Regional Geriatric Program of Eastern Ontario

INTRODUCING

Joanna Letemplier

RN, GNC(C), CPMHN(C)

Joanna is a Registered Nurse who currently works as the Centralized Intake Coordinator with Geriatric Psychiatry Community Services of Ottawa (GPCSO). She previously worked in a variety of settings including geriatric rehab in complex continuing care, long-term care, as well as community ALS-HRS. She is certified in geriatrics and psychiatric/mental health nursing.

INTAKE COORDINATOR

GPCSO

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www.rgpeo.com

Depression

Joanna Letemplier

Intake Coordinator

GPCSO

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Acknowledgement

Presentation by Shauna Thaler Adeland. M.S.W., RSW
Psychogeriatric Resource Consultant
Geriatric Psychiatry Community Services of Ottawa

Presentation revised by Joanna Letemplier.

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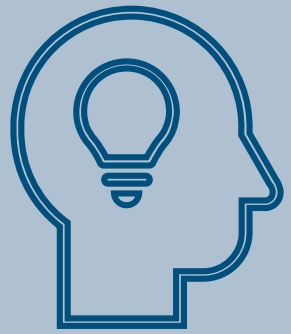
LEARNING OBJECTIVES



Identify, Assess, Intervene and Apply

- Review red flags and screening tools
- Explore treatment options
- And Hopefully; de-mystify mental health and increase confidence in starting conversations about mental health with older adults.

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AGENDA

- Myths of depression and seniors
- Review risk factors, screening and assessment of depression
- Analysis and interpretation
- Care planning and intervention
- How can I help? Review of resources

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WHAT IS MENTAL HEALTH AND HOW DOES IT DIFFER FROM MENTAL ILLNESS?

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MENTAL HEALTH VS MENTAL ILLNESS

Mental Health is being able to manage life in ways that help us cope with stress and reach our goals. It's a sense of emotional and social well-being.

Mental Illness refers to a wide range of disorders that affect our mood, thinking, and behavior, such as depression or anxiety.

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MYTH OR FACT?

CHAT

Mental illness will never affect me

Myth!

- All of us will be affected by mental illnesses.
- 1 in 5 Canadians will experience a mental illness at some point in their life.
- You may not experience a mental illness yourself, but it's very likely that a family member or friend will experience challenges.

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MYTH OR FACT?

Depression is a normal part of aging

Myth!

- Depression is not a normal part of aging
- Risk of depression increases with number of changes in roles and social network
- Risk of depression increases with isolation/loneliness
- Good outcomes with treatment in older adults

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MYTH OR FACT?

Canadians 65 and older are at high risk for suicide

CHAT

Fact!

- Experiences of loss such as loss of health, loved ones, physical mobility and independence
- Major life changes such as retirement, change in financial status, a transition into care facilities
- Chronic illness and pain

Source: https://www.suicideinfo.ca/resource/older-adults-suicide-fact-sheet/

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DEPRESSIVE DISORDERS

- 10.8% estimated lifetime prevalence of major depressive disorder in Canadians.
- *Increases with:*

- ❑ older physically ill patients
- ❑ Widows
- ❑ Brain changes due to vascular disease (stroke, Parkinson's)
- ❑ Excessive use of alcohol
- ❑ lack a supportive network/social disadvantages
- ❑ Losses (bereavement, incapacities)
- ❑ financial strain
- ❑ long-term caregiving
- ❑ history of depression or suicide attempt

National Guidelines for Seniors Mental Health
British Columbia Psychogeriatric Association, 2012

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BOTH ARE IMPORTANT AND TIMELY TO UNDERSTAND

Isolation: a state that arises from having too few or no social relationships

Loneliness: The subjective perception of having insufficient social relationships or not enough meaningful contact with people

You can be an isolated senior and not feel lonely
You can be a well supported senior and feel extremely alone

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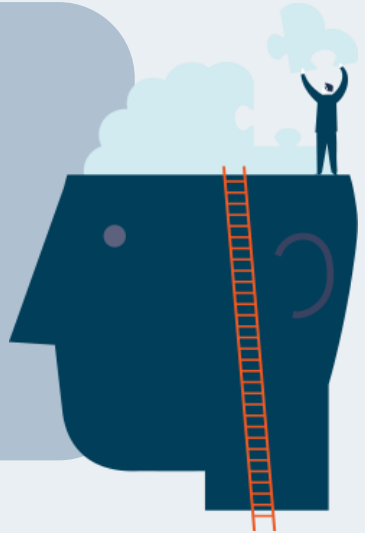
RISK IDENTIFICATION, SCREENING & ASSESSMENT



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DEPRESSION

Behavior	Physical	Feelings	Thoughts
• Stopped going out • Not getting things done around the home • Withdrawing from friends and family • Increased use of alcohol and sleeping pills • Stopped doing enjoyable activities • Unable to concentrate	• Tired all the time • Sick and run down • Headaches and muscle pains • Churning gut • Sleep problems • Loss or change in appetite • Significant weight loss or gain	• Overwhelmed • Guilty • Irritable • Frustrated • No confidence • Unhappy • Indecisive • Disappointed • Sad • Miserable	• "I'm a failure" • "It's my fault" • "Nothing good ever happens to me" • "I'm worthless" • "Life's not worth living" • "People would be better off with out me"

Beyond Blue, 2016

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GRIEF VS DEPRESSION

Grief	Depression
Intense Sadness withdrawal from usual activities Psychosomatic complaints	Intense feelings of worthlessness Withdrawal from usual activities Psychosomatic complaints
The world looks poor and empty (Freud)	The person feels poor and empty (Freud)
Painful feelings come in waves	Mood and/or interest (pleasure) are decreased for two + weeks. (Diagnosis criteria – up next)
Frustration or negative talk about the situation	Frustration or negative talk about self

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APATHY VS DEPRESSION

Apathy

- Lack of feeling or emotion (impassiveness)
- Lack of interest or concern (indifference)
- Common symptom of dementia

Depression

- Varying degrees of sadness, despair, and loneliness and that is typically accompanied by inactivity, guilt, loss of concentration, social withdrawal, sleep disturbances, and sometimes suicidal tendencies

- *Anhedonia*: a psychological condition characterized by inability to experience pleasure in normally pleasurable acts

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DEPRESSION: SCREENING

- How do you screen or assess for depression in your workplace? (standardized/nonstandardized)?
- What tools or outcome measures are typically used?

- DSM=the Diagnostic and Statistical Manual
- GDS=Geriatric Depression Scale (/15 + /30)
- PHQ-2=Patient Health Questionnaire 2 questions
- PHQ-9=Patient Health Questionnaire 9 questions
- CSDD=Cornell Scale for Depression in Dementia

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Depression: M SIG E CAPS

DSM-5: Major Depressive Disorder (MDD) = 5 or more/ 2 weeks with at least **depressed mood** *(i.e. sad, empty, hopeless, tearful, irritable)* **OR loss of interest/pleasure.**

M: Mood

S : Sleep disturbed (too much or insomnia)

I : Interest decreased (subjective or observed)

G : Guilt feelings (worthlessness, poss. delusional)

E : Energy lower (fatigue) Somatic complaints

C : Cognition/Concentration (reduced abilities)

A : Appetite disturbed (loss interest, unexplained ↓lbs)

P : Psychomotor retardation or agitation (observed)

S : Suicidal ideation (not just fear of dying)

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Monkey Smoking In Green Eyeglasses & CAPS

- Monkey
- Smoking
- In
- Green
- Eyeglasses
- CAPS

GP SO SCGPO

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PHQ-9

Name : _____

Date : _____

PATIENT HEALTH QUESTIONNAIRE – 9 (PHQ-9)

Over the last 2 weeks how often have you been bothered by any of the following problems? (use "√" to indicate you answer)	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching the television				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead, or of hurting yourself in some way				
ADD COLUMNS:				
TOTAL:				

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

I
M
S
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A
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C
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CHEAT SHEET ON FLIP SIDE

Using PHQ-9 Diagnosis and Score for Initial Treatment Selection

A depression diagnosis that warrants treatment or treatment change, needs at least one of the first two questions endorsed as positive (*little pleasure, feeling depressed*) indicating the symptom has been present more than half the time in the past two weeks.

In addition, the tenth question about difficulty at work or home or getting along with others should be answered at least "somewhat difficult."

When a depression diagnosis has been made, patient preferences should be considered, especially when choosing between treatment recommendations of antidepressant treatment and psychotherapy.

PHQ-9 Score	Provisional Diagnosis	Treatment Recommendation
5-9	Minimal Symptoms*	Support, educate to call if worse; return in 1 month
10-14	Minor depression++	Support, watchful waiting
	Dysthymia*	Antidepressant or psychotherapy
	Major depression, *mild*	Antidepressant or psychotherapy
15-19	Major depression, *moderately severe*	Antidepressant or psychotherapy
≥ 20	Major depression, *severe*	Antidepressant and psychotherapy (especially if not improved on monotherapy)

* If symptoms present ≥ two years, then probable chronic depression which warrants antidepressants or psychotherapy (ask, *"In the past 2 years have you felt depressed or sad most days, even if you felt okay sometimes?"*).

++ If symptoms present ≥ one month or severe functional impairment, consider active treatment.

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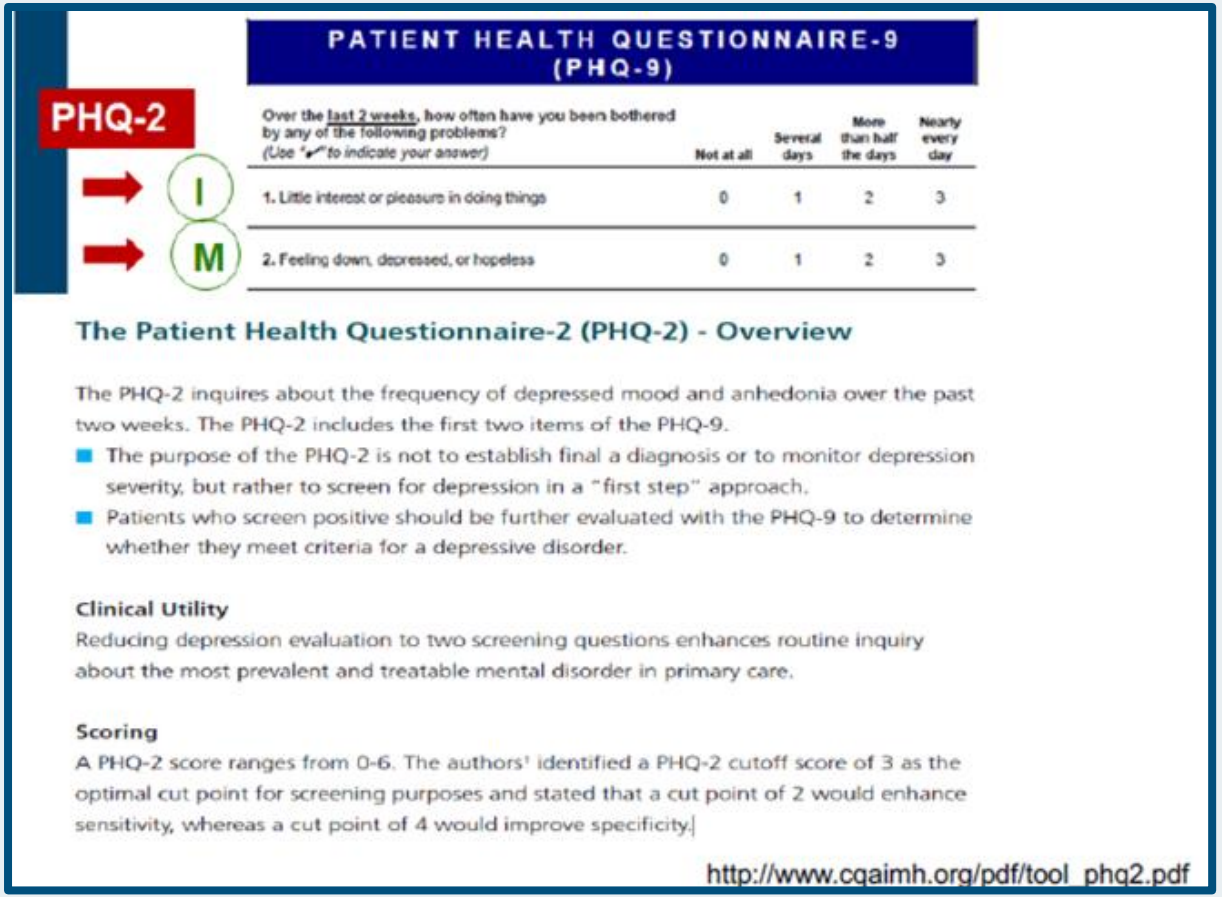
PHQ-2



PHQ-2

I

M

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use ✔ to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

The Patient Health Questionnaire-2 (PHQ-2) - Overview

The PHQ-2 inquires about the frequency of depressed mood and anhedonia over the past two weeks. The PHQ-2 includes the first two items of the PHQ-9.

- The purpose of the PHQ-2 is not to establish final a diagnosis or to monitor depression severity, but rather to screen for depression in a "first step" approach.
- Patients who screen positive should be further evaluated with the PHQ-9 to determine whether they meet criteria for a depressive disorder.

Clinical Utility

Reducing depression evaluation to two screening questions enhances routine inquiry about the most prevalent and treatable mental disorder in primary care.

Scoring

A PHQ-2 score ranges from 0-6. The authors[1] identified a PHQ-2 cutoff score of 3 as the optimal cut point for screening purposes and stated that a cut point of 2 would enhance sensitivity, whereas a cut point of 4 would improve specificity.

http://www.cqaimh.org/pdf/tool_phq2.pdf

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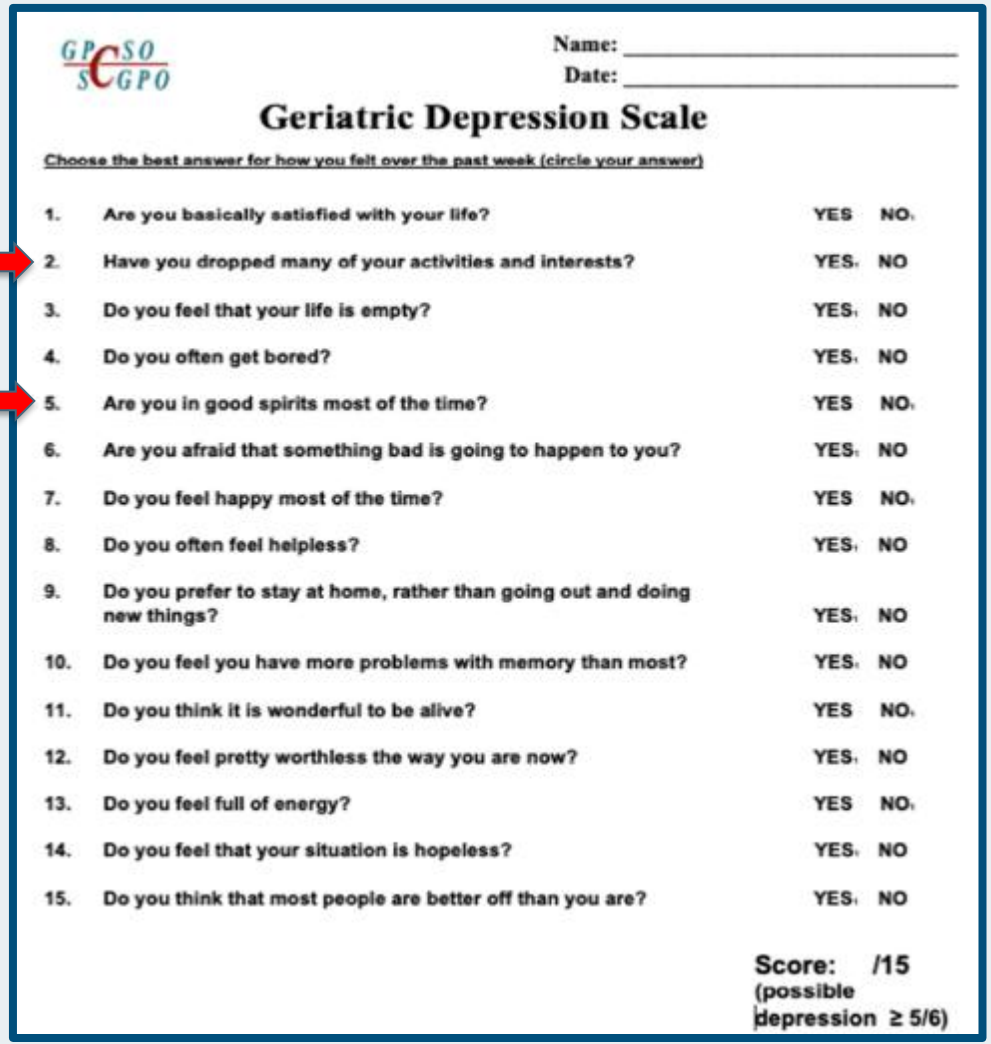
GDS SHORT VERSION (/15)



Name: _____

Date: _____

Geriatric Depression Scale

Choose the best answer for how you felt over the past week (circle your answer)

1.	Are you basically satisfied with your life?	YES NO
2.	Have you dropped many of your activities and interests?	YES NO
3.	Do you feel that your life is empty?	YES NO
4.	Do you often get bored?	YES NO
5.	Are you in good spirits most of the time?	YES NO
6.	Are you afraid that something bad is going to happen to you?	YES NO
7.	Do you feel happy most of the time?	YES NO
8.	Do you often feel helpless?	YES NO
9.	Do you prefer to stay at home, rather than going out and doing new things?	YES NO
10.	Do you feel you have more problems with memory than most?	YES NO
11.	Do you think it is wonderful to be alive?	YES NO
12.	Do you feel pretty worthless the way you are now?	YES NO
13.	Do you feel full of energy?	YES NO
14.	Do you feel that your situation is hopeless?	YES NO
15.	Do you think that most people are better off than you are?	YES NO

Score: /15
(possible depression ≥ 5/6)

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GDS LONG VERSION (/30)

No.	Question	Answer
1.	Are you basically satisfied with your life?	YES / NO
2.	Have you dropped many of your activities and interests?	YES / NO
3.	Do you feel that your life is empty?	YES / NO
4.	Do you often get bored?	YES / NO
5.	Are you hopeful about the future?	YES / NO
6.	Are you bothered by thoughts you can t get out of your head?	YES / NO
7.	Are you in good spirits most of the time?	YES / NO
8.	Are you afraid that something bad is going to happen to you?	YES / NO
9.	Do you feel happy most of the time?	YES / NO
10.	Do you often feel helpless?	YES / NO
11.	Do you often get restless and fidgety?	YES / NO
12.	Do you prefer to stay at home, rather than going out and doing new things?	YES / NO
13.	Do you frequently worry about the future?	YES / NO
14.	Do you feel you have more problems with memory than most?	YES / NO
15.	Do you think it is wonderful to be alive now?	YES / NO
16.	Do you often feel downhearted and blue?	YES / NO
17.	Do you feel pretty worthless the way you are now?	YES / NO
18.	Do you worry a lot about the past?	YES / NO
19.	Do you find life very exciting?	YES / NO
20.	Is it hard for you to get started on new projects?	YES / NO
21.	Do you feel full of energy?	YES / NO
22.	Do you feel that your situation is hopeless?	YES / NO
23.	Do you think that most people are better off than you are?	YES / NO
24.	Do you frequently get upset over little things?	YES / NO
25.	Do you frequently feel like crying?	YES / NO
26.	Do you have trouble concentrating?	YES / NO
27.	Do you enjoy getting up in the morning?	YES / NO
28.	Do you prefer to avoid social gatherings?	YES / NO
29.	Is it easy for you to make decisions?	YES / NO
30.	Is your mind as clear as it used to be?	YES / NO
		TOTAL

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Cornell Scale for Depression in Dementia

(Cornell scale for depression in dementia. Biol Psych 1988; 23:271-84.)

Name: _____ Age : _____

Date : _____

Rating should be based on symptoms and signs occurring during the week prior to interview.

A = unable to evaluate 0 = absent 1 = mild or intermittent 2 = severe

A. MOOD RELATED SIGNS				
1. Anxiety: anxious expression, rumination, worrying	A	0	1	2
2. Sadness: sad expression, sad voice, tearfulness	A	0	1	2
3. Lack of reactivity to pleasant events	A	0	1	2
4. Irritability: easily annoyed, short tempered	A	0	1	2
B. BEHAVIOURAL DISTURBANCE				
5. Agitation: restlessness, hand wringing, hair pulling	A	0	1	2
6. Retardation: slow movement, slow speech, slow reactions	A	0	1	2
7. Multiple physical complaints (score 0 if GI symptoms only)	A	0	1	2
8. Loss of interest: less involved in usual activities (Score only if occurred acutely i.e. In less than 1 month)	A	0	1	2
C. PHYSICAL SIGNS				
9. Appetite loss: eating less than usual	A	0	1	2
10. Weight loss (score 2 if greater than 5 lb in month)	A	0	1	2
11. Lack of energy: fatigues easily, unable to sustain activities (score only if change acutely, i.e. In less than 1 month)	A	0	1	2
D. CYCLIC FUNCTIONS				
12. Diurnal variation of mood: symptoms worse in the morning	A	0	1	2
13. Difficulty falling asleep: later than usual for this individual	A	0	1	2
14. Multiple awakenings during sleep	A	0	1	2
15. Early morning awakening: earlier than usual for this individual	A	0	1	2
E. IDEATIONAL DISTURBANCE				
16. Suicide: feels life is not worth living, has suicidal wishes or makes suicide attempts	A	0	1	2
17. Poor self esteem: self blame, self depreciation, feelings of failure	A	0	1	2
18. Pessimism: anticipation of the worst	A	0	1	2
19. Mood congruent delusions: delusions of poverty, illness or loss	A	0	1	2

TOTAL:_____/38

Scores above 10 indicate a probable major depression.

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ANALYSIS & INTERPRETATION

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ANALYSIS

- Screening tools help to clarify symptoms presence, frequency, and intensity
- They can justify referrals & services
- They can be used to monitor change over time

What else should be considered for your analysis and interpretation?

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THE CLIENT'S STORY …

- Are you able to gather collateral information (family, friends, neighbors, pharmacist, etc.)
- Review timeline (new onset, big events, losses, change)
- Have there been changes to function?
- Safety concerns
- Are they medically stable? Can something else account for what you are seeing?

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OTHER CONSIDERATIONS

- Unintentional weight loss >5%/1month?
- Affecting social relationships?
- Affecting physical health care engagement?
- Self-neglect, unexplained change in baseline?
- Delusional excessive worry content?
- Suicidal ideation and/or plan?

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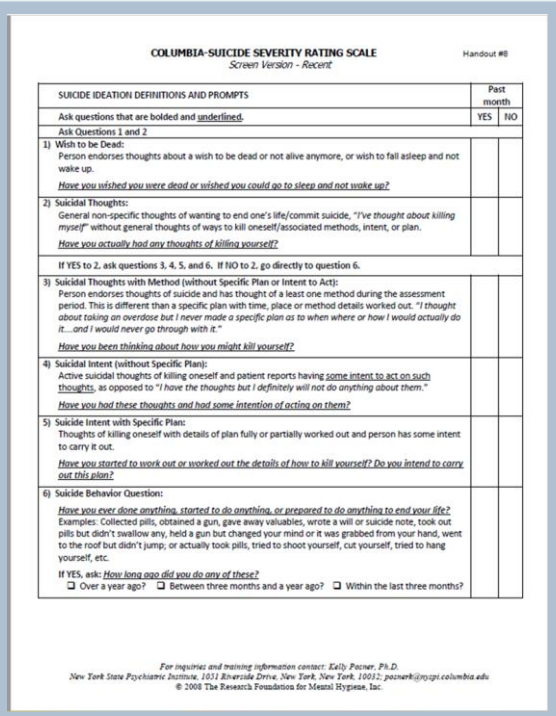
Assessing Suicidal Thoughts



COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen Version - Recent

Handout #8

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
Ask questions that are bolded and underlined.	YES	NO
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, *"I've thought about killing myself"* without general thoughts of ways to kill oneself/associated methods, intent, or plan. *Have you actually had any thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. *"I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it…and I would never go through with it."* *Have you been thinking about how you might kill yourself?*		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."* *Have you had these thoughts and had some intention of acting on them?*		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*		
6) Suicide Behavior Question: *Have you ever done anything, started to do anything, or prepared to do anything to end your life?* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. If YES, ask: *How long ago did you do any of these?* ❑ Over a year ago? ❑ Between three months and a year ago? ❑ Within the last three months?		

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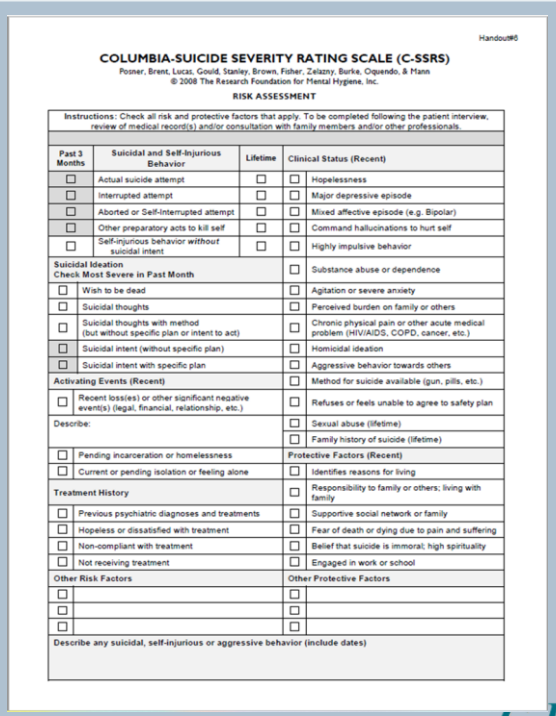

Handout#6

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)
Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann
© 2008 The Research Foundation for Mental Hygiene, Inc.

RISK ASSESSMENT

Instructions: Check all risk and protective factors that apply. To be completed following the patient interview, review of medical record(s) and/or consultation with family members and/or other professionals.

Past 3 Months	Suicidal and Self-Injurious Behavior	Lifetime
☐	Actual suicide attempt	☐
☐	Interrupted attempt	☐
☐	Aborted or Self-Interrupted attempt	☐
☐	Other preparatory acts to kill self	☐
☐	Self-injurious behavior *without* suicidal intent	☐

Suicidal Ideation Check Most Severe in Past Month	
☐	Wish to be dead
☐	Suicidal thoughts
☐	Suicidal thoughts with method (but without specific plan or intent to act)
☐	Suicidal intent (without specific plan)
☐	Suicidal intent with specific plan

Activating Events (Recent)	
☐	Recent loss(es) or other significant negative event(s) (legal, financial, relationship, etc.)
Describe:	
☐	Pending incarceration or homelessness
☐	Current or pending isolation or feeling alone

Treatment History	
☐	Previous psychiatric diagnoses and treatments
☐	Hopeless or dissatisfied with treatment
☐	Non-compliant with treatment
☐	Not receiving treatment

Other Risk Factors	
☐	
☐	
☐	

Clinical Status (Recent)	
☐	Hopelessness
☐	Major depressive episode
☐	Mixed affective episode (e.g. Bipolar)
☐	Command hallucinations to hurt self
☐	Highly impulsive behavior
☐	Substance abuse or dependence
☐	Agitation or severe anxiety
☐	Perceived burden on family or others
☐	Chronic physical pain or other acute medical problem (HIV/AIDS, COPD, cancer, etc.)
☐	Homicidal ideation
☐	Aggressive behavior towards others
☐	Method for suicide available (gun, pills, etc.)
☐	Refuses or feels unable to agree to safety plan
☐	Sexual abuse (lifetime)
☐	Family history of suicide (lifetime)

Protective Factors (Recent)	
☐	Identifies reasons for living
☐	Responsibility to family or others; living with family
☐	Supportive social network or family
☐	Fear of death or dying due to pain and suffering
☐	Belief that suicide is immoral; high spirituality
☐	Engaged in work or school

Other Protective Factors	
☐	
☐	
☐	

Describe any suicidal, self-injurious or aggressive behavior (include dates)

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Safety Planning

Suicide Crisis Helpline 988

Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Crisis Line 1-866-996-0991 crisisline.ca

Step 6: Making the environment safe:

1. _____
2. _____

The one thing that is most important to me and worth living for is:

_____

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DIAGNOSIS OF DEPRESSION

Diagnoses of mental health disorders are made by geriatric psychiatrists, nurse practitioners, medical doctors and/or doctors of clinical psychology.

All other clinicians can screen but not make an official diagnosis.

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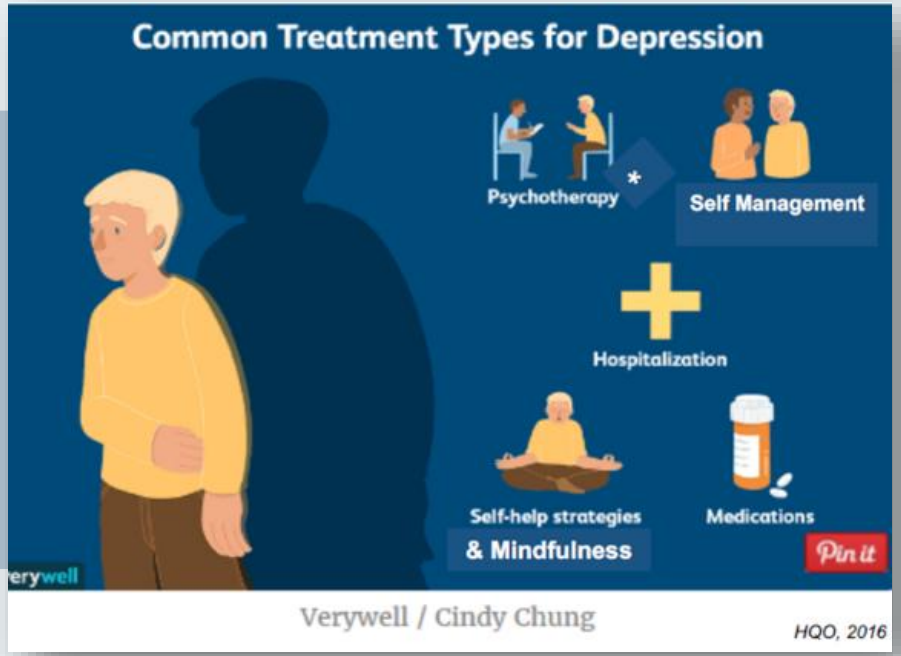
CARE PLANNING & INTERVENTION



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MEDICATIONS

	Medication Options	
DEPRESSION	***SSRIs*** Citalopram (Celexa) Escitalopram (Cipralex) Sertraline (Zoloft)	***H***eadache ***A***gitation ***N***ausea ***D***iarrhea ***S***weating ***S***omnolence
	Less preferred: Paroxetine (Paxil; anticholinergic), Fluoxetine (Prozac), Fluvoxamine (Luvox)	
	SNRIs Venlafaxine (Effexor) Duloxetine (Cymbalta)	↑Risk of falls
	Mirtazapine (Remeron)	
ANXIETY	***SSRIs*** (Citalopram, Escitalopram, Sertraline) Trazodone, Benzodiazepine	

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PSYCHOTHERAPY

- CBT
- Interpersonal psychotherapy
- Brief dynamic/solution focused therapy
- Reminiscence therapy
- Mindfulness-based cognitive therapy
- Behavioral activation therapy
- Short-term dynamic psychotherapy
- Couple/family

CBT and counselling can be just as effective as medication, however…

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WHEN IS HOSPITALIZATION APPROPRIATE?

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Geriatric Psychiatry Community Services of Ottawa (GPCSO)

- Excellence in mental health care for seniors within their community.
- Fully bilingual geriatric psychiatry program. We work with older adults living in our community to optimize their mental health and/or dementias with challenging behaviors.
- Team of Case Managers (Social workers, Occupational Therapists and Registered Nurses) and Geriatric Psychiatrists

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CHAT

What are some Self-Management & Mindfulness strategies that you use to promote your mental health and wellbeing?

Put it in the chat!

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SELF-MANAGEMENT & MINDFULNESS

- **Self-management strategies**
  - ✓Sleep hygiene
  - ✓Physical activities
  - ✓Nutrition
  - ✓Behavioral activation
  - ✓Increase social connections
  - ✓Mindfulness – here and now!

- **Monitoring for treatment adherence & response**
- **Education and support (relationships, recurrence, crisis)**

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OPTIMIZING HEALTH & RESILIENCE

The Fountain of Health Prescription: 5 Things You Can Do

Changing the way you think about aging might be one of the most important ways to stay healthy. As it turns out, attitude is key to longevity and happiness! Here are the 5 key actions that can help you stay healthy for life:

fountain of health

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ADDITIONAL RESOURCES

- Advocacy Centre for the Elderly
- Champlain Local Health Integration Network - Home and Community Care and Champlain Health Line
- Local Community Centers and Senior Center Without Walls
- Coalition of Community Health and Resource Centers of Ottawa
- Geriatric Psychiatry Caregiver & Family Support Group
- Helpline - Ontario Caregiver
- Primary Care Outreach to Seniors
- Service Access to Recovery (Addictions referral resource) Montfort Renaissance
- Specialized Geriatric Services
- Online Resources: BounceBack program, Councelling Connect, The Walk-In Counselling Clinic

GPCSO.org

Resources for Patient and Families

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What do I do? How can I help?

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What to do in a non-MH setting?

- Talking about it makes things better, not worse.
- Give many opportunities to open up & offer to listen.
- Share your concern, ask how they are feeling and how long it's been going on.
- Ask if they know something about depression or know someone who has experienced it before.
- Have realistic expectations for the person
- Genuine caring and understanding are more important than what you say (Listen, empathy)
- Encourage and give hope

Mental Health First Aid Australia, 2008

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HOW TO START THE CONVERSATION…

- I've been worried about you. Can we talk about what you are experiencing? If not, is there someone you are comfortable talking to?
- I am someone who cares and wants to listen. What do you want me to know about how you are feeling?
- What can I do to help you to talk about issues with your family or someone else who cares about you?
- I'm concerned about your safety. Have you thought about harming yourself or others?

US Department of Health & Social Services

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WHAT IF THEY DON'T WANT HELP?

- Check reason (mistaken beliefs, stigma, finances)
- Remain friendly and open
- Let them know they can contact you if they change their mind
- Respect their right to refuse, unless…

If unsure/need help: CALL MENTAL HEALTH CRISIS LINE

1-866-996-0991

CALL 911: If someone wants to injure themselves/end their life or hurt someone else

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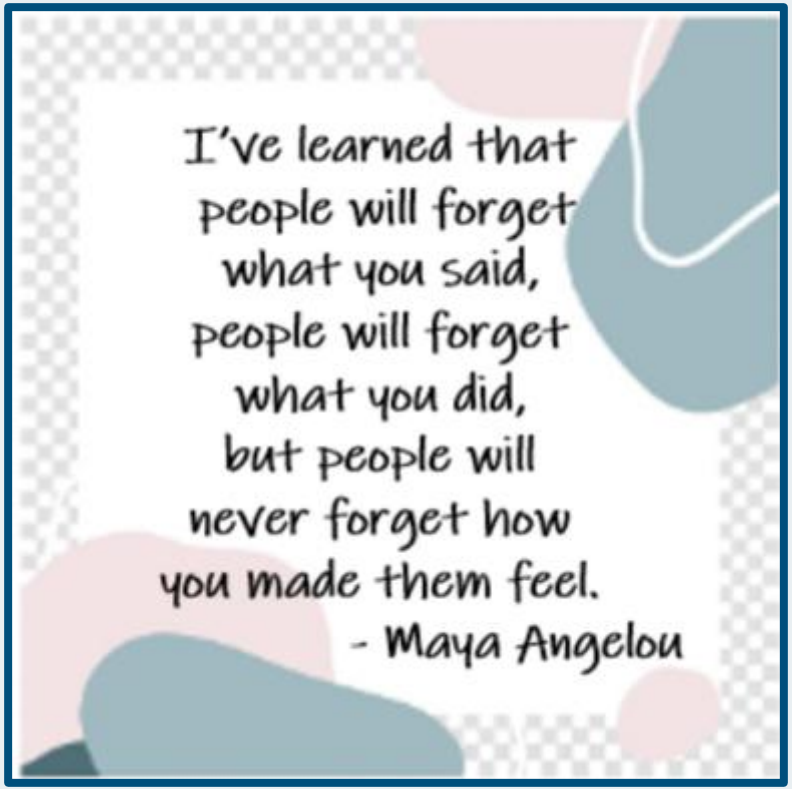

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Now What?!!

- How can/will this change your professional practice?
- What will you try when you go back to work? (screening, assessment, treatment, care planning?)
- What will you share with others and how?

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THANK YOU!

QUESTIONS?

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