Youth Mental Health First Aid

Teaching Notes and Slides

Session 3

Session 3 *(3.5 hours)*

Session 3
Part 1 (1.25 hours)

Non-suicidal self-harm

Learning objectives

- To learn about self-harm behaviour
- To apply the MHFA Action Plan to help a young person who is engaging in self harming behaviour
- To learn crisis first aid for self harm
- To learn about the treatments and resources for young people who engage in self harm

Instructor resources

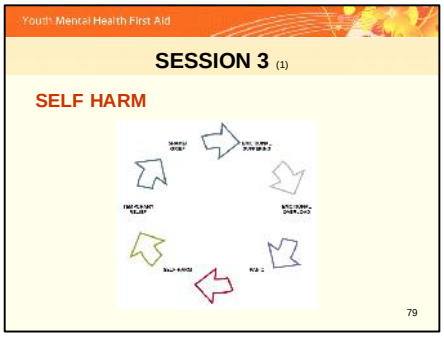
Additional resources:

YMHFA manual: Chapter 8: Non-fatal deliberate self-harm in young people.

YMHFA PPT slide numbers: #79–#93

Introduction to self- harm

Slide 79: Title slide



Group activity 3.1_1

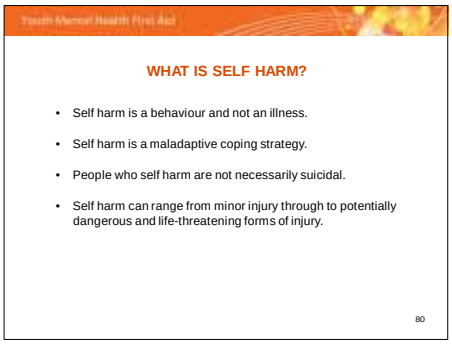
Self harm quiz

Ask the group the nine questions on the quiz and get to write down their answers according to whether they think the statement is: FACT, FICTION or SOMEWHERE IN BETWEEN.

The quiz can be used in a number of ways.

- Break into groups and ask each group to prepare a response for a number of the questions. Come back into big group and discuss and qualify answers as appropriate.
- Break into groups or pairs and ask each group or pair to answer all the questions. Come bag to big group and discuss and qualify answers as appropriate.
- Once you have discussed the answers, you may want to talk about why some of the 'fictions' are pervasive.

Slide 80: What is Self Harm?



- Use slide to run through some of the key points about Self Harm
- Stress that it is behaviour and not an illness.

Read through slide.

Slide 81: The range of self-harming behaviours

- Self harm ranges from behaviours that can result in death, to behaviours with no visible injury.

- Slide sequence runs from most harmful through to least harmful methods of Self Harm
- Most common methods of self harm are cutting and scratching the skin.

Read through slide.

Additional information:

- Non-fatal self-harm is rare in children and becomes more common during adolescence.
- A large survey in 2002 of year 10 and 11 students found that 12% had harmed themselves at some time in their lives, while 6% had done so in the previous twelve months.
- Females were more likely to engage in self harming behaviour than males.
- The most common methods were cutting and taking an overdose of medication.
- Non-fatal self-harm can occur as part of many different mental health problems, including depression, substance use disorders and personality disorders.

Slide 82: Reasons for engaging in Self Harming behaviour

People who engage in self harming behaviour give a wide range of reasons for their behaviours. They include the following.

Read through slide.

Additional information:

- Some young people repeatedly engage in self harming behaviour.
- Because self harm can reduce tension and help control mood, it can be self-reinforcing and becomes a habit.

Risk factors for Self harm

Slides 83 and 84: Risk factors for Self harming behaviour

- We have already learnt that self-harm is more common in females and in people with mental disorders such as depression and substance use disorder.
- There are additional risk factors which include the following.

Facilitate a general discussion around risk factors for self harm. The major headings: personal characteristics, social and family environment, psychological characteristics, biological characteristics and situational factors maybe useful prompts.

Summarise and run through slides.

Risk factors for self harm

- **Personal characteristics**

  Social disadvantage: Low income, low socioeconomic status and living in poverty are risk factors.

  Gay, lesbian or bisexual orientation: Same-sex attraction increases risk, particularly around the time that person realises they are not heterosexual.

- **Social and family environment**

  Adverse childhood experiences: Risk is greater for children of separated or divorced parents or where there is conflict in the home. Experiencing physical, emotional or sexual abuse or neglect also increases risk.

  Social isolation: Having good social support and people to confide in reduces risk.

- **Psychological characteristics**

  Impulsive: A tendency to act without reflecting fully on the consequences increases risk. Many individuals who engage in self harming behaviour report that they made their decision only minutes beforehand.

Poor problem solving: People who engage in self harming behaviour tend to have poor problem solving skills and impaired decision making.

Prone to emotional distress: People who engage in self harming behaviour tend to be more sensitive and emotional.

- **Biological factors**

  Genetic vulnerability: mental disorders in parents increase risk.

  Brain functioning: There is evidence for changes in the chemical messenger serotonin in the brains of people who engage in self harming behaviour.

- **Situational factors**

  Adverse life events: Bad things happening in the person's life can trigger self harming behaviour, particularly conflict with others or the breakdown of a relationship.

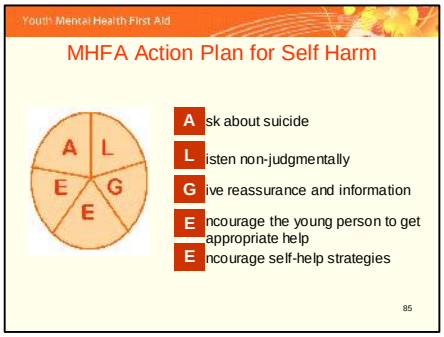
  Media influence: If suicide or self harm is publicised in the media, it is known to increase risk. To reduce this influence, there are now professional standards for journalists to follow in reporting on suicides and other mental health related news stories.

  Peer influence: Sometimes incidents of self harm can occur in a cluster of people around the same time. This is because young people can be influenced by what their peers do.

  Alcohol intoxication: Alcohol increases the risk by making people more impulsive and by exacerbating anxiety and depression.

MHFA action plan for non-suicidal self-harm

Slide 85: MHFA Action Plan



- Revision of ALGEE
- Application of model to self harming behaviour.

Ask about suicide

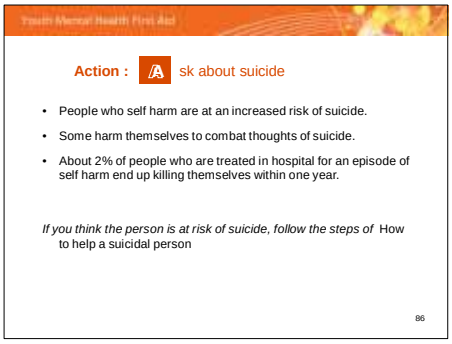
Listen non-judgmentally

Give reassurance and information

Encourage the young person to get appropriate help and support

Encourage self-help strategies

Slide 86: ACTION A: Ask about suicide



Young people who engage in self harming behaviour need to be monitored closely.

Pose the questions:

- "Are young people who engage in self harming behaviour at increased risk of suicide?"
- "Are young people who engage in self harming behaviour at increased risk of accidental death?"
- "Are young people who engage in self harming behaviour at risk of more serious injury?"
- *Answer* to each question is yes.

Read through slide.

Addition note:

- Physical first aid may be required as well as Mental Health First Aid.

further information about the risk of suicide or other harm

- **Are young people who engage in self-harm at increased risk of suicide?**

  Some people engage in self harming behaviour because they are feeling suicidal and feel that the release of pressure that self-harm can provide gives them an alternative to suicidal behaviour. The self harming behaviour may be a non-suicidal response to suicidal feelings.

  People who engage in self harming behaviour do so when they are experiencing high levels of distress. Most have an underlying mental health problem. These also increase the risk of suicide.

People with a history of self harming behaviour are at higher risk of suicide in the long-term.

If someone is engaging in self harming behaviour, regardless of current suicidal ideation, they are in need of help. The right response now might prevent later suicidal thoughts and behaviours.

- **Are young people who engage in self-harm at increased risk of accidental death?**

  A cut which is deeper than the young person intended it to be can result in arterial bleeding and death.

  Some people harm themselves by swallowing items which can result in choking and death.

  Some people harm themselves by ingesting poisons or medicines. Even if the intent is not suicide, the outcome may be death.

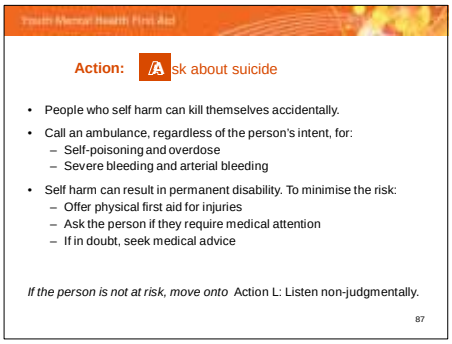
  If someone has ingesting poisons or medicines, even if the intent is not suicide, this is a medical emergency. Seek medical assistance immediately.

- **Are young people who engage in self-harm at risk of more serious injury?**

  Sometimes, whether it is because of a lack of familiar tools, a particularly high level of distress, intoxication, or other reasons, people harm themselves more severely than they intend to. This can lead to physical complications.
  Lack of care with injuries can also result in infection. Untreated infections can lead to serious medical consequences. Some injuries can be less obvious than others. Someone who has been punching a wall or other hard object will probably have bruising, swelling, and possibly bleeding, all of which will be visible. However, they may have broken a bone or bones.

  If in doubt about the severity of an injury, seek medical assistance.

Slide 87: ACTION A: Ask about suicide



Self-harm is most frequently superficial and only requires simple wound management. If someone has injured themselves superficially, offer physical first aid, but don't insist on giving it; caring for the injury may be part of what

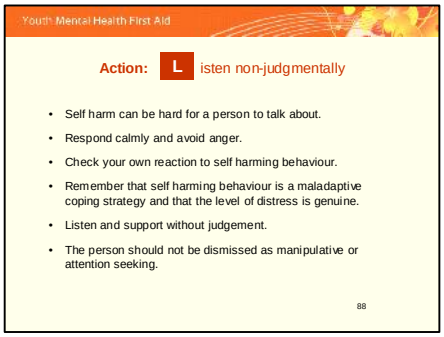
the person needs to do to relieve their emotional state.

Self-harm can be a medical emergency, however, and people can kill themselves accidentally or cause permanent disability. Emergency help should be sought if bleeding is arterial or otherwise severe. (You can ask the group how you can tell if bleeding if arterial; the answer is rapid, pulsing bleeding.)

Emergency help should be sought if the person has taken an overdose of medication or taken poison; regardless of the person's intention, the outcome of this is unpredictable and can be fatal.

Remember that improper wound care can result in more serious problems. Even scratches from fingernails, perhaps not even deep enough to cause bleeding, can become infected if they are not kept clean.

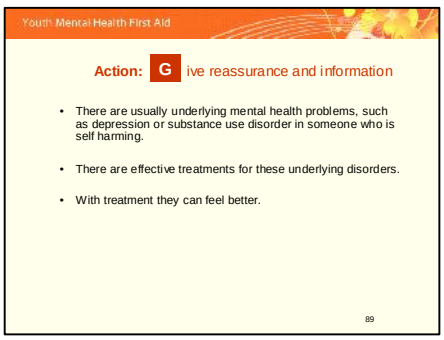
Slide 88: ACTION L: Listen non-judgmentally



- Most people who engage in NSSH keep it secret from others.
- It can also be very hard for the young person to talk about.
- It can also be hard for the "first-aider" to listen non-judgmentally as our personal response to NSSH can vary.
- When preparing to broach the subject of NSSH with a young person, you need to reflect on your own state of mind and be confident that you can react calmly.

How do we listen non-judgmentally? - Read through slide and discuss as required.

Slide 89: ACTION G: Give reassurance and information



Optional group activity

Providing information and reassurance to young people

Before showing slide:

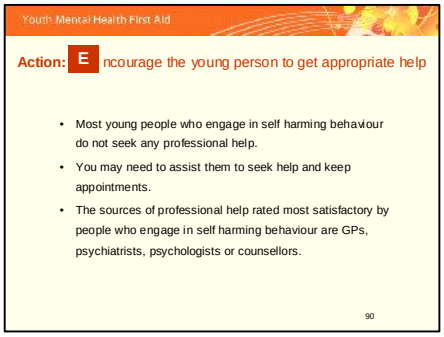
- Get group to break into pairs: one person is the youth, the other the first-aider.
- The task of the "first-aider" is to provide appropriate information and reassurance to the young person about their NSSH.

Feedback/discussion:

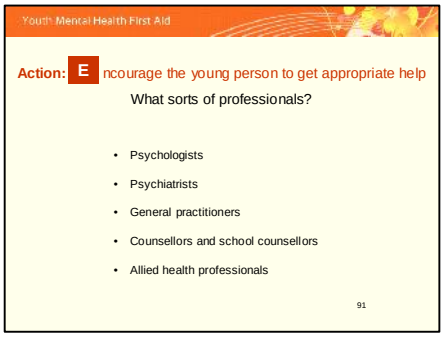
- What was it like for the young person? Did you feel reassured, did you get appropriate information? Did you feel that you were listened to?
- For the first-aider? Was the task easy or hard, what was your reaction to someone who is engaging in NSSH, did you feel confident about what information to give, did you feel that you provided reassurance?

Show slide and read through points.

Slide 90–92: ACTION E: Encourage young person to get appropriate help and support



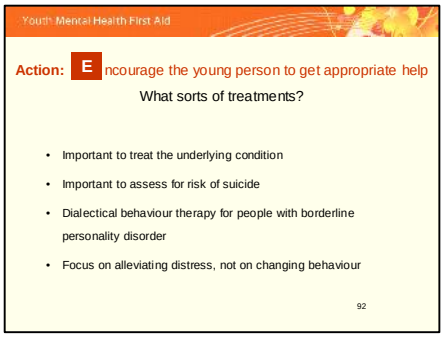
- Key point – most young people who engage in NSSH do not seek help.



What sorts of professionals?

- Key point – important to treat the underlying mental disorder, so the usual professionals are recommended.

Appropriate help and support (continued)



What sorts of treatments?

- Key point – important to treat the underlying mental disorder rather than try to stop the person from harming themselves.

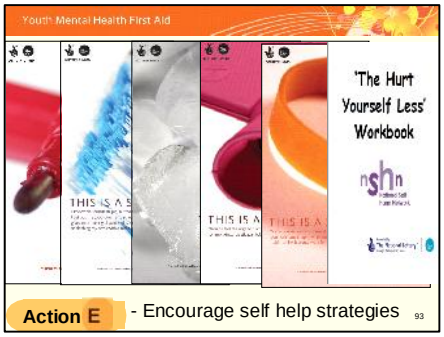
Additional note:

- If an adolescent who has been engaging in NSSH is given antidepressant medication, careful monitoring by the prescribing doctor and parents or guardians is essential.

There is a small risk that suicidal thoughts can increase when starting treatment with antidepressants. This risk may be higher amongst young people who engage in NSSH.

- A person who has already injured themselves can be taken to a hospital emergency department. The staff there will treat any injuries. They should also offer a psychiatric assessment, or you can ask for one.

Slide 93: ACTION E: Encourage self-help strategies



- Support from families and friends are seen as an important type of help by young people who have engaged in NSSH.

Read through slide.

Group discussion

Alternative ways of dealing with stress/distress

One way in which support can be provided by friends and family is by suggesting and reinforcing more functional and less harmful ways of dealing with distress. Whilst the underlying mental health problems need to be addressed some short term strategies may assist some young people, particularly if there is going to be a long wait to see a professional.

As a group, let's brainstorm some alternative methods that are not harmful, or that you have found useful in your work with young people.

Note These are not suggestions to be use in place of professional help.*

Write list on whiteboard.

List could include the following: talking to someone, use of a journal, relaxation techniques, using a red felt pen on the skin, elastic band on wrist, punching a pillow or punching bag, squeezing ice cubes till your fingers go numb, eating chilli or something really hot, having a cold shower, exercise.

Conclude session with helpful resources

End of Session 3 Part 1

Session 3
Part 2 (2.25 hours)

Psychosis

Learning objectives

- To learn about the symptoms and causes of psychosis in young people
- To apply the MHFA Action Plan to help a young person who may have psychosis
- To learn crisis first aid for a person who may be threatening
- To learn about the treatments and resources for young people with psychosis

Instructor resources

DVD: Youth MHFA Film Clip DVD: Mental Health First Aid for Psychosis.

Booklets:

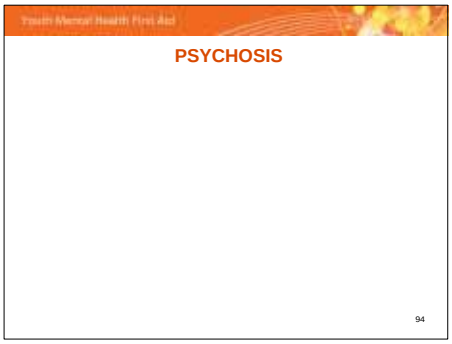
factsheets:

YMHFA manual: Chapter 5: Psychosis in youth..

YMHFA PPT slide numbers: #94–#115

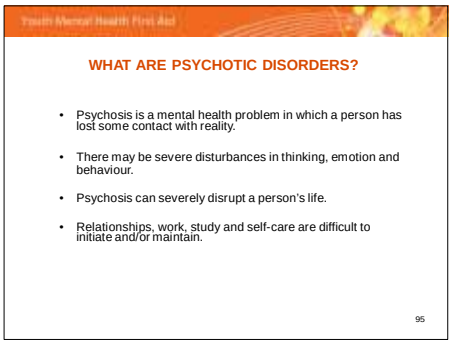
Introduction to psychosis

Slide 94: Title slide



- Psychotic illnesses are not common mental disorders.
- Psychotic illnesses are *low prevalence* disorders.
- Over a lifespan the risk of developing schizophrenia is 1% and for bipolar disorder 2%.
- Psychotic illnesses are misunderstood by members of the public and misrepresented by the media. This has led to fear, ignorance and stigma.
- However, they are among the best-understood and best-researched disorders in psychiatry. A wide range of effective treatments are available.

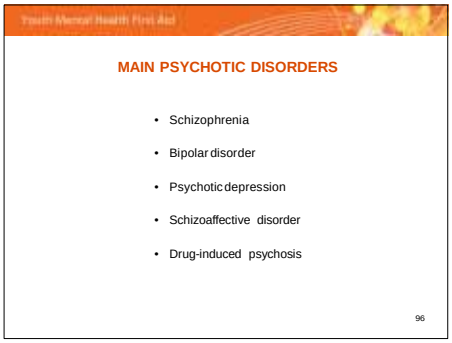
Slide 95: What are psychotic disorders



Slide summarises key features of psychotic disorders.

Read through slide.

Slide 96: Main psychotic disorders

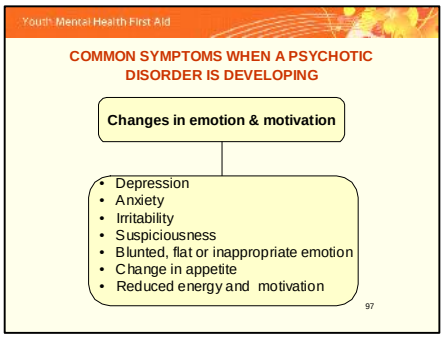


- Slide provides a list of the main psychotic illnesses.
- "When someone is experiencing a psychotic episode for the first time it is particularly difficult to diagnose the exact type of psychosis. A firm diagnosis requires consistency in the psychotic symptoms over a long period of time."
- "We will look particularly at schizophrenia and bipolar disorder, and then briefly discuss the features of psychotic depression, schizoaffective disorder and drug induced psychosis."

Common symptoms when a psychotic illness is developing.

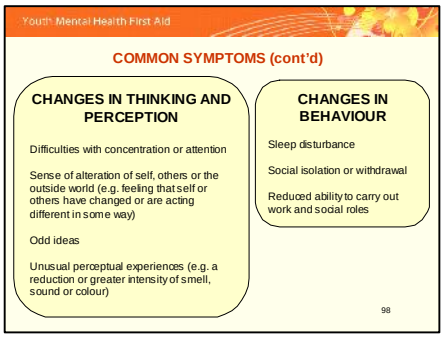
Read through both slides

Slide 97: Changes in emotion and motivation



- Note how non-specific many of these symptoms are.

Slide 98: Changes in thinking and perception, changes in behaviour



These symptoms are a bit more specific, but not specific enough.

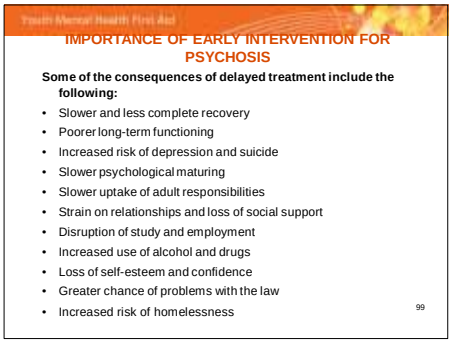
Additional notes:

- The symptoms on these two slides are common to the 'prodrome' of schizophrenia – milder symptoms that can last for a year or more before frank psychosis presents.
- Because of this and other reasons, people in the early stages of psychosis may go undiagnosed for a year or more before receiving treatment.
- Cannot 'diagnose' a prodrome, but in some cases, early intervention may be possible.
- A major reason for this is that psychosis often begins in late adolescence or early adulthood and the early symptoms involve behaviours and emotions which are common in this age group.
- Average onset for males is 18 years and for females is 23 years of age.

Criteria for distinguishing normal variations in behaviour from more serious problems:

- **Duration** – Consider as potentially harmful any problems that last more than a few weeks; reassess mental state on several occasions.
- **Persistence** and severity of fixed symptoms – Loss of normal fluctuations in mood and behaviour.
- **Impact** of symptoms – School work, interpersonal relationships, home and leisure activities.

Slide 99: Importance of early intervention for psychosis



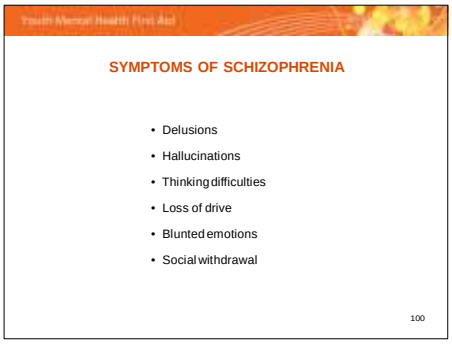
It is unfortunate that psychosis often takes so long to be treated. The consequences of delayed treatment include:

- Why do you think treatment delays occur? (Symptoms are unclear, young person withdraws from people who could offer support)

Read through slide.

We will now have a more detailed look at two psychotic illnesses: schizophrenia and bipolar disorder.

Slide 100: Symptoms of schizophrenia



Schizophrenia means “fractured mind”. This might be why many people think that people with schizophrenia have multiple personalities.

The mind hasn’t broken apart, however; it has broken away from reality. Psychosis causes people to lose touch with reality.

- Nearly three-quarters of sufferers are young people between the ages of 16 and 25 when first affected.
- The illness affects more males than females and males tend to develop it earlier.
- About one-third of people who develop the illness have only one episode and fully recover, another one-third have multiple episodes but are well in between, and a further third have a life-long illness.

Read through slide, and introduce notion of positive (added to) and negative (taken away) symptoms.

Positive symptoms: (points 1–3) – delusions, hallucinations and thinking difficulties*. **Negative symptoms:** (points 4–6) – loss of drive, blunted emotions and social withdrawal.

*Thinking difficulties are sometimes described as ‘disorganised thinking’. They may be classed as positive or negative symptoms and are sometimes classed as both.

Group activity 3.2_1

Auditory hallucinations

Introduce exercise by explaining that the group is going to learn about some of the difficulties and frustrations people who experience auditory hallucination encounter.

- To a degree, people who have never experienced clinical depression or an anxiety disorder can imagine what it might be like.

Everyone experiences sadness, stress and anxiety. So we can imagine what it would be like if it was much worse, and lasted longer.

- It is much more difficult to imagine what it would be like to truly see or hear something that is not there.

Step 1: ask for 3 volunteers, or break group into 3s

Point out the voluntary nature of the exercise and that it is for people who are feeling particularly robust today and who have not had experiences of psychosis in the past.

Step 2: Briefly outline roles and role play as per Hearing voices Handout.

Step 3: Participants select their roles, remembering that the person experiencing auditory hallucinations must be someone who is feeling robust, and who has not experienced psychosis themselves in the past.

Step 4: Do the role play.

Step 5: Debrief/process

Ask participant 2:

How was the experience of trying to hold a conversation whilst hearing the voice?

Allow participant 2 to answer and thanks them before proceeding to debrief.

Ask participant 1:

What was it like to try and carry on a conversation with this person?

Thank all participants and allow them to return to their seats.

Important notes:

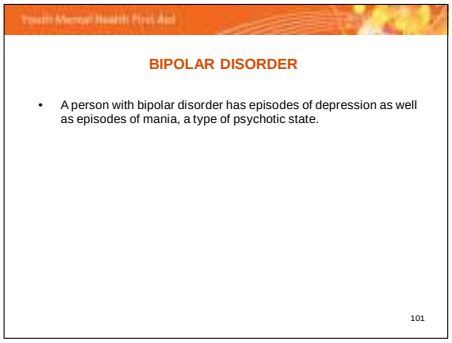
Some people have used audio tracks and headphones in this role play. Your participants may comment that they have seen a similar exercise on television using headphones.

Mental health first Aid does NOT endorse this method as it can be upsetting and may be dangerous without adequate clinical supervision.

Please use the scripts provided for the auditory hallucination. They were written to be as accurate as possible without being distressing or unkind.

This can be a powerful learning tool if used properly and dangerous if used improperly

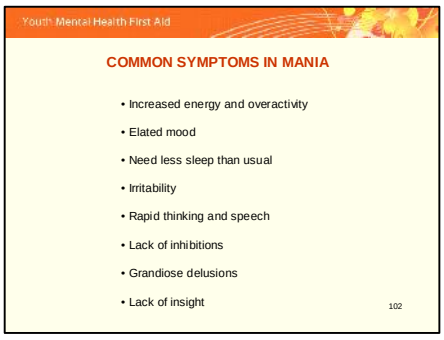
Slide 101: Bipolar disorder



People suffering from bipolar disorder (manic depression) have extreme mood swings, fluctuating between periods of depression, mania and normal mood.

- It can take a long time to be diagnosed correctly because the person needs to have episodes of both depression and mania.

Slide 102: Common symptoms in mania



Introduction: Tell the group that symptoms of depression have already been covered and pose the question:

"What are the common symptoms in mania"?

Compare list generated by the group to those listed on the slide.

Add information to the points if not mentioned in discussion.

- Increased energy and over-activity: *full-on.*
- Elated mood: *High, happy, on top of the world, invincible.*
- Need less sleep than usual: *Can go for days with little sleep.*
- Irritability: *particularly if others disagree with their unrealistic plans.*
- Rapid thinking and speech: *Talks too much, too fast and topic jumps.*
- Lack of inhibitions: *Can disregard risk, can spend money extravagantly, can be promiscuous.*
- Grandiose delusions: *Very inflated self-esteem; belief that they are superhuman, especially talented or an important religious figure.*
- Lack of insight: *Convinced that their manic delusions are real.*

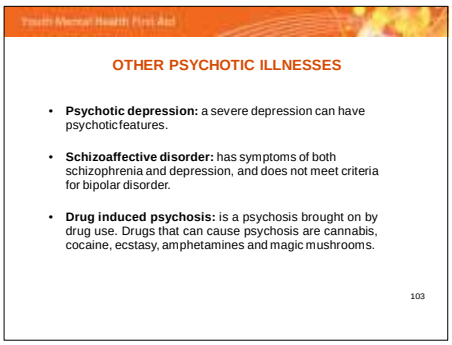
Mention that hypomania is a milder form of mania. People who experience hypomania rather than mania are said to have "bipolar II disorder".

For people with bipolar 2, the episodes of depression are no less severe, only the episodes of mania.

Additional notes:

- Males and females are equally affected.
- The illness is often first diagnosed when people are in their twenties or thirties. However, it may be earlier, and is sometimes diagnosed in older adults.
- Some people experience a number of episodes of depression over a period of years, and are not aware that the underlying disorder is bipolar disorder until they experience an episode or more of mania.
- People do not tend to become suicidal when they are manic. They may however, engage in activities that harm them or bring about their death.

Slide 103: Other psychotic illnesses

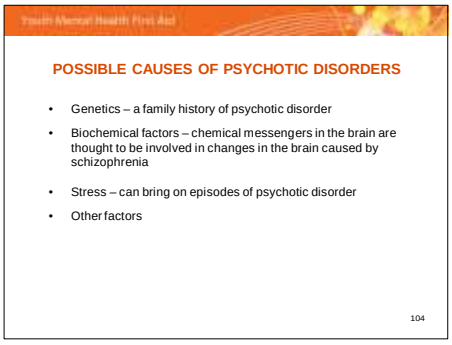


Slide covers:

- **Psychotic depression:** This is an episode of major depression with some psychotic symptoms. The psychotic symptoms are not typical of mania, with elated mood; they are more typical of schizophrenia.
- **Schizoaffective disorder:** This diagnosis is made when the person has symptoms of both a mood disorder and a psychotic disorder. Schizoaffective disorder looks quite different to mood disorders and schizophrenia.
- **Drug induced psychosis:** Use of, or withdrawal from alcohol and drugs can be associated with the appearance of psychotic symptoms. These symptoms will resolve as the effects of the substances wear off.

This is not the same as a psychotic illness which has been caused by ongoing drug or alcohol use.

Slide 104: Possible causes of psychotic disorders – schizophrenia, and bipolar



It is believed that psychosis is caused by a combination of factors including genetics, biochemistry, stress and other factors.

- Other factors include head injury, complications around birth or being born in winter.

Read through slide and add additional information as required.

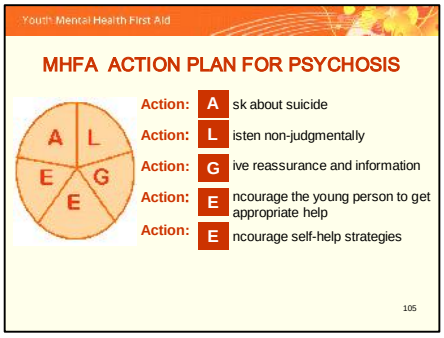
- **Genetic factors:** Neither illness is directly inherited. However, people who have a parent affected are more likely to develop the disorder. The more affected individuals in a person's family, the greater their vulnerability.
- **Biochemical factors:** Both illnesses are believed to be associated with a chemical imbalance in the brain.
- **Stress:** The onset of a **psychotic episode** often follows stressful events in a person's life. However, stress is not in itself the cause of the psychotic illness. It can act as a trigger for an episode for people who are vulnerable to the disorder.
- **Other factors:**
  Minor risk factors for **schizophrenia** include head injury, birth complications or being born in winter.

  There is some evidence that episodes of **mania and psychosis** are more common in spring, and depression more common in winter.

  The use of **cannabis** is well known to be a trigger for the onset of a psychotic illness among individuals with a known genetic vulnerability to psychosis. It also appears that long term use of **cannabis** can be a trigger for the onset of a psychotic illness, even in people with no known genetic vulnerability.

MHFA action plan for psychosis

Slide 105: First Aid for Psychosis: the five actions



Revisit and revise ALGEE.

Ask about suicide

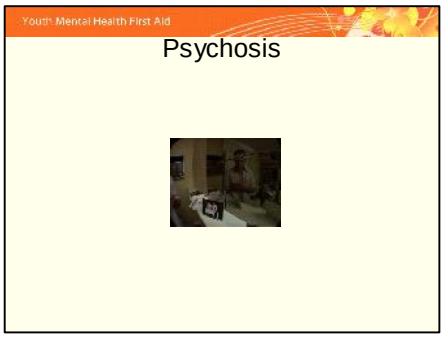
Listen non-judgmentally

Give reassurance and information

Encourage the young person to get appropriate help and support

Encourage self-help strategies

⦿ Introduce MHFA Pychosis DVD (11 minutes)



Now we will watch a short film showing two people trying to help a young man becoming unwell and disturbed with his delusions and hallucinations. Let's see if any of the eight points we have just discussed are demonstrated.

☺ ⦿ Group activity 3.2_2

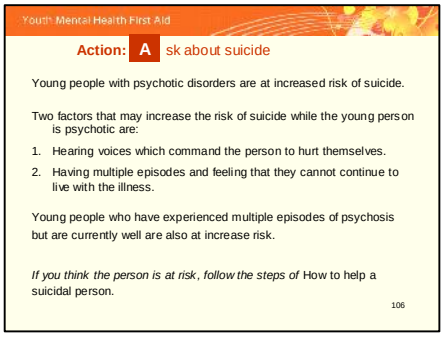
Psychosis DVD

Discuss/list the helpful and unhelpful things that Sarah and Dianna did in their intervention with Peter, using the detailed notes in the Handout provided in your Exercises Tab.

MHFA action plan for psychosis

ACTION A: Ask about suicide.

Slide 106: When the young psychotic person is at risk of suicide



Ask the question:

Are young people who are psychotic at higher risk of suicide?

Answer is YES

- Psychotic disorders involve a high risk of suicide.
- About one in ten people suffering from schizophrenia completes suicide.

Ask the question:

Are young people who are psychotic at higher risk of injury?

Answer is YES

- Young people who are psychotic may be at risk of injuring themselves.
- May be intentional – between episodes of psychosis, some people are distressed and may engage in NSSH.
- May be accidental – when psychotic, may engage in behaviours which are potentially dangerous.

Ask the question:

Are young people who are psychotic at risk of harming others?

Answer is YES

- It is important to remember that people who experience psychosis are far more likely to be the victims of violent crime than the perpetrators.
- However, occasionally, people who experience psychosis become violent.

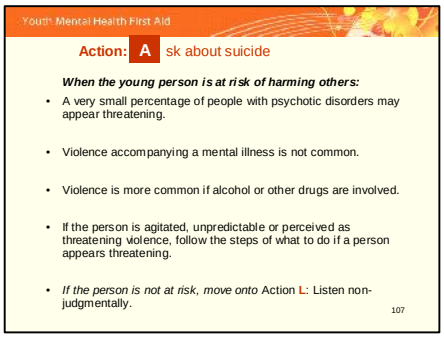
This is usually in response to a perceived threat, often triggered by a delusion or hallucination (eg, a voice saying that someone in the room plans to hurt them) or by confrontation with someone who does not understand what is happening.

It is occasionally triggered by a command hallucination (ie, a voice telling them to hurt someone).

A major factor that may increases the risk of suicide is having experienced multiple episodes of psychosis and feeling unable to go on. Many people who commit suicide do so within the first 5 years after the initial diagnosis.

Read through slide

Slide 107: When the young psychotic person is at risk of harming others



Read through the slide.

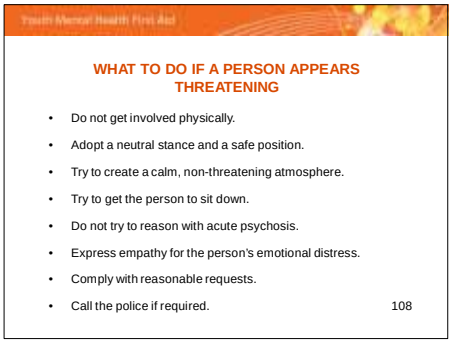
Additional notes:

Unfortunately the media tends to publicise the few people with a mental illness who become violent.

“Have you ever noticed a time when a newspaper or TV news report stated that the perpetrator of a crime had a mental illness, or schizophrenia specifically?”

“Can you think of a time when a newspaper or TV news report stated that the perpetrator of a crime had *no known history* of mental illness?”

Slide 108: What to do if a person appears threatening



Introduction: ask the group to close their manuals and ask the question;

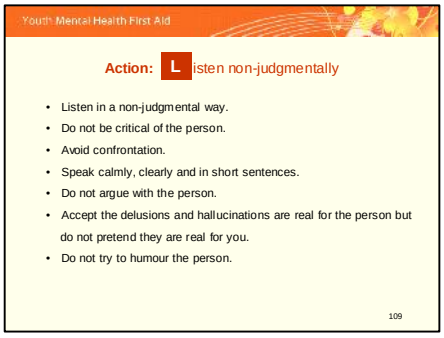
“What do you do if a person appears threatening?”

- Obtain a number of answers and then run through the slide and refer the group to the manual, for the expanded version and run through the points.

- Place emphasis on point 6 and 7: that the person may be acting the way they are because of delusions or voices that are very real and very frightening to them. Accept that these irrational perceptions are real for them, but do not pretend that the delusions or voices are real for you.

ACTION L: Listen non-judgmentally

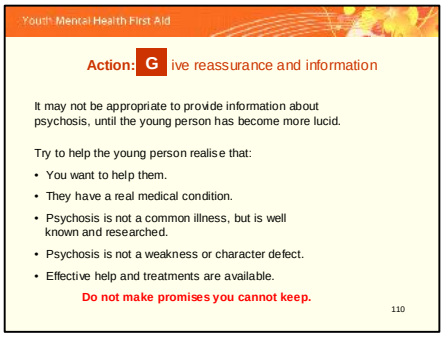
Slide 109



Read through the slide.

Discuss some of the challenges of listening to a person who is psychotic.
ACTION G: Give reassurance and information.

Slide 110

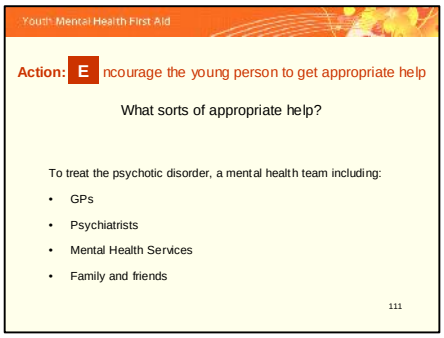


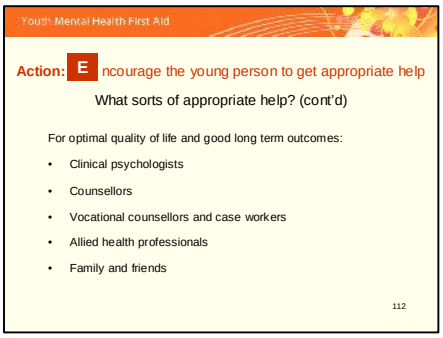
- When a young person is in a psychotic state, it is usually difficult and inappropriate to try to give them information about psychosis.
- A more appropriate time would be when the young person is recovering from the illness and is more lucid and in touch with reality.

Read through slide.

ACTION E: Encourage the young person to get appropriate help and support

Slides 111–113





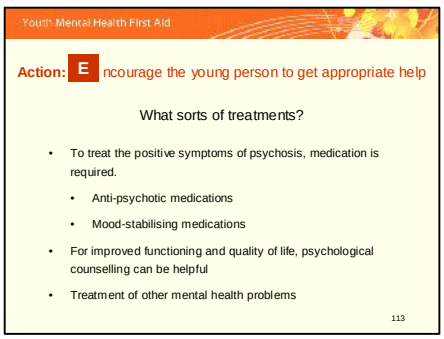
What sorts of professionals? Part 1 (treating psychosis)

Case workers can liaise with medical professionals, assist with day to day difficulties (including employment, school and housing) and monitor for changes in functioning Case workers have different roles in different agencies and consumers and carers should find out the limitations of their roles when a case worker is assigned.

What sorts of professionals? Part 2 (cont'd)

- It is important to get the young person to medical help as early in the illness as possible.
- A person with a psychotic illness needs to see a doctor and be placed on antipsychotic medication.
- Vocational counsellors can assist people to find employment or re-enter school and other training.

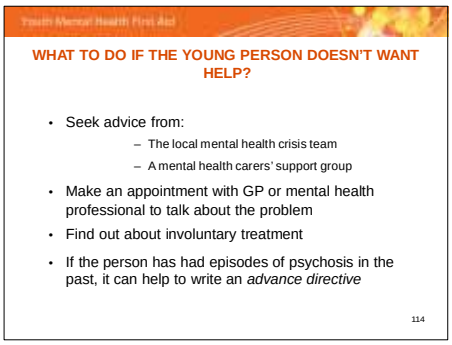
Run through the slide and refer to manual.



What sorts of treatments?

- It is not realistic to expect manage a psychotic illness without medication. Many would argue that it is not possible.
- However, medication is not the only answer. Psychologists and other mental health professionals can help to increase the young person's quality of life.

Slide 114: What to do if the young person does not want help

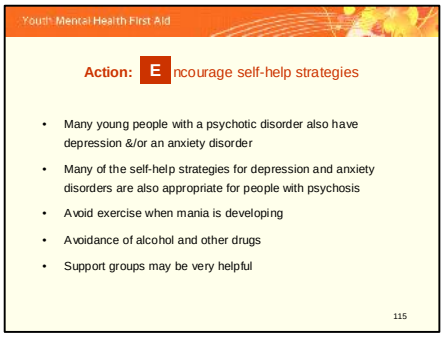


- When a person is very psychotic, they may lack insight into their illness and see no need to seek help.
- Some people develop insight into their illness over time. Others do not. They may admit they have a mental illness between psychotic episodes, but once the psychosis sets in, they lose that insight.
- There is no easy solution if a psychotic person is unwilling to seek professional help.

Slide suggests some practical and helpful strategies that are outlined in further detail in the manual.

ACTION E: Encourage self-help strategies

Slide 115



Read through slide.

Note that exercising when a manic episode is building can bring the episode on.

Once the young person is receiving treatment and symptoms have been brought under control the doctor can help them to work on self-help strategies to decrease the number and severity of relapses.

Conclude with helpful resources for psychosis: refer to manual.

End of Session 3 Part 2