18
   RECOGNIZING AND COPING WITH PROBLEM SITUATIONS ........ 19
   CAREGIVER BURN-OUT .................................................... 19
   LIMIT SETTING ............................................................... 19
   FAMILY SUPPORT AND RESpite SERVICES ......................... 20
   LIVING ARRANGEMENTS ................................................ 20
   HOUSING RESOURCES .................................................... 21
CHAPTER 7: TREATMENT OPTIONS AND RECOVERY ............................................. 22
  Medications ................................................................. 22
  Psychosocial Treatments ........................................... 24
  Psychotherapy .......................................................... 24
  Recreation ................................................................. 24

CHAPTER 8: MEDICATION CONTROL AND RELAPSE ................................. 25
  Medication Control ..................................................... 25
  Relapse ................................................................. 25

CHAPTER 9: FOLLOW UP AND COMMUNITY RESOURCES IN THE WEST ISLAND . 27
  Follow up and Assistance ........................................... 27
  Crisis Centre ............................................................ 27
  Therapeutic Treatment Centre .................................. 28
  Day Centres ............................................................ 28
  Housing Resources ................................................... 28
  Work / Training ....................................................... 28

CHAPTER 10: KNOWING AND WORKING WITH ‘THE SYSTEM’ .................... 30
  Questions to Ask ....................................................... 30
  Things to Keep in Mind When Dealing with ‘The System’ ........ 30
  Confidentiality ........................................................ 31
  Mental Health Professionals ....................................... 31

CONCLUSION ........................................................................ 32

EMERGENCY DIRECTORY ......................................................... 33

CRISIS REVIEW WORKSHEET .................................................. 33
INTRODUCTION

Few people are knowledgeable about mental illness. When a loved one is affected no one is really ready to face this new challenge that is disrupting family life. Nevertheless, the place of family members in the care, treatment and recovery of mental illness has been substantially documented: the best treatment for mental illness includes supporting the family and other caregivers. In the past thirty years, families have been moving from a passive role to an active role wherein they are considered to be partners in care.

This guide is in response to the needs of families to possess a better understanding of mental illness and the different resources available, as well as how to manage and better cope with the situation.

Learning to live with mental illness demands time, patience and courage.

You are not alone!
Friends for Mental Health is a bilingual and non-profit organization dedicated to helping families that have a relative experiencing mental illness. At Friends for Mental Health, we cooperate with local hospitals, CLSC, community organizations, and allied professionals such as social workers, with the intention of maximizing the potential of mental health services. Through our educational programs, we identify and correct public misconceptions about the nature of mental illness. Friends for Mental Health services include:

**INFORMATION RESOURCES**

A bimonthly newsletter carrying short articles and descriptions of upcoming events (also available on our web site, www.asmfmh.org).
A lending library for members with catalogued books, periodicals and audio/visual materials.

**GROUP MEETINGS**

Conferences where prominent professionals from different fields present information relevant to mental health issues.
Support groups which discover ways in which members can help each other.
Discussion groups, which offer practical information and also coping strategies for caregivers in the form of animated workshops.

**PERSONALIZED SUPPORT**

Telephone assistance providing support, orientation and referrals.
Confidential counseling and individual consultation.
Family support program providing psychological help, liaisons with other institutions’ resources, and accompaniment of parents in difficult circumstances.
Respite program specifically aiming at the prevention of physical and emotional exhaustion of family members by means of home visits to caregivers (direct respite) and group outings, community suppers and camps for their loved ones (indirect respite).

All services are confidential and free.
Understanding Mental Illness

Mental illness is a brain disorder of one's thoughts, behaviours, and/or emotions. Mental illness varies in severity depending on many factors, including type of illness. Some persons will need assistance from professionals for a certain period of time, while others may need more long-term care. Over the years, different theories have been formulated in trying to explain mental illness. Today the dominant approach to mental illness is the bio-psycho-social model, which has been incorporated into the mental health policy of the Quebec government. This systemic approach identifies three aspects that have an impact on the health of the person: the biological (genetic and physiological); the psychological (emotional, cognitive and relational), and the social (i.e. the individual situated in their environment, culture and epoch). The future well-being and health of the ill person depends on how all these aspects are integrated and interrelated. This means that the patient's mental health is treated as part of the health of the whole person.

Noticing changes in the person close to you is usually the first sign that something is not quite right. Here are some signs and symptoms to look out for followed by a description of the major types of mental illness.

Possible Signs of Mental Illness

Unusual or Disorganized Behaviour: Social withdrawal; sudden loss of interest in activities, school, or work; pacing, staring, talking and laughing to oneself; inability to sit still or conversely being inert or apathetic; showing deterioration or change in personal hygiene and appearance; excessive spending or destructive behaviour; changes in sleep and appetite and uncharacteristic abuse of alcohol and/or drugs.

Emotions: Giving inappropriate emotional responses; displaying hostility or uncharacteristic anger; inability to cry or excessive crying; talking or thinking about suicide; excessive pessimism or optimism; lack of empathy or compassion; uncharacteristic problems with relationships; inappropriate laughter.

Cognition: Having trouble concentrating; strange speech and conversation; memory impairments; disorientation to time, place, or person; problems with judgement; grandiose ideas; difficulty with responsibility; hallucinations and delusions (see below).

Hallucinations: seeing, hearing, or smelling things that exist only in the person's mind, e.g. hearing voices; feeling or seeing things crawl on their bodies; smelling imaginary smoke, etc.

Delusions: having false beliefs, e.g. believing one is a prophet, or paranoia, e.g. that one is being spied on.

Changes in an individual's behaviour, thoughts and emotions may be gradual or abrupt. The person displaying these symptoms may be very frightened and have serious difficulty explaining...
their problems to others. It is therefore important to be as patient and understanding as possible. Having the mental illness recognized and treated as soon as possible is essential to increase chances of recovery. Bear in mind that in this situation it is normal for the whole family to experience anxiety and fear and to deny that anything is wrong.

"My daughter kept talking about these ‘people’ that were out to ruin her life. She referred to them as ‘them’, and would say things like ‘you know who I am talking about’, ‘I can’t tell you too much information about them, they are listening everywhere’, etc. Her life revolved around ‘them’. She wasn’t sleeping well, she wouldn’t go out, she was acting very strange, and she was obsessed and very frightened. ... I didn’t know what to do. ... Nothing I said seemed to change her mind.”

**Note:** It is important to first seek out a careful physical examination in order to rule out the possibility of there being a medical problem such as a thyroid disorder or a brain tumor.

### FIRST PSYCHOTIC EPISODE (ACUTE)

Psychosis results from a major disruption in brain functioning and affects up to 3 percent of the population. It involves loss of contact with reality and significant changes in thoughts, perceptions, beliefs and behaviours. Symptoms of psychosis include: hallucinations and delusions (see above); the feeling that thoughts are speeding up or slowing down; paranoia; unusual social behaviour and speech; confusion; and feeling ‘changed’ in some way. Psychosis can be triggered by a number of different conditions, such as the onset of schizophrenia; severe depression; bipolar disorder and substance abuse. In most cases, psychosis will not go away by itself and therefore it is extremely important to seek medical treatment as soon as it is detected. For further information on early psychosis intervention visit the Canadian Mental Health Association website: [www.cmha.ca](http://www.cmha.ca)

### TYPES OF MENTAL ILLNESS

#### Schizophrenia

Schizophrenia touches 1 percent of the population worldwide. This is a disorder of the brain that affects mental processing of thoughts, perceptions and moods. What all persons with schizophrenia have in common is the presence of one or more psychotic symptoms. The onset of the illness most often occurs in late adolescence or early adulthood. Early symptoms of schizophrenia can often be confused with difficult phases of adolescence. It is a lifelong illness with an episodic course and a severity that fluctuates over time. With early intervention and with the help of new medications, many of the symptoms can be relieved and make recovery possible. The symptoms of schizophrenia are usually described in terms of ‘positive’ and ‘negative’.

**Positive symptoms include:** hallucinations; delusions; thought disorder; bizarre and disorganized behaviour; incoherent communication.

**Negative symptoms include:** deficiency in flow of thought and speech (alogia); inability to experience pleasure (anhedonia); lack of emotional and physical expression (flat affect); isolation; social withdrawal; lack of motivation and interest (apathy).
MOOD DISORDERS (ALSO KNOWN AS AFFECTIVE DISORDERS)

DEPRESSION - As a mood disorder, depression is characterized by extreme sadness and feelings of hopelessness. There may be noticeable changes in appetite and sleeping patterns. Other symptoms include difficulty in concentrating and in decision-making; irritability; social withdrawal; fatigue; headache and stomach-ache. There may also be thoughts of suicide (see chapter 3). Thirty percent of the population will experience at least one major depressive episode during their lifetime. Mild depression can strike anyone at any age and should not be mistaken for ‘the blues’, which is a normal temporary response to certain life events (e.g. mourning, divorce or job loss). However if this condition persists it could develop into a major depression. Consult a doctor as there are medications available to treat most forms of depression.

BIPOLAR DISORDER - Also known as manic-depression, bipolar disorder is a mood disorder characterized by cycles of depression and mania. A bipolar disorder episode can last from several days to several months. These cycles differ in intensity, with the frequency tending to increase over the first ten years of the disease but to decline within twenty years of its first onset. Bipolar disorder often surfaces in late adolescence or early adulthood. As in those with schizophrenia, persons with bipolar disorder can also experience psychosis. Persons who are diagnosed as having bipolar disorder experience ‘low’ periods of depression (as described above) and ‘high’ periods of mania. With mania, the person often experiences symptoms of excessive elation and inflated self-esteem. Other symptoms may include: irritability; grandiose ideas; talking overly fast and loud; high heart rate and irregular breathing; delusional thoughts; and reckless behaviour such as overspending, promiscuity and dangerous driving. During a manic episode a person may be having ideas or thoughts that are far more rapid than they can write down or talk about.

“My wife always had her ups and downs but nothing like how they are now. When she’s ‘up’ she has these huge ideas and is all over the place. One minute she wants to start her own business and is calling banks about business loans. The next day she will be making plans to join the Peace Corps and seems to know the solution to world hunger! I have to watch her every move, if not I don’t know what she’ll end up doing! When she’s like this it is impossible to rationalize with her, our conversations don’t even make sense sometimes. I become exhausted just listening to her... Now I know the early signs of when she’s going up again and I make sure she goes to see the doctor. We have a deal about her taking her medication. She takes it or the kids and I go away until she helps herself. I hate having to make ultimatums but if I don’t, everyone’s lives, especially the kids, are at stake. She understands this when she is well.”
**Schizoaffective Disorder**- This is a mood disorder although it is sometimes categorized as a form of schizophrenia due to the presence of psychosis. Persons with schizoaffective disorder have symptoms of both schizophrenia and mood disorder, although not at the same time. Medications for both of these illnesses are available. Mood disorders are subdivided clinically according to their severity, episodic nature and duration.

**Further Information can be found at the following web sites:**

*Revivre (association québécoise de soutien aux personnes souffrant de troubles anxieux, dépressifs ou bipolaires):* www.revivre.org  
*Depression and Bipolar Support Alliance:* www.dbsalliance.org  
*Depression Central:* www.psycom.net/depression.central.schizoaffective.html  
*Déprimés Anonymes:* http://membres.lycos.fr/danonyme/  
*Depression Screening:* www.depression-screening.org/

**Anxiety Disorders**

At some time in life almost everyone experiences anxiety. However, a true anxiety disorder manifests itself when the fears and anxiety are so intense as to prevent normal functioning. It is known that from 7 to 15 percent of the population suffer from severe anxiety disorder. Approximately two thirds of these people are also diagnosed with depression. Researchers believe that anxiety disorders can be traced to hormonal/biological, psychological or neurophysiological causes. There are six types of anxiety disorder.

**Panic Disorder**- A person with panic disorder experiences sudden, brief and overwhelming 'panic attacks'. The emotional symptoms of a panic attack consist of intense feelings of fear, terror and also a sense of depersonalization (i.e. a lost sense of personal identity or a feeling of unreality). Physical symptoms consist of breathlessness, dizziness, racing heart, chills, trembling, and/or chest pains. The attacks can last from a few minutes to a few hours. It is therefore not uncommon for people experiencing a panic attack for the first time to rush to the emergency room believing they are having a heart attack. Eventually, the anticipation of an attack and feelings of helplessness can contribute to heightened anxiety.

**Generalized Anxiety Disorder (GAD)**- In contrast to panic disorder where the person experiences sudden and acute attacks, persons with GAD have chronic anxiety and worry excessively about money, health, family or work, always expecting the worst even when there are no signs of trouble. These worries generally interfere with the patient's day-to-day routine to the extent of affecting their entire life.

**Phobias**- A phobia is a persistent fear reaction that is out of proportion to the reality of the danger. People who have phobias are usually aware that their fears are excessive and irrational and want them to go away but feel that they have no control in making this happen. Phobias can be categorized as specific phobias (e.g. blood, elevators, dogs, water) and social phobias (i.e. fear of being observed).
Agoraphobia. Agoraphobia is defined as a subtype of panic disorder because it usually occurs in the context of panic. This means the person is not only afraid of the public place itself, but of the potential risk of having a panic attack while out in public. People with agoraphobia go to great lengths to avoid places and situations such as streets, crowds, open spaces, bridges, elevators and any situation from which escape might be difficult or where help is not available. Many people with this disorder are unable to leave their homes.

Obsessive Compulsive Disorder (OCD): As its name implies, OCD is a two-part disorder made up of both obsessions and compulsions. Obsessions involve worrying excessively about something, which in turn often causes a great deal of anxiety or distress. Compulsions involve the need to do something to help get rid of the anxiety caused by the obsession. Obsessions are unwanted, disturbing, repetitive thoughts, images, or impulses that ‘obsess’ the mind and are nearly impossible to control or dismiss. The person with these thoughts, which are fear based, realizes that they are unreasonable and/or inappropriate and tries to temporarily relieve the anxiety by acting on their compulsions. Common examples of obsessions are persistent fears of contamination by dirt or germs, thoughts of being responsible for harm to one's self or others, or the fear of forgetting to do something. Compulsions consist of rigid rituals or routines that people with OCD are compelled to perform as a means of controlling the anxiety associated with their obsession. Examples might be physical actions such as constant watch checking, cleaning, locking the door; or mental acts such as counting or praying. As with the other anxiety disorders, depression is likely to be present with OCD.

Post-Traumatic Stress Disorder (PTSD): This is a serious disorder that affects a multitude of people each year. In fact, in any given year 5 percent of the population can expect to have PTSD. It can develop in anyone who has experienced or witnessed a traumatic event, such as a car accident. Two people might experience the same event but have completely different reactions. One will not suffer any adverse effect while the other will continue to experience the traumatic event over and over again, sometimes for months or years. They often have flashbacks or recurring nightmares. They may begin to avoid situations or conversations that remind them of the trauma. They might experience sleeping problems and/or depression that were not present before the trauma; inability to remember parts of the event(s); apathy; a feeling of detachment, and a decrease in everyday functioning such as relationships and work.

For further information visit:
Association/Troubles Anxieux du Quebec: www.ataq.org
Panic/Anxiety disorders: www.panicdisorder.about.com
Anxiety Disorders Association of America: www.adaa.org/
National Institute of Mental Health: www.nimh.nih.gov/anxiety/anxietymenu.cfm
The Anxiety Panic Internet Resource: www.algy.com/anxiety/anxiety.html
OCD Online: www.ocdonline.com
**PERSONALITY DISORDERS**

Personality is defined as the psychological and behavioural characteristics of an individual that remain relatively stable throughout one’s lifetime. It is the way the person views and relates to the world. A personality disorder exists when the manner in which the patient views and relates to the world is maladaptive and dysfunctional and clashes with accepted social norms. Therefore, personality disorders can differ greatly from culture to culture. Personality disorders are believed to be caused by both genetic factors and past life experiences. There are different types of personality disorders. Two such examples are:

**Antisocial Personality Disorder** - In the past, persons with this disorder were labeled ‘psychopaths’ or ‘sociopaths’. Antisocial Personality Disorder is defined as ‘someone having chronic insensitivity and indifference to other people, which has direct negative consequences for society’. People with this disorder are characterized by one or more of the following behaviours: social and/or sexual aggression; self-mutilation (e.g. cutting oneself); stealing; lying and recklessness that endangers others; lack of remorse or of moral concern, or of any sense of responsibility; an impulsiveness and tendency to be manipulative.

“I love my son, but I don’t trust him. It took years for his father and I to finally put our foot down and say ‘no’ to him when he asked for money or wanted to come and stay with us. He is always in and out of the hospital and in trouble with the police. We just can’t cope with his stealing and lies anymore. ...What are we supposed to do? ... We can’t tie him down ...We can’t afford to always bail him out of trouble...”

**Borderline Personality Disorder** - Persons with Borderline Personality Disorder are challenged by chronic feelings of emptiness, boredom and identity confusion. Their experience is one of intense and unstable interpersonal relationships; erratic mood swings; frequent displays of temper; potentially self-damaging impulsiveness and unpredictability. Self-mutilation is also associated with this disorder.

My daughter is a very capable girl. She can be very productive at work, but when it comes to intimate relationships she cannot handle it. You never know what to expect. She can love you one day and hate you the other. A little incident can make her change her feelings instantly. We are always walking on eggshells. It seems you never do enough or the right thing for her.

Other types of personality disorders are paranoid, schizoid, histrionic, avoidant, dependent, narcissistic, and obsessive-compulsive (not to be confused with OCD) or non-specific.

**Further information on personality disorders can be found by searching these web sites:**

*Mental Help Net - Personality Disorders: http://personalitydisorders.mentalhelp.net*
*Personality Disorders Foundation:  http://pdf.uchc.edu*
*Borderline Personality Disorder Central:  www.bpdcentral.com*
SUBSTANCE ABUSE

Although not necessarily labeled a mental illness, statistics show that from 20 to 50 percent of the psychiatric population have problems with drugs and alcohol. There are a variety of different explanations for this. Many people confess that the drugs and alcohol help them to feel better and that they get some relief from the symptoms (i.e. are self-medicating), allowing them to socialize more. Another reason is that many people develop mental illness at a young age when they are still likely to be ‘experimenting’ with drugs in their peer groups. Drugs and alcohol, especially when mixed with medications, can put patients at a higher risk of relapse. Someone might experience only one single psychotic episode that is drug-induced while for another substance abuse can trigger the disease. Consumption of drugs and alcohol can also create psychotic symptoms that are difficult to distinguish from those of a single psychotic episode or from the disease itself, thus complicating the psychiatrist’s assessment. Alternatives to drugs and alcohol are not easy to find but have to be encouraged. If your relative has a mental illness and also has a problem with drugs or alcohol it is highly recommended that the fact be brought to the attention of the doctor or psychiatrist.

FOR FURTHER INFORMATION CONTACT:
Drug and Alcohol Addiction Unit- Department of Psychiatry of the Montreal General Hospital- (514) 934-8311
Foster Pavilion- Adult Out-Patient Clinic- (514) 486-1304
Ensemble- (514) 697-1230
Drugs Help and Referral 24 hour hotline- (514) 527-2626
COPING WITH PSYCHOSIS (HALLUCINATIONS AND DELUSIONS)

No one is prepared for the shock and panic of watching their loved one in midst of a psychotic episode. A psychotic episode occurs when the patient is experiencing hallucinations and delusional thoughts to the point where they are no longer in control or in touch with reality. Here is a list of things to try and keep in mind and to do when dealing with a person who is experiencing psychosis.

- It is important for the family to seek medical attention as soon as possible; one option is to go directly to the emergency room at the hospital. If the patient is already under treatment, the family should also phone the Out Patient Department. Another option is to phone the Crisis Centre. (514) 684-6160 or 911 (see page 3).
- If the patient is not too aggressive or paranoid, tell them that you are going to seek help and that you will accompany them to the hospital. It might help to tell them that you are worried about them, but don’t try to tell them that what they are feeling or seeing is not real, because for a person in a psychotic state, the voices they hear are very real. Trying to empathize with their emotions is better than trying to correct their delusions. However you can let the patient know that you aren’t experiencing what they are.
- Try to remain as calm as possible. Do not shout. Showing emotion on your part could make matters worse.
- Try to decrease other distractions, e.g. if it seems to help, turn off the television and radio. Ask others to leave the room or have people speak one at a time.
- Allow the patient their personal space. Don’t stand over them if they do not want you to. Try standing next to the person rather than facing them. Avoid eye contact as much as possible. This is less threatening, especially if they seem paranoid.
- If the caregiver is in danger call 911.

Remember: you don’t need to go through this alone. There are people and resources ready to help you!

COPING WITH AGGRESSION

People with a mental illness can sometimes be violently aggressive due to hallucinations or delusions. Individuals who are prone to violence are much more likely to perform violent acts when they are psychotic or if they are not taking their medications.

- If you notice that the patient is feeling aggressive, avoid all confrontations, preferably by leaving the scene. Do not put yourself in physical danger.
- If the patient is violent, you may not have time to phone the psychiatrist or the Crisis Centre for advice - both would probably advise you to call 911. The person’s altered state of mind may put everyone’s safety (including their own) at risk. Taking the person to the hospital on your own may not be possible. The best choice in this situation may be to call the police without hesitation. Tell them it is for someone with a mental illness and that this person needs to go to the hospital.
Remember that the patient, who is your loved one, may not even realize who you are and might perceive you as their persecutor, or perhaps even the devil incarnate. Do not forget that if your loved one is being aggressive towards you, it is only because of the illness.

- Aggressive behavior is often preceded by physical changes. It is important to take note of these warning signs. Although they will differ from one person to another, the same person will display the same signs from one crisis to the next. Some signs to watch for may be excessive agitation, specific facial expressions, rapid breathing, or delusional conversations.

**SUICIDE**

Tragically, suicide is a great risk for persons with mental illness, especially during the first five years or so after the onset of the illness. Reasons for this include depression; poor response to medication; realization that they are ill and that their future looks bleak to them; social isolation and lack of emotional support. A popular belief is that people who threaten suicide don’t really mean it and are just seeking attention. Although this is sometimes the case, you should never take that chance—threats of suicide should always be taken seriously! (See page 14)

**SUICIDE – WHAT ARE THE SIGNS?**

- The person at risk talks about death in excessive detail e.g. what it would be like, how one does it or how it would solve everything.
- The person talks about making a will, or giving away their personal effects.
- The person persistently describes himself/herself as worthless or hopeless.
- The person, who has been depressed for some time, suddenly and without reason, seems happy and full of life. This may be only because they feel suicide is the perfect solution.

Do not hesitate to phone Suicide-Action Montreal at (514) 723-4000 (24/7), Crisis Centre (514) 684-6160 or Friends for Mental Health (514) 636-6885 for further information and concerns.

If the person seems on the point of enacting a suicidal plan, call the police immediately or get a court order, depending on the urgency of the situation.

**PLANNING FOR EMERGENCIES**

- Keep a list of phone numbers handy for the police; e.g. the hospital; the psychiatrist; the social worker and Crisis Centre.
- Know which hospital you are to go to.
- Explain the emergency procedure to your loved one and discuss it with the whole family.
- Have a list of family members and friends whom you can rely on for support.
- If you feel the police may need to be involved at some point, it may be a good idea to explain the situation to them ahead of time.

*See Emergency Directory and Crisis Review Worksheet provided in back of manual.*
“Our first time dealing with the hospital was back when my daughter was living on her own. She phoned me in the middle of the night. She was hysterical, and wouldn’t stop crying. This was something that was happening more and more often. I finally convinced her to let me pick her up and take her to the hospital. When we arrived at the emergency, she had calmed down a bit. I told them (at the hospital) that she had been acting strange for a while and that it was getting worse. She finally saw the psychiatrist after a very long wait. My persistence paid off.”

In many cases, people are unsure of what to do, whom to call, and where to go to help a loved one who is experiencing mental health problems. You and those close to you may be exhausted and feel overwhelmed by this situation. You are not alone; there are many trained professionals to help you through this difficult period. If you have any concerns regarding psychological disturbances or mental illness, the person needs to be seen by a health professional. Information on where you should go and what to do can be found by talking to your general practitioner/family doctor, Friends for Mental Health, or through your local CLSC (each CLSC has a 24 hour 7 days/week Info Santé telephone service that will answer your questions).

Unfortunately there may be a risk of having to wait for a certain period of time to receive psychiatric attention. If this is the case and you feel that your loved one is in need of immediate services i.e. is in crisis, do not hesitate to present yourself at the emergency room at the hospital of the ill person’s sector. The patient’s postal code is the determining factor for admission.

**VOLUNTARY HOSPITAL ADMISSION**

If the person is new to the psychiatric system and it is their first time trying to be admitted to the hospital, they must go through the hospital emergency services (ER). It may be a good idea to telephone the hospital and ask to speak with the psychiatric liaison nurse (e.g. Lakeshore Hospital Department of Psychiatry - 4th floor), inform them of the situation and that you will be bringing someone in. The patient will be evaluated and a decision will be made as to whether or not they will need to see the psychiatrist. The doctor or psychiatrist may recommend a hospitalization or treatment and/or follow up with the outpatient clinic or general practitioner. Because it is dependent on the severity of the condition, hospitalization is not needed in every case. Admission for someone who is known to the system may be arranged through the outpatient clinic or by someone from their follow-up team, such as their social worker, psychiatrist or psychiatric liaison nurse. However, if it is a crisis the patient must also go through the ER.

It is always preferable to give the treatment team valuable information on your loved one’s condition: What are the symptoms? How long have they been present? Has a recent event precipitated this state? Are they taking medication? How are they reacting to this situation?
Unfortunately your loved one may not understand that they need treatment. This is not uncommon; in fact it is part of the illness. For everyone concerned this can be an extremely stressful and frightening situation to deal with. If you believe that your loved one is a danger to themselves or to others and is refusing treatment you should seek an involuntary psychiatric evaluation. As hard as it may be to do this against your loved one’s will, it is usually the best thing you can do for them. Here is a basic overview of how the process works.

In case of immediate danger you must call 911. State that there is a psychiatric emergency, that the person is not willing to go to the hospital, and that you want an ambulance to be sent as well. When the police come (with or without the ambulance), if they judge that the person is an immediate danger to themselves or others, they will bring the person to the hospital. Once the person is at the hospital, the emergency physician will see them. If the physician also judges that the person’s mental state presents an immediate danger then the person can be placed under preventative confinement for approximately 72 hours. If the person opposes the assessment during the preventative time period, the institution could make a request to the Quebec Court for a temporary confinement, which would allow for a psychiatric examination.

During the time period of the confinement, the institution must obtain a court order to have the person undergo a psychiatric assessment. A psychiatric assessment includes two psychiatric evaluations conducted by psychiatrists to evaluate the danger of the situation and determine if the confinement should be extended. Once the person is admitted, the hospital must continue to examine the person until it is judged that they that they are no longer a danger to themselves or others.

It is important to note that the police may decide not to take the sick person to the hospital if they decide that this person is not a danger to themselves or to others. Another possibility is that once the person arrives at the hospital the physician or psychiatrist may decide that they do not need to be confined. In any case, the person is not required to have a psychiatric assessment and is free to leave the hospital. If you are faced with such a situation, and you still feel that the person needs help, it may be time to look into obtaining a court order. Remember that everyone has a right to decide whether or not they will be treated. It is only if the person is in extreme danger to themselves or others (which sometimes can be hard to determine or prove) that this human right can be taken away.

“We were so desperate... Our son refused to go and see a doctor. Nothing he was saying made sense. He would rant and rave and make all sorts of threats. One day we were in the mall and he started screaming at this man we did not know. Luckily the man realized that something was up and didn’t fight back but these were the types of things he was doing all the time. Another time he lit a fire in his bedroom by the window for ‘protection’. He needed help so badly but he thought that nothing was wrong with him. We were afraid for everyone’s safety. The social worker at the CLSC gave us the number for Friends for Mental Health and we called them and they helped us to file for a court order. When he was hospitalized he finally agreed to try medication. He was in there for about two months and now he is home again. He is still trying to readjust and is quite sleepy but he is not so scared anymore, us too.”
COURT ORDERS

A court order is a preventative measure. Although a crisis may not yet have erupted, you may feel that the ill person or those around them are at risk. An example of risk would include a person in a psychotic state sleeping with a weapon beside their bed. Someone who is in a manic state might drive fast and dangerously. Perhaps the person is paranoid that someone is poisoning their food and therefore refuses to eat. All of these things put the person or others in a “possible” danger. If you are thinking about a court order you have probably reached a point of desperation. Fortunately court orders are easy to fill out but you may need some emotional support in doing so.

To fill out the motion for a court order you should contact your family support association such as Friends for Mental Health, or the CLSC. Someone there will help you fill out the application and make the appropriate arrangements for the hearing. You and an interested person, i.e. someone who knows the person and the situation, must be prepared to provide evidence on why you feel a court order is necessary.

You will be required to appear and provide information in front of a judge. If the court order is granted it should be brought as soon as possible to the hospital and to the police station of the ill person’s sector. By bringing the court order to the hospital you are letting the staff know that you are available and want to be part of the situation. Arrangements will then be made to have the person brought, usually by the police and/or ambulance, to the hospital.

It must be noted that a court order only guarantees a psychiatric assessment. Once the person is assessed and judged a danger to themselves or others, the hospital will obtain another court order to have the person confined against their will until they are no longer deemed a danger. Although a court order does not guarantee treatment, it can be a major step towards convincing the person that they need help and treatment.
CHAPTER 5  ACCEPTING THE ILLNESS

Families and close friends of a person with a mental illness face a broad array of emotional responses ranging from self-blame to resentment. These feelings are normal. Depending on the severity of the illness, this may just be the most serious and difficult crisis you will ever face. Many people will agree that the ultimate goal is actually to achieve acceptance of the fact that your loved one has a mental illness. This may be a long and heart-wrenching road to take but one that is nonetheless possible for you to negotiate and survive. We shall identify phases of accepting your loved one’s illness that are common to most families, although the precise sequence is not necessarily the same in all cases. Obviously there is no set course in which these feelings must occur. Each family will have its own ways of coping that are appropriate to their situation.

PHASES OF ACCEPTANCE

CONFUSION / SHOCK / PANIC
No one is prepared for the shock of having a loved one change right before one’s eyes. Of course you as a caregiver are scared, worried, and confused, it is as if the world is turned upside down because people’s whole lives are so affected. You are now faced with situations you never thought you would have to deal with. At this point you may desperately need help. Fortunately, Friends for Mental Health is able to help you through your pain, to advise you, and to answer the many questions you will have.

DENIAL
As mentioned earlier, it will usually be the changes in your loved one’s behaviour that will be the first warning sign that something is “not quite right”. Although you may not understand why these changes are happening, a common reaction is to try to explain them away. It is easier to convince oneself that what is happening is temporary or just a phase your loved one is going through rather than understanding that there is a serious problem that needs to be dealt with. Denial is a normal stage of grief; sometimes the truth is just too difficult to face and acknowledge. Interestingly enough, it is known that initially a certain amount of denial can be beneficial in terms of hope of recovery. By believing the illness either does not exist, is not so serious or that it is just a phase, the caregiver is more apt to fight for the loved one to return to ‘normal’. Although this reaction has its advantages, the negative side is that by believing the illness does not exist or by expecting a full recovery (in some people), realistic goals are not being set and therefore not met. Hence some actions - like seeking medical help - are not envisaged. Once you and the family have accepted the illness your energies can now be focused on the rehabilitation of your loved one.

SORROW / GRIEF
It is not uncommon to hear that having a loved one develop a severe mental illness is similar to experiencing a death in the family. Unlike a death, the ill person is present and the family is continuously reminded of how the loved one once was, and mourns the future that may never be.
Both the caring family and the patient feel the pain. This may be a good time to seek professional help, such as support groups and/or individual counseling.

**Guilt**
Families who have a great deal of knowledge about mental illness and of its impact may still have those gnawing feelings of guilt. Even knowing that no one is at fault and that guilt is irrational does not stop one from dwelling on the “what ifs” and “if onlys”. The effects of guilt feelings are unfortunately often underestimated. Depression, diminished self-confidence, becoming overprotective, and losing problem-solving skills and quality of life can all result from excessive feelings of guilt. Although these guilt feelings may never completely disappear, there are ways to modify thinking patterns to avoid such repercussions. Discussion of these guilt feelings with other caregivers in similar situations can be very productive. Focus on how you can improve the present and future rather than dwell on events of the past. And remind yourself frequently that although your loved one’s life may not necessarily be a good one at present, it is counterproductive not to live yours to its fullest.

**Frustration / Anger / Resentment**
Frustration and anger at the health care system, the ill person’s limitations, and the sheer exhaustion of having issue after issue to deal with are only natural. Families of someone with a severe mental illness can find themselves under an enormous amount of stress and will feel helpless and perceive the situation as out of control. It is often the case that people become angry or resentful at the person with the mental illness - rather than at the illness itself - without even realizing it. Siblings may be resentful that their parents’ attention was taken away and their lives disrupted. Spouses may become angry that they are now the caregiver rather than partner. Children may feel they lack support and safety because their parent is always sick, in and out of the hospital, and so on... Even if not voiced, thoughts of it ‘not being fair’, and ‘why me?’ may be present. The reality is of course that it isn’t fair, and we don’t know why some people are healthy and others not, but it is a fact of life and - amazingly enough - people find ways of coping with it. Exploring healthier ways to channel these feelings is very important because the consequences of not doing so can be damaging for everyone concerned. Some beneficial coping mechanisms include telling a friend about how you are feeling; exercising; taking up a hobby; going for long drives; joining a support group; or volunteering with a mental health organization. And always remember to leave room for communication.

“At first I hid the fact that he was ill from my friends. Actually, I basically stopped socializing altogether so that I didn’t have to deal with it and explain it to everyone. I didn’t want to begin to try and explain why ‘Johnny’ dropped out of University, is now living at home and has been diagnosed with schizophrenia. Honestly, I was ashamed and embarrassed. ...’Johnny’ was always the popular kid ...I bragged about him in my x-mas cards ...girls loved him. Eventually I joined a family support group and learned more about schizophrenia and slowly began to teach others about it as well. I finally came to terms with the fact that this person was the same person that I loved all his life and although he is not going to be the same as before, that he was capable of other things. This helped ‘Johnny’ out so much. I was so confused that it didn’t even occur to me that how I was reacting would hurt him.”
SHAME

Although times have changed and mental illness has begun to be discussed and better understood, there is still a strong and damaging stigma attached. People fear the unknown, and mental illness remains a mystery and a taboo to the general public. Unfortunately it is common for families of persons with a mental illness to feel a sense of shame at themselves and/or their loved ones. They may feel that others see them as a ‘bad family’, and that they are necessarily at fault for the person’s illness. Although we cannot change the world’s mentality overnight, we can change our own ways of viewing each other and ourselves. Feeling ashamed and uncomfortable about your situation can be overcome by some of the following actions: continuously educate yourself and those around you; develop coping strategies for dealing with embarrassing situations (which will be discussed further); modify your expectations of your relative; and above all focus on your loved one’s abilities rather than disabilities - this can make the world of difference!
EFFECTIVE COMMUNICATION AND INTERACTION

Any family can experience communication problems. However, where mental illness is present, communication may be even further disrupted. Many of the communication problems may be directly linked to the symptoms of the illness. For example, someone with schizophrenia may hear voices so much of the time that they have difficulty focusing on what is really being said to them. Or, someone who is experiencing depression may be so demoralized and unmotivated that nothing you say makes a difference. Maybe the person experiences negative symptoms (refer to chapter 2), which make it difficult to read how they are feeling. Any of these can cause a great deal of frustration, sometimes resulting in arguments and hurt feelings.

There are still other factors that may lead to a breakdown in communication. You may feel as though your relative does not appreciate the efforts you have made to help and consequently you find yourself angry most of the time. Or you may find yourself breaking down in tears every time a conflict arises. Maybe you are unsure of how responsible your loved one is for their behaviour and therefore avoid addressing certain issues. Perhaps your loved one is prone to outbursts and therefore the whole family is “walking on eggshells” to keep the peace.

All of these experiences are normal reactions to the stress of having to understand and cope with mental illness in the family. Here are some basic tips that may be useful in trying to increase communication and interaction and decrease the possibility of conflict within the family:

- If possible, schedule a weekly or monthly family meeting to discuss how everyone is doing or try to have a sit-down meal with everyone at least once a week.
- Try not to raise your voice to get your point across, and don’t look for someone to blame. Avoid criticism.
- Express your feelings directly, using “I” statements such as, “I am upset when you don’t clean your room” and try not to use ‘shoulds’ and ‘musts’ too often. Try, “I would appreciate” or “It might be a good idea”. Don’t assume that your relative knows how you are feeling or even is able to show empathy.
- Try not to put off addressing a conflict. Discuss it as soon as everyone calms down.
- Do not always ask the person what they are thinking about, or why they are doing what they are doing.
- Always try to put yourself in their shoes. You may not understand their fears, but you can empathize with what fear feels like.
- Since it may be difficult to have conversations, try to spend time together doing things that don’t require talking, such as listening to music, watching a movie.
- Encourage your relative and acknowledge their efforts around goals that are realistic for them.
- If you need the person to do something for you and you feel they may forget, write it down for them or leave a message.
- Keep your explanations calm, simple, brief, and to the point. Listen carefully; don’t rush them.
- Ask questions when you don’t understand what the person is saying.
- Concentrate on one topic at a time.
RECOGNIZING AND COPING WITH PROBLEM SITUATIONS

Every family is going to have different problems when it comes to their loved one's behaviour. Certain problem situations such as inappropriate social behaviour, poor personal hygiene, and poor sleeping patterns are seen more often than others. And of course some of these will be more serious than others. Professionals and experienced family members suggest that the best way to tackle problem areas is one at a time. Trying to change all behaviours at once is not only going to be frustrating for you but also confusing and stressful for your relative. Try to choose one issue that is a priority, something that is an immediate problem, and leave the rest for a later date. If you find that your relative does not respond well to your help, talk to a professional for advice and support. See the section below on limit setting and realistic goals for further suggestions.

“Everywhere my brother goes he has to talk to someone. Whether it is the bus driver, the cashiers, just people he walks by. Although he has been taking his medication properly for years, he is still acting weird, so he doesn’t make much sense a lot of the time. This used to drive me crazy! I was so embarrassed to be seen with him but I am really the person he has. I would roll my eyes and make up excuses for him to everyone. As we have gotten older I have come to accept and appreciate him more. When we go out I try and keep his attention focused on me. Or when he starts talking nonsense to strangers I sometimes even join in on it with him and everyone ends up laughing. He is actually a very funny guy with a great sense of humor. I figure that it is his life that has been damaged so badly, not mine, and that if he wants to talk to strangers, so be it. There are far worse things he could be doing.”

CAREGIVER BURN-OUT

Families, especially the caregivers, without even realizing it, often get swept into meeting others’ needs at the expense of their own. This attempt cannot be sustained for long before the ability to cope diminishes. Fatigue, physical ailments, sadness, anxiety, and increased levels of frustration only too easily envelop caregivers' lives. To avoid this situation, it is important that caregivers protect themselves by establishing limits on what they are willing to do and the behaviours they are willing to accept.

SETTING LIMITS

Establishing limits to what one can do as a caregiver is essential for one's own health. With this in mind consider first what are your own needs if you are to lead a balanced life. This must include consideration for personal time, self-care, leisure and relationships. Ask yourself if you are currently fulfilling these needs. Often, caregivers forget that they do have a choice. For example, they may feel guilty if they don't cook on a daily basis for their loved one or regularly keep the loved one's room clean. In situations such as these it is unhealthy for both parties to continue this pattern. Just as the caregiver lacks personal time by looking after others, the person who is ill is not learning the necessary skills to function at their highest level of autonomy.

Deciding to apply your limits is the first step. Putting limits requires encouraging your loved one to realize that changes need to be made and that they must respect these new boundaries.
It is important to convey your confidence in your loved one’s abilities. Communicate to them that their mental illness does not release them from meeting your expectations.

The next step is to look at the problematic behaviours and divide them into three categories: a) those absolutely unacceptable such as violence, b) those that need to be changed as soon as possible such as following treatment properly, and c) those you would like to see changed but can live with at least for the moment such as messiness. Now ask yourself what effect your loved one’s behaviour will have on yourself. Are you in physical or psychological danger? What stress does it put on you and your family? What would happen if you were no longer able to care for your loved one? Once you have seriously considered the behaviours in question, think about how you can encourage the cooperation of your loved one to make a plan with you.

A concrete plan needs to be set in place. All parties need to understand the expected behaviours and the exact consequences should they not be adhered to. The plan may be more effective if it is put in the form of a joint contract developed between you and your loved one. Make sure the perceived consequences are realistic because you are the one who must enforce them. For example, physical violence must naturally result in the ill person having to face the authorities, and messiness will result in articles being removed from the ill person’s room for it to be kept clean.

Follow through with the contract and with the predetermined consequences. By not doing so, you are communicating to your relative that you are not taking the situation seriously. Take time to discuss and evaluate your loved one’s progress and acknowledge the changes that are being made. Through positive reinforcement you give your loved one motivation to continue working towards self-improvement.

Establishing limits can be a great challenge. But it is important to keep in mind that failing to help yourself first may eventually result in an inability to assist your loved one. Setting limits helps everyone.

**FAMILY SUPPORT AND RESPITE SERVICES**

Caring for a loved one who is mentally ill can be exhausting and stressful. Only too often the caregivers do not receive the help and support they need. Fortunately Friends for Mental Health offers support and respite services. Contact us for information about the services we can offer to alleviate your stress. You are not alone!

**LIVING ARRANGEMENTS**

A major challenge faced by individuals with a mental illness and their caregivers is determining the most appropriate living arrangements. There are a number of different factors to consider such as the housing resources available in your area; the severity of the illness and the dynamics of the family. However all of these factors are dependent on the immediate mental health of the loved one and the resources of the caregiver. The goal is to have the patient reach their optimum degree of autonomy in the present and foreseeable future. This will be beneficial not only for the patient but for the whole family.
Caregivers involved with their loved one will find that whatever is happening to their relative will somehow affect them too. The less anxious and distraught the patient, the less anxious and distraught will be the caregiver’s family, and vice versa. The more the patient relies on the community and their own independent living skills, the less the family is stressed. Hence more time can be placed on strengthening relationships and reinforcing a healthy lifestyle. By helping the person become as independent as possible the caregivers are also benefiting themselves. There are no right or wrong answers here. Each option comes with pros and cons to consider. This may be a good time to consider getting aid and advice from professional organizations and even friends who are familiar with the situation.

“My goal was for my son to go back to University, to get a job, whatever; to be normal again. Nagging at him to work harder at getting better. If I left it up to him he would stay in his room all day listening to music, smoking cigarettes, and not speaking to anyone. I began to burn out. We were fighting all the time. It took a while but I finally agreed to let him move into a group home. This is what he, and the rest of the family wanted. I hated thinking of him living with other people who were mentally ill. He lived there for two years and now he is living in a care apartment with two room-mates and has a part time job. Our relationship is much better now.”

**HOUSING RESOURCES**

In some instances, you and your family may realize that for all concerned it would be better for the loved one to leave home. Some families will feel guilty about this, especially if the ill member has difficulty understanding the decision and is against it. A helpful way to view this issue is to recognize that you are not always going to be around and therefore your ill family member is going to have to survive without you at some point. For the ill person, making this transition while you are still in a position to offer support is easier than if they had to make this transition without you. Once again, keep in mind that the ultimate goal is for the person to achieve as much autonomy as possible with a good support system. And this can usually be better achieved if they live away from home. Yes, the person has a mental illness, but this does not mean that they cannot lead an independent and productive life.

Autonomy is an important goal in life for everyone, and so it is for a person with a mental illness. Some support will be needed, but the goal should be pursued to maximize the person’s capabilities. It is often surprising how much a person can do when given responsibilities and independence. If it is decided that the person will not live at home there are a variety of options available, although they are limited. Examples are group homes, care apartments, semi-supervised apartments, and independent living. Talk to a social worker who knows the neighbourhood for more information on these options. Please note that if it is decided that your relative will use a housing resource, the sooner their name is put on the waiting list(s) the better. Refer to chapter 9 for a description of housing resources.

In the case of hospital discharge, the Crisis Centre (see chapter 9) may be suggested as a place to ease the transition from the hospital to community living. They can offer short-term housing, and aid in finding appropriate housing. In addition, the Crisis Centre offers counseling and short-term follow-up services.
Ideally, the person who has a mental illness will leave the hospital with a treatment plan arranged by their team. It can be helpful to let hospital personnel know that you are open to any advice that would help ease your loved one’s discharge from the hospital. Also, it might be preferable to send the hospital a letter stating that you would be very interested to meet with them so that you can be informed of possible options and be kept up to date on eventual release. Overworked hospital staff just might forget to inform the family. The treatment will usually include medication(s) and/or a type of individual or group therapy. During the initial stage of recovery the person will most likely be quite fragile. It is also possible that the person has not yet accepted the illness, and this will place barriers on recovery. Because most medications take a certain amount of time to begin to reduce symptoms, the person may not yet be stable enough to take part in treatment activities. Everyone’s recovery will differ depending on the person’s needs and wants and the severity of the illness. Here is a brief list and description of the most commonly used psychiatric medications followed by other treatment options:

**MEDICATIONS**

Medications for persons with mental illness are used to both reduce symptoms and to prevent relapse. Because virtually all mental illness stems partly from a biological cause, medication is considered by most to be essential for treatment. For example, it is believed that with medication the chance of relapse over a two-year period for someone with schizophrenia is reduced by half. Yet as one of the biggest issues surrounding mental illness, medication control and use is subject to much controversy. Due to side effects and the need for monitoring, not to mention a person’s denial of their illness, many people refuse or cease to take their medications (see chapter 8). Fortunately, there have been great advances in psychiatric medications. Although far from perfect, they can effectively treat (though not cure) the symptoms of mental illness.

**Antipsychotic Medications**— also known as neuroleptics or major tranquilizers, antipsychotics are prescribed to people who are experiencing psychosis (hallucinations and delusions). Most antipsychotics substantially improve symptoms in approximately two-thirds of people. Statistics taken from the Schizophrenia Society of Canada state that about half of these persons experience full remission of symptoms. The other half sees substantial improvements while still experiencing some symptoms. Unfortunately, the remaining third do not respond successfully to the medicine. Many types of antipsychotic medications exist. While some people respond well to one drug, others may not. Doctors may suggest that the person try a number of different medications until they find one that works for them. Here is a list of the some commonly used older and newer antipsychotic medications:

**Newer:** Clozapine (Clozaril), Olanzapine (Zyprexa), Risperidone (Risperdal), Quetiapine (Seroquel). These have fewer side effects.
OLDER: Haloperidol (Haldol), Methotrimeprazine (Nozinan), Loxapine (Loxapac), Trifluoperazine (Stelazine).

COMMON SIDE EFFECTS: weight gain, muscle spasms or stiffness, restlessness, dizziness, increased appetite, decreased libido, loss of menstruation, blurred vision, dry mouth, constipation and difficulty urinating.

SIDE EFFECT MEDICATIONS: also known as, anticholinergics. Used to manage side effects such as those mentioned above. Most commonly used: Congentin and Kemadrin.

ANTIDEPRESSANT MEDICATIONS- Antidepressants are used to treat depression (chronic and acute), depression in bipolar disorder, obsessive compulsive disorder (OCD), chronic pain, and some anxiety disorders. Unfortunately it usually takes between three to six weeks before these medications begin to take effect, but when they do they are usually very successful in treating the symptoms of depression. Approximately 75 percent of persons respond well to antidepressant medications. And like antipsychotics, there are a number of different types for the doctor to choose from. Once a medication is found to be effective it is highly recommended to stay on it. Medication should never be discontinued without talking about it with the doctor who prescribed it. Here is a list of the most commonly prescribed antidepressant medications: Paroxetine (Paxil), Bupropion (Wellbutrin), Fluoxetine (Prozac), Sertraline (Zoloft), Venlafaxine (Effexor).

COMMON SIDE EFFECTS: dry mouth, weight gain, decreased libido and sleep disturbances.

MOOD STABILIZERS- Mood stabilizers are used to treat mania and its subtypes, and for prevention in bipolar disorder. Sometimes people who are on mood stabilizers are also prescribed antipsychotics. Mood stabilizers such as Lithium must be monitored by blood test to control dosages. These medications usually take several weeks to take effect. Most commonly prescribed mood stabilizers: Lithium, Valproic acid (Epival), Carbamazepine (Tegretol).

COMMON SIDE EFFECTS: weight gain, sleepiness, and thirst.

INJECTIONS- some medications are available in injectable form. Injections can be used when the person does not commit well to treatment and also when the person is unable to take their pills daily. People on an injection either present themselves at the hospital/clinic to receive it, or at the CLSC.

Sometimes a combination of different types of medications is needed. In some cases, it has been found to be effective to combine antipsychotics and antidepressants. Prescriptions of medications target symptoms that are occurring at a certain time but because of changes in symptoms, medications are prone to change also.

TO FIND OUT MORE INFORMATION ON PSYCHIATRIC MEDICATIONS AND THEIR SIDE EFFECTS, VISIT THESE WEB SITES:

Internet Mental Health: www.mentalhealth.com/fr30.html
American Psychiatric Association: www.psych.org
Psychiatric Medications Overview: www.healthyplace.com/site/psychiatric_medications.htm
PSYCHOSOCIAL TREATMENTS

The best treatment for mental illness is a combination of medication and psychosocial intervention. Whereas medication targets the symptoms of the illness, psychosocial treatment targets learning to adjust to life with having a mental illness. This includes basic life skills that have been affected by the illness, such as improving cognition and memory, self-esteem, stress management, psychosocial skills, and arranging job or school reinsertion. For information on what types of psychosocial treatments are available in your area for your loved one, talk with your social worker, or contact us at Friends for Mental Health.

PSYCHOTHERAPY

There are a number of different psychotherapeutic approaches. Some approaches are more appropriate than others depending on the type of illness and goal of therapy. Once the person is stabilized medically, some form of psychotherapy can be encouraged. Information on psychotherapy and on seeking the services of a psychotherapist can be found by contacting your local CLSC, the Order of Psychologists of Quebec, your doctor, or the hospital. Or call us at Friends for Mental Health to help you find a therapist who would best fit your needs.

RECREATION

Recreation plays a major role in building, or re-establishing, a person’s sense of autonomy, self-esteem, and dignity, not to mention the physical and psychological benefits of keeping active! Too often, persons with mental illness are left with a large amount of time on their hands and don’t know how to use it. Finding activities, be it a social group, swimming, art classes, or chess club has positive effects. Everyone needs to have something that they enjoy doing and feel that they are good at. For someone with a mental illness, especially if they are not working or going to school, this can be a true lifesaver. Contact a day centre for adults with a mental illness or recreational facility, such as the YMCA or the Community Resource Centre (514) 694-6404 for further information on what is available in your area.
MEDICATION CONTROL

Unfortunately, persons with mental illness often stop taking their medications - on their own - for a variety of reasons. Knowing why your relative is ‘non-compliant’ with their medication may make it easier to try and counter it.

Here a few of the most common reasons given by persons with mental illness for not taking medication:

- They believe they do not need their medication anymore because ‘they feel better now’.
- They do not like the side effects of the medications, such as feeling sleepy or weight gain.
- Someone who is important to them disagrees with medication.
- The medication regime is too complicated for the individual to follow and they forget.

INDICATIONS OF NOT TAKING MEDICATION

- There are pills left in the container.
- The person has not been filling their prescription.
- The person has no idea what the name of the medication is or the amount they were prescribed.
- Symptoms that had disappeared with the medication have begun to reappear.

SOME TIPS TO ENCOURAGE MEDICATION

- Explain to the person that they may end up back in the hospital if they don’t take their medication properly. Accentuate the positive sides of taking medication, such as improved concentration, less restlessness and decreased anxiety.
- If other members in the family take any medication, try taking it at the same time. Try associating taking the medication with another daily activity (for example, brushing teeth).
- Obtain unity in the family about the value of medication. If even one person disagrees with it, it could effect your relative’s compliance.
- If non-compliance is primarily due to side effects, see if it is possible for the doctor to adjust the dosage. If weight gain is an issue, perhaps you and your relative could join a gym or go walking together daily.
- Don’t lie to your relative about the medication or sneak it into their food. This will create distrust and can feed paranoid ideas.
- If the regimen is too complicated for your loved one, ask the doctor if an injectable form can be administered.

RELAPSE

Relapse means that the symptoms of the illness that seemed to have responded well to treatment return. This can be very disappointing for everyone concerned but is not an uncommon thing to happen. There are a number of reasons that can bring on a relapse. These include: stopping
medication, insufficient dosage of medication, stress, lack of sleep, big life changes, alcohol or drug abuse, or the evolution of the illness.

Indications of relapse (basically the signs that first brought the illness to attention) are: Sleeplessness, confusion of day and night, social withdrawal, deterioration of personal hygiene, hyperactivity or inactivity, bizarre speech and thoughts, hallucinations and delusions, blank expression, and others.

The best way to prevent relapse is to plan ahead for the possibility of it happening and to respond as soon as possible if there are signs of deterioration. You and the person who is ill should make a plan (while they are in the stable phase) for avoiding relapse and what to do if it should happen. For example, discuss the triggers of relapse e.g. stopping medication, lack of sleep, and plan that they let someone know if they are not feeling well. Let them know that you will not abandon them if they relapse, and will intervene in their best interests.

**Things to Look For:**
- What was happening in the person’s life before relapse occurred?
- Had there been any changes in their routine?
- Were they taking their medication as prescribed?
- Were they abusing drugs/alcohol?
- Were there any arguments or interpersonal conflicts going on?
- What are the potential recurring triggers?

This can be an occasion to learn and develop awareness for the future and thus have a better management of the illness.

*See Crisis Review Worksheet in back of manual.*
There are services available for your loved one to help them adjust to returning to the community. This should begin as soon as possible to avoid relapse and to build skills to enable the person to cope with having a mental illness. Here is a description of the most commonly used resources available for persons with mental illness living in the West Island area. Remember that each organization offers different services. What works for one person may not be appropriate for another person’s need.

**FOLLOW UP AND ASSISTANCE**

**The Lakeshore General Hospital Outpatient Clinic** - during the person’s hospital stay, the psychiatrist or another psychiatric specialist will most probably refer the person to the hospital’s Outpatient Department (OPD) for follow up. Here they will receive medication and health consultation and treatment. There are a variety of services associated with the OPD. Contact them at (514) 630-2010 for further information.

**PACT Team** - headed by a psychiatrist from the Lakeshore hospital, the PACT Team is a mobile community-based treatment team for persons with severe and persistent mental health problems. It is a multidisciplinary agency which functions interchangeably to provide treatment, rehabilitation, and support for persons to live successfully within the community.

**Community Perspective in Mental Health** - Community Perspective offers adults with mental illness individual support and follow-up; help finding appropriate, low cost housing; and assists the person with basic life skills such as budgeting and human rights education. A community worker, through home visits, helps to enhance the quality of life by maximizing coping skills and by developing a support network. 16115 Gouin Blvd #300, Ste. Genevieve, (514) 696-0972

**West Island Citizen Advocacy** - Citizen Advocacy provides advocacy and support to adults with mental illness and other persons in need of their services. Volunteers, supervised and trained by social service professionals, are there to provide emotional and practical support (such as banking, shopping and activities) to persons living independently in the community. They also provide individual and collective defense of rights assistance. Their Church Apartment Program offers permanent semi-supervised homes for adults with mental illness. 68 Prince-Edward, Pointe-Claire, (514) 694-5850

**CRISIS CENTRE**

**Services D’Intervention Psycho-Sociale (SIP)** - The West Island Crisis Centre is a 24 hour 7 days/week service for persons with mental health or psychosocial problems in crisis. Its main objective is to encourage autonomy by helping the individual in developing the
necessary skills for their integration into the community. It can be very helpful in avoiding hospitalization. The Centre can also provide a place of transition between the hospital and the community. The Crisis Centre offers a 24-hour crisis telephone line, short-term housing (up to two weeks), individual counseling, short term follow-up, and a mobile crisis intervention team. All services are arranged by telephone and are subject to an evaluation. (514) 684-6160

**THERAPEUTIC TREATMENT CENTRE**

**Ensemble**- Ensemble is a treatment centre for adults with mental illness. Each client is offered individualized programs aimed at preventing hospitalization and improving quality of life by using a multi-disciplinary and holistic approach. Ensemble offers programs such as clinical intervention; individual, group, and family therapy; art therapy; social re-adaptation programs and community outreach. Ensemble works closely with the Lakeshore Outpatient Department. A referral from a mental health professional is needed. 2840 Saint-Charles Blvd, Suite 202, Kirkland, (514) 697-1230

**DAY CENTERS**

**Omega Day Centre**- Omega is a unique and unstructured day centre for adults with mental illness. Participants benefit from an informal, warm environment and are offered a place to socialize, work programs, daily lunches, outings, and an array of leisure groups such as creative arts, swimming in the summer, and cooking classes. You can contact them personally or be referred. 600 Ave de L'Eglise, Dorval, (514) 631-2760

**Centre Bienvenue**- Centre Bienvenue is a day centre for adults with mental illness that offers programs such as human relations, life skills, health skills, and recreational activities. It promotes improved lifestyles, provides mutual support programs and offers services in social re-adaptation. This centre offers a caring and supportive environment for all of its members experiencing mental health difficulties. You can contact them personally or be referred. 12694 Gouin Blvd, Pierrefonds, (514) 421-9312

**HOUSING RESOURCES**

**Omega Group Home**- Omega group home offers a 24-hour supervised environment aimed at increasing independent living skills for adults with mental illness. Each person has an individual follow-up plan through a worker at the home. The group home has nine places with a maximum stay of two years for both men and women. 5043 Labrosse, Pierrefonds, (514) 683-1647

**West Island Citizen Advocacy**- Citizen Advocacy has permanent semi-supervised apartments throughout the West Island (Church Apartment Program) but places are limited. Volunteers and mental health professionals offer their clients services in budgeting, accompaniment, follow-up and other on-the-spot support. 68 Prince-Edward, Pointe Claire, (514) 694-5850
WORK/TRAINING

L’ÉQUIPE ENTREPRISE - L’Équipe Entreprise is an employment program for adults who have a mental illness. It provides part-time work in areas of catering, cooking, mailing, and room set-ups. Persons are able to retain the safety net of social assistance while receiving an additional amount for their work involvement. L’Équipe Entreprise is a great place to begin gaining the skills needed to re-integrate into the work force, and the food is excellent as well!
750 Dawson Ave, Dorval, (514) 636-1081

OMEGA DAY CENTRE - Omega offers opportunities for some people to work at the centre. Jobs include maintenance, secretarial work and kitchen aid. These positions are part of a government-sponsored employment-reinsertion program.
600 Ave de L’Église, Dorval, (514) 631-2760

PLACEMENT POTENTIEL - Placement Potentiel is an adaptive work centre that provides employment services for persons with disabilities. 111 Donegani Ave, (514) 694-0315

L’ARRIMAGE - L’Arrimage has specialized employment programs for persons with mental illness who wish to reintegrate into the work force. Their services include evaluation and counseling, training and preparation for employment, job search, work placement, and follow up.
(514) 389-9393

It is important to note that the downtown area also offers a number of interesting employment opportunities for persons with mental illness. Information on these can be attained through contacting the Information and Referral Centre of Greater Montreal at (514) 527-1375.
KNOWING AND WORKING WITH ‘THE SYSTEM’

Mental health professionals are recognizing the important impact of family involvement. Knowledge is empowering. When dealing with the system, understanding the situation and what is available is a great advantage for you and your loved one. Families with relatives with a mental illness cannot stress enough the importance of building strong relationships between themselves and their loved one’s staff and caregivers. Remember that you are the one who best knows your loved one, and what you communicate to the professionals is invaluable information. You have known your loved one for a long time and will continue to see them, whereas professionals can come and go. Initially it may seem impossible to understand the system and to be able to communicate effectively but with time you may just become an unofficial mental health expert! Once you have read over the list of questions and tips, you may want to add some of your own.

QUESTIONS TO ASK

- Is there a diagnosis and what does it mean?
- What are the therapeutic treatment options available at present and where can I find this information?
- Has an evaluation ruled out all other possible illnesses?
- What about second opinions?
- Who will be part of the treatment team and what are their roles?
- Will psychotherapy be offered? Should I look into private therapy?
- Whom do we contact for questions or problems?
- What about the side effects of medications and precautions needed to be taken?
- What about educational workshops and conferences on mental illness?
- Will a social worker be involved with my relative?

THINGS TO KEEP IN MIND WHEN DEALING WITH THE ‘SYSTEM’

- Keep copies and records of everything! List the questions you have asked and the responses given. Write down the name of the person you have dealt with or have asked information from. Keep a list of the dates and events of treatments, appointments, and meetings as well as important life events and sensitive issues in your loved one’s life.
- Keep track of all medication prescribed, changes made, and worrisome side effects.
- Ask for clarification if you do not understand what is being said to you. It is easy for the staff to forget that not everyone understands mental health jargon. If you have in-depth questions to ask and they are too busy, ask for an appointment or ask where you can find the answers elsewhere. It may be easier if you write down all of your questions while they are fresh in case you cannot speak to someone immediately.
- Communicate to the treatment team how your loved one is doing, your concerns, and your suggestions.
- Make sure you know the names and contact numbers of all the people assigned to work with your relative, and that they also know how and when to reach you.
- If you are unhappy with some aspect of the treatment and feel you are not being taken seriously you have the right to make complaints. You may speak to those in power or write calm and rational letters to the heads of the department concerned.
- It is recommended to try not to be rude and impatient with your relative’s staff. Although it is sometimes frustrating because they can be so busy, there is more chance of them responding to your needs if you remain friendly and cooperative.
- Become a member of one or some of the mental health associations such as the Schizophrenia Society of Canada, or the Canadian Mental Health Association, to keep updated on current treatments and services.

CONFIDENTIALITY

Doctor-patient confidentiality is a basic principle in the practice of medicine. Family members of adults with a mental illness must also respect the laws of confidentiality, which means that information can only be released if the person in question authorizes the institution or professional to do so. Unfortunately, there are times and situations when these laws can be problematic. Families who wish to be involved in the treatment and surrounding issues, sometimes find it difficult to do so due to the refusal of information from the institution(s). Information such as details discussed in therapy should not be pushed for, but if you feel that there is important information being withheld that may be detrimental to your best caring for your loved one, you may wish to seek advice concerning your rights. Remember that confidentiality does not prohibit you from providing a health care professional with information you feel is important. At times calling the doctor or sending a fax about your concerns can be helpful. Remember that this information might be shared with the patient. For further information and support, contact us at Friends for Mental Health.

Information that is considered confidential includes the following:
- All information given to the professional of an institution or organization by the person and about their situation.
- All information contained in their files and records, including observations.

Circumstances when confidentiality can be broken:
- When the person concerned gives their authorization to release the information.
- When someone’s life, health, or safety is in danger, e.g., threat of suicide.
- If the person is really considered unable to give consent to care. The person who assumes this responsibility must therefore receive all information to make the decisions concerning the person in question.

MENTAL HEALTH PROFESSIONALS

Psychiatrists are trained medical doctors who specialize in brain biochemistry and are able to identify symptoms, diagnose and propose appropriate treatment. Psychiatrists generally work
in hospitals, private offices or clinics, and/or in the outpatient clinics. Psychiatrists often work in cooperation with a treatment team such as psychiatric nurses, social workers, and other mental health professionals.

**Psychiatric Nurses** work closely with the psychiatrists. Their role is to regulate medications, refer the person to appropriate services, meet with family members, act as educators, and provide psychological support. They may be easier to contact than the psychiatrist. They are well aware of the patient’s file and can transmit information or concerns given by the family to the psychiatrist.

**Social Workers** can be found both in the clinical setting and within many community resources. They serve as the liaison between the person, the family, the institution and the community. They provide follow-up with the person in and out of the hospital. Usually it will be the social worker that assists the person and family in arranging housing, financial aid, and community programs. Some social workers also provide individual and group therapy.

**Psychologists and Psychotherapists** offer individual and group psychotherapy. These individuals are usually seen privately, with cost depending on the person’s income. Their role is to evaluate, counsel and alleviate symptoms through different psychotherapeutic approaches.

**Pharmacists** can offer valuable and pertinent information on the medications themselves, their side effects and their interactions with other medications. As well, they might be more accessible than psychiatrists and they are usually quite willing to help out.

Other mental health professionals you may come in contact with include recreational therapists, occupational therapists, rehabilitation counselors, art therapists, and community mental health workers/counselors.

**CONCLUSION**

Caring for a mentally ill relative presents a unique set of problems and challenges, whether you are directly involved on a daily basis or not. By not sacrificing your own well-being or the needs of other family members, you automatically maintain the hope for recovery. Staying well informed, as well as obtaining the support you need, will help to guarantee the patient’s best potential recovery.

Surviving mental illness is possible. Chances of recovery are constantly improving with new medical advances and increasing knowledge in psychotherapies.

Despite the difficult times, the experience of dealing with mental illness also brings a richness to your life, with its moments of personal discovery and profound humanity.
EMERGENCY DIRECTORY

IMPORTANT NAMES AND PHONE NUMBERS:

- **Hospital**
  - Emergency
  - Psychiatry

- **Police Station**
- **Crisis Centre**
- **Psychiatrist**
- **Social Worker**
- **Emergency Hotlines**
- **Friends and Family**
- **Members to Reach**

OTHERS:

**Crisis Review Worksheet**

Use the information you have gathered from meeting with other people involved in your relative’s most recent crisis (including your relative if possible) to complete this worksheet. While this sheet may be for your use, understanding these factors is important for you and your ill relative. If possible discuss these issues with them to help be more aware and develop a preventative attitude.

Briefly describe the crisis:

What was happening in your relative’s life before the crisis occurred?

What were the early signs that a crisis was building? (Specific small changes or symptoms can be important).

What actions were taken to resolve the crisis? Place a star next to those that were effective.

What could have been done to improve how the crisis was resolved?
What is the plan of action for preventing a similar crisis in the future?
Steps in plan:

1.

2.

3.

4.

5.

What is the plan of action for responding to a similar crisis in the future?
Steps in plan:

1.

2.

3.

4.

5.