Vancouver Island Crisis Society

IN CONNECTION

Box 1118, Nanaimo, BC V9R 6E7 Toll Free 1-877-753-2495 T (250) 753-2495 F (250) 753-2475 E info@vicrisis.ca

Fall/Winter 2020

Celebrating 50 Years of Helping People Find Their Way

Vancouver Island Crisis Society

1970–2020

Image of gears by Gerd Altmann on Pixabay.com

In Appreciation of Your Donations

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Our 50th Annual Report

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1-888-494-3888
VANCOUVER ISLAND CRISIS LINE

Helping People

Vancouver Island Crisis Society
P.O. Box 1118, Nanaimo, BC V9R 6E7

Toll Free: 1-877-753-2495
Phone: (250) 753-2495
Fax: (250) 753-2475
Email: info@vicrisis.ca
Website: www.vicrisis.ca

The Vancouver Island Crisis Line is also the public access to Mental Health Crisis Response Services 1-888-494-3888

Crisis Chat Online Emotional Support
6:00 pm to 10:00 pm every night
Accessed at www.vicrisis.ca

Crisis Text
6:00 pm to 10:00 pm every night
Text 800-250-3806

Join Us!

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island health | BRITISH COLUMBIA | Canada Suicide Prevention Service | Service Canadien de Prévention du Suicide | CLABC | NANAIMO CHAMBER | CASP ACPS Canadian Association for Suicide Prevention / Association canadienne pour la prévention du suicide | AMERICAN ASSOCIATION OF SUICIDOLOGY

Crisis Line/Chat/Text Interventions

911	185
Police non-emergency	11
MCFD	45
Other	159
MH Crisis Response	1,970
Total	2,370

Represents 6.9% of Total Calls/Chats/Texts

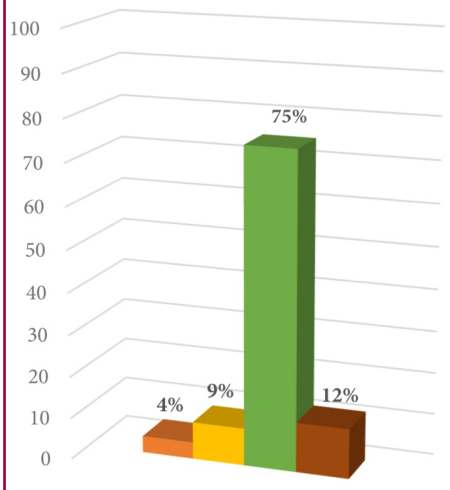
Vancouver Island Crisis Services Statistics

April 1, 2019 to March 31, 2020

(regional listing does not include Canada Suicide Prevention Service's call and text statistics)

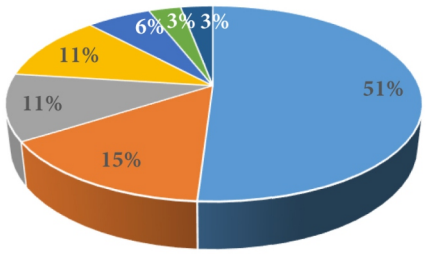
	Crisis Line		Crisis Chat	Crisis Text
Total Calls	33,170	%	567	432
Victoria & area	14,294	43	237	203
Nanaimo/Ladysmith	8,084	24	136	87
Unknown	3,454	10	45	0
Cowichan Valley & area	1,695	5	21	53
Comox Valley & area	1,559	5	31	41
Campbell River & area	934	3	10	8
BC Off Island	1,214	4	39	30
Parksville/Qualicum	1,150	3.5	11	4
Pt Alberni/West Coast	463	1.5	25	5
Mt. Waddington & area	240	1	12	1
Rest of Canada/USA	83	–	0	0

Total Number of Contacts by Our Crisis Workers for Each Service



- 1800SUICIDE
  1-800-784-2433 (provincial)
  1612 calls
- 310Mental Health Support
  310-6789 (provincial)
  3429 calls
- VI Crisis Line
  1-888-494-3888 - 28,129 calls
  VI Crisis Chat & Crisis Text - 999 visits
- Canada Suicide Prevention Service
  1-833-456-4566
  4331 calls & 702 texts

Why People Call the Crisis Line



Mental Health & Substance Use Crisis Response Interventions (Crisis Calls)

Campbell River Crisis Nurse	8
Courtenay Crisis Intervention Nurse	63
Duncan Crisis Response Team	27
Nanaimo Community Outreach Response	515
Oceanside Crisis Response Nurse	21
Port Alberni Community Response Team	42
Mt. Waddington Mental Health Daytime	3
Victoria Integrated Mobile Crisis Response Team	1,125

Note: Communities with lower intervention numbers have the option to access mental health crisis services directly.

The year that it is: The Crisis Society and COVID-19

Image by Tumisu, Pixabay.com

by Lyndsay Wells
Community Education Program Coordinator

When a Community Education Department loses its community

On March 12, 2020, trainers from our Community Education Department were in Victoria teaching a three-hour workshop called *Recognizing and Responding to Mental Distress*. We were scheduled to be on base in Esquimalt for a two-day ASIST (Applied Suicide Intervention Skill Training) workshop early the next week, and our school calendar was fully booked into June.

Although we had been hearing concerns from local government about a mysterious illness they were calling "the Corona Virus," like most people, were still taken by surprise when on March 13, the world as we had known it, shut down. Schools closed, volunteer training was postponed, and workshops were cancelled. Though our crisis lines were busier than ever as Crisis Workers met the virus head on and many of these workers were trained to respond to interactions from home if needed, the Community Education department was in a precarious place.

How does a Community Education department continue without a community to visit?

There is a long-standing belief that sits at the ground floor of all crisis intervention work and that is, crisis, though difficult, can always provide an opportunity for change and growth if we approach it that way. This is what Vancouver Island Crisis Society decided to do. We decided that this temporary loss of community provided an opportunity to begin developing

The COVID-19 Year that it is *continued on page 5*

Our Funders & Donors (2019-20)

VISIONARIES (Funders) ($5000+)

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Vancouver Island Crisis Line
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100.3 The Q THE ISLAND'S ROCK

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Promotion of the Vancouver Island Crisis Line

intraworks I.T. MANAGEMENT

Vancouver Island Crisis Line
and Community Education

We acknowledge the financial support of the
Province of British Columbia
for Community Education programming

Crisis Services Canada | Services de crises du Canada

F L T

Odd Fellows Columbia Lodge No. 2, Victoria
Youth Suicide Prevention Programs
and Crisis Chat and Crisis Text

Provincial Health Services Authority
Province-wide solutions. Better health.

Cowichan Valley Ride for Suicide Awareness

We are pleased to share the list of those who supported the Crisis Society financially or with in-kind donations from April 1, 2019, to March 31, 2020. We would especially like to thank those organizations that contributed to keep our Youth Suicide Prevention Programs in our schools, and who supported our Crisis Chat and Crisis Text services.

Thank You!

NORTH STARS ($2500 to $4999)

Mambo Gourmet Pizza T-Shirt Fundraiser
Meyer Norris Penny Jeans Day Fundraiser
Wanderlust Tattoo Fundraiser

LIGHTHOUSE KEEPERS ($1000 to $2499)

Nanaimo Harbor Lites Lioness
Royal Canadian Legion Branch #76 Qualicum Beach

LIFE PRESERVERS ($500 to $999)

Chamelon Hair Inc. Fundraiser
Fraternal Order of Eagles – Chemainus – Crofton Aerie No. 4400
Ladysmith Lions Club
Lynn Wood
M Graham & Associates Inc.
Nanoose Bay Lions Club
Peter Hudson Comedy Fundraisers
Royal Canadian Legion – Br #191 Chemainus
Royal Canadian Legion – Br #134 Shawnigan Lake/Mill Bay
Vault Café Fundraiser
Westwood Metals Ltd.

ANCHORS (under $499)

Alexandra Kamprath
Bev Ford
Caroline Bailey in honour of Kyle Bailey
Coast Capital Savings Credit Union

Coast Capital Savings – Kris Moan
Charlotte Coleman
CUPE Local 556, Courtenay
David Baanstra
Joanne Hogan
Knight Mid-Island Charitable Society
Ladysmith Secondary Student Council
Lynn Wilson
Marcia Bell in honour of Heather and Rick Owen
Marion Harrison in honour of Casey Harrison
Marilyn McKnight in memory of Derrek Cauchie
Megan Schram
Nanaimo Magazine and Vancouver Island Voyager Magazine
Parkland Fuel Corporation
Royal Canadian Legion Br #257 Lantzville
Royal Canadian Legion Br #211 Bowser
Shelby Warner
SignAge
Sean McCulloch
Takesadollar Campaign – Andrew Degroot and Wes Richardson

The COVID-19 Year that it is *continued from page 3*

a learning environment option we had been wanting to provide for a long time: Make all of our programs accessible Island-wide by presenting them virtually on online platforms.

We began with our popular COPE School Program and, because of the generosity of a Vancouver-based film maker, **Matt Wells at Clinically Creative Productions**, we were able to produce 11 short videos, along with an activity booklet, a discussion guide, and a program description trailer that promoted this free program so that schools and families throughout Vancouver Island could have access to the important information presented in this program. Please see the **Back Cover** for more details about COPE.

Island-Wide Suicide Bereavement Support is launched!

We then decided to look again at our suicide bereavement support. We had been planning to re-start our suicide bereavement support group in Nanaimo in May, but the pandemic gave us the opportunity to re-visit what suicide bereavement support might look like. Since September 2, in recognition of World Suicide Prevention Day on September 10, we have returned to offering a monthly Suicide Bereavement Support group meeting. It takes place on the first Wednesday of every month. We also offer individual support sessions that can take place online, over the phone, or in person. Please see **page 6** for more details.

Virtual learning is now available for MANY of our Community Education Programs!

The final hurdle for us to overcome was familiarizing ourselves with various online meeting platforms. We are delighted that all of the Community Education workshops we have developed, including Crisis Intervention Skills Training (CIST), our school-based peer gatekeeper GRASP program, and each of the three-hour workshops we have developed, continue to be available to all Vancouver Island communities—this time, on the Zoom platform.

We continue to offer ASIST and safeTALK, both developed by LivingWorks, in person either at our Crisis Training Centre in Nanaimo, or off-site, as we strictly adhere to the COVID-19 protocols implemented by WorkSafeBC.

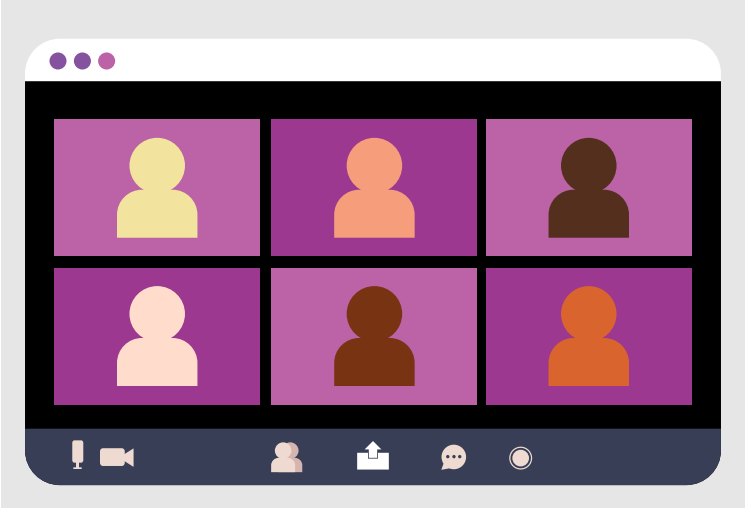
*Please call 1-877-753-2495 or email us at **info@vicrisis.ca** for more information.*

Suicide Bereavement Support

From 2006 to 2013, the Vancouver Island Crisis Society facilitated a monthly suicide bereavement support group out of our conference room in Nanaimo. We were always cognizant of communities that did not have access to these kinds of supports, even as we offered our Crisis Services (Line, Chat, and Text) throughout Vancouver Island. We hoped that we could begin to support those who dealt with the complexity suicide bereavement brings.

Vancouver Island Crisis Society is offering ISLAND-WIDE Suicide Bereavement Support!

The academic literature tells us that suicide loss survivors perceive a lack of empathy and judgmental attitude from those not grieving a suicide death (Cyinar, 2005; Jordan, 2001; Mitchell et al., 2007). Consequently, they report feeling their natural relationships and environment are no longer safe places for them to share their confusing and daunting grief reactions. It may be that those in one's social network may wish to provide support but are ill-equipped emotionally or are too uncomfortable to do so (Jordan, 2001; Kovac & Range, 2000).



Our Suicide Bereavement Support Group meets the first Wednesday of every month via the Zoom platform

The purpose of our support group is to create a safe space once a month for sharing feelings of loss and grief with others who have an understanding of what it is to survive a suicide loss. We are also here to help one another navigate new situations and complicated questions we've never been confronted with—like having to grocery shop at midnight or prepare ourselves for particularly difficult times like holidays or anniversaries, as well as to sort through the kinds of complicated emotions that often accompany suicide bereavement.

Longer-term help is beneficial to the healing process

The Crisis Society believes that a longer-term therapeutic alliance between a qualified and experienced bereavement support person and someone bereaved by suicide has the potential to be an integral part of that person's healing journey and their overall wellness and resilience. This is where individual support sessions come in. For people in need of more than a monthly bereavement group, individual sessions with one of our suicide bereavement support staff over the

phone, via Zoom, or in person, can be arranged. These are available to provide an additional level of support for those who are struggling with the intricate details of how their loved one died.

"Predetermined, time limited therapy and quick fixes are not likely to be useful to individuals experiencing complicated grief reactions, who often require longer-term assistance in addressing the overwhelming feelings of hopelessness" (Cutcliffe, 2006; Jordan & McMenamy, 2004). The survivor's grieving process can take as long as three to four years before experiencing some feeling of resolution (Murphy, 2000).

A Flexible, Individual Approach

As highlighted by Brown et al, 2007, "suicide bereavement support services need to be flexible in how they respond to the unique needs of survivors." This is what Vancouver Island Crisis Society provides: flexible, individualized, longer-term support through an online monthly suicide bereavement support group powered by Zoom, individual support sessions, and educational programs.

To learn more about our Suicide Bereavement Support, please call 1-877-753-2495 or email info@vicrisis.ca

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Suicide bereavement and complicated grief

ABSTRACT

Losing a loved to suicide is one is one of life's most painful experiences. The feelings of loss, sadness, and loneliness experienced after any death of a loved one are often magnified in suicide survivors by feelings of quilt, confusion, rejection, shame, anger, and the effects of stigma and trauma. Furthermore, survivors of suicide loss are at higher risk of developing major depression, post-traumatic stress disorder, and suicidal behaviors, as well as a prolonged form of grief called complicated grief. Added to the burden is the substantial stigma, which can keep survivors away from much needed support and healing resources. Thus, survivors may require unique supportive measures and targeted treatment to cope with their loss. After a brief description of the epidemiology and circumstances of suicide, we review the current state of research on suicide bereavement, complicated grief in suicide survivors, and grief treatment for survivors of suicide.

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Online access to
Authors' academic affiliations and complete references

INTRODUCTION

Nearly 1 million people die by suicide globally each year.[1] Suicide is one of the top ten leading causes of death across all age groups. Worldwide, suicide ranks among the three leading causes of death among adolescents and young adults. During 2008-2009, 8.3 million people over age 18 in the United States (3.7% of the adult US population) reported having suicidal thoughts in the last year, and approximately 1 million people (0.5% of the adult US population) reported having made a suicide attempt in the last year. There were just under 37,000 reported deaths by suicide (completed suicides) during the same time period, and almost 20 times that number of emergency room visits after nonfatal suicide attempts.[2] Rates of suicidal thoughts and behaviors vary by age, gender, occupation, region, ethnicity, and time of year. According to a 2011 report[2] released by the CDC, in 2008, the highest prevalence of suicidal thoughts, plans, and attempts among those surveyed in the US was reported by adults aged 18 to 29 years, non-Hispanic white males, people who were unemployed, and people with less than a high school education. There were no reported differences in the rates of suicide attempts by geographical region, though people living in the Midwest region of the US were most likely to have made a suicide plan in the last year, and those in the Midwest and Western region of the US reported the highest prevalence of suicidal ideation. While rates of completed suicides tend to be higher among men than women and higher among middle aged or older adults than among younger people, rates of nonfatal suicidal behavior are higher among females and adolescents and young adults.[1]

The most commonly employed methods of suicide are by gunshot, hanging, drug overdose or other poisoning, jumping, asphyxiation, vehicular impact, drowning, exsanguination, and electrocution. There are other indirect methods some attempters may employ, such as behaving recklessly or not taking vitally required medications. Many suicides go unreported, as it can be difficult to identify indirect suicide attempts as suicide, and even some of the more direct methods of suicide may not be clearly identifiable attempts. For example, drug overdoses or vehicular impact attempts are more passive methods, and it may be difficult to determine whether an event was an attempt or accident. Conversely, accidental drug overdoses can often be confused with suicide attempts. If the deceased left behind a note or told someone about their plans or intent to take their own life, this can help those left behind, the suicide survivors,

to distinguish between an attempt and an accident, but often no such explanation exists.

Nearly 90% of all suicides are associated with a diagnosable mental health or substance-abuse disorder.[3] The underlying vulnerability of suicidal behavior is the subject of intense research scrutiny, and includes biological, social, and psychological underpinnings.[4-8] While depression and bipolar disorder are the most common disorders among people who attempt suicide, suicide attempters may also suffer from substance abuse disorders, other psychiatric disorders such as schizophrenia, and may feel that suicide is the only way to end an unbearable pain they may be feeling as the result of their mental illness, trauma, or a significant loss, rejection, or disappointment. Additionally, a past history of suicide attempts is the best predictor for future attempts.[9] Common themes among suicide attempters are feelings of hopelessness, despair, and isolation from family and friends. Despite loved ones' and professionals' best efforts to support them in their suffering, suicide attempters are often unable to think clearly and rationally through their pain.

It is estimated that 85% of people in the United States will know someone personally who has completed suicide.[3] For each suicide completed, at least six loved ones are directly affected by the death.[10] While not everyone exposed to a suicide will be acutely affected by the death,[11] this is likely an underestimation as reported figures may not account for the emergency responders, health care providers, coworkers, and acquaintances also affected by the suicide. That said, individuals most closely related to the deceased are usually those most adversely affected by the death.[7,12]

GRIEF REACTIONS AND CHARACTERISTICS

Grief is the universal, instinctual and adaptive reaction to the loss of a loved one. It can be subcategorized as acute grief, which is the initial painful response, integrated grief, which is the ongoing, attenuated adaptation to the death of a loved one, and finally complicated grief (CG), which is sometimes labeled as prolonged, unresolved, or traumatic grief. CG references acute grief that remains persistent and intense and does not transition into integrated grief.

Acute grief

After the death of a loved one, regardless of the cause of death, bereaved individuals may experience intense and distressing emotions. Immediately following the death,

A complete listing of references is available online

bereaved individuals often experience feelings of numbness, shock, and denial. For some, this denial is adaptive as it provides a brief respite from the pain, allowing time and energy to accept the death and to deal with practical implications: interacting with the coroner's office, planning a funeral, doing what is necessary for children or others affected by the loss and settling the estate of the deceased. But, for most, the pain cannot be put off indefinably. It may not be until days, weeks, or even months following the death that the reality is fully comprehended, both cognitively and emotionally, and the intense feelings of sadness, longing, and emptiness may not peak until after that recognition sets in. Indeed, grief has been described as one of the most painful experiences an individual ever faces. Shock, anguish, loss, anger, guilt, regret, anxiety, fear, intrusive images,

Complicated Grief *continued on next page*

Complicated Grief *continued from previous page*

depersonalization, feeling overwhelmed, loneliness, unhappiness, and depression are just some of the feeling states often described.

Feelings of anguish and despair may initially seem everpresent but soon they occur predominantly in waves or bursts—the so-called pangs of grief—brought on by concrete reminders of or discussions about the deceased. Once the reality of the loss begins to sink in, over time, the waves become less intense and less frequent. For most bereaved persons, these feelings gradually diminish in intensity, allowing the individual to accept the loss and re-establish emotional balance. The person knows what the loss has meant to them but they begin to shift attention to the world around them.

Integrated grief

Under most circumstances, acute grief instinctively transitions to integrated grief within several months. However, as described later, this period may be substantially extended for those who have lost a loved one to suicide. The hallmarks of "healing" from the death of a loved one are the ability of the bereaved to recognize that they have grieved, to be able to think of the deceased with equanimity, to return to work, to re-experience pleasure, and to be able to seek the companionship and love of others.[13-15] For many, new capacities, wisdom, unrecognized strengths, new and meaningful relationships, and broader perspectives emerge in the aftermath of loss. However, a small percentage of individuals are not able to come to such a resolution and go on to develop a "complicated grief" reaction.[16]

Complicated grief

CG is a bereavement reaction in which acute grief is prolonged, causing distress and interfering with functioning. The bereaved may feel longing and yearning that does not substantially abate with time and may experience difficulty re-establishing a meaningful life without the person who died. The pain of the loss stays fresh and healing does not occur. The bereaved person feels stuck; time moves forward but the intense grief remains. Symptoms include recurrent and intense pangs of grief and a preoccupation with the person who died mixed with avoidance of reminders of the loss. The bereaved may have recurrent intrusive images of the death, while positive memories may be blocked or interpreted as sad, or experienced in prolonged states of reverie that interfere with daily activities. Life might feel so empty and the yearning may be so strong that the bereaved may also feel a strong desire to join their loved one, leading to suicidal thoughts and behaviors. Alternatively, the pain from the loss may be so intense that their own death may feel like the only possible outlet of relief.

Some reports suggest that as many as 10% to 20% of bereaved individuals develop CG.[17,18] Notably, survivors of suicide loss are at higher risk of developing CG.[11,19] CG is associated with poor functional, psychological, and physical outcomes. Individuals with CG often have impairments in their daily functioning, occupational functioning, and social functioning.[20-23] They have increased rates of psychiatric comorbidity,[19,24-26] including higher rates of comorbid major depression and posttraumatic stress disorder (PTSD). Furthermore, individuals with CG are at higher risk for suicidal ideation and behavior.[27-32] Additionally, CG is associated with poor physical health outcomes.[33,34] Overall, untreated CG results in suffering, impairment, and poor health outcomes, and will persist indefinitely without treatment.

BEREAVEMENT AFTER SUICIDE

Suicide survivors often face unique challenges that differ from those who have been bereaved by other types of death. In addition to the inevitable grief, sadness, and disbelief typical of all grief, overwhelming guilt, confusion, rejection, shame, and anger are also often prominent.[11,35] These painful experiences may be further

A complete listing of references is available online

complicated by the effects of stigma[36,37] and trauma.[38] For these reasons, grief experienced by suicide survivors may be qualitatively different than grief after other causes of death. Thus, while Sveen and Walby[39] found no significant differences in rates of comorbid psychiatric disorders and suicidality among suicide bereaved individuals compared with other bereaved individuals across 41 studies, they did find higher incidences of rejection, blaming, shame, stigma, and the need to conceal the cause of death among those bereaved by suicide as compared with other causes of death.

As outlined by Jordan,[11] certain characteristics of suicide bereavement that are qualitatively different from other forms of bereavement may lead to delays in survivors' healing.

Need to understand, guilt, and responsibility

Most suicide survivors are plagued by the need to make sense of the death and to understand why the suicide completers made the decision to end their life. A message left by the deceased might help the survivors understand why their loved one decided to take his or her own life. Even with such explanations there are often still unanswered questions survivors feel they are left to untangle, including their own role in the sequence of events.

Another common response to a loved one's suicide is an overestimation of one's own responsibility, as well as guilt for not having been able to do more to prevent such an outcome. Survivors are often unaware of the many factors that contributed to the suicide, and in retrospect see things they may have not been aware of before the event. Survivors will often replay events up to the last moments of their loved ones' lives, digging for clues and warnings that they blame themselves for not noticing or taking seriously enough. They might recall past disagreements or arguments, plans not fulfilled, calls not returned, words not said, and ruminate on how if only they had done or said something differently, maybe the outcome would have been different.

Parents who have lost a child to suicide can be especially afflicted with feelings of guilt and responsibility.[40] Parents who have lost a child to suicide report more guilt, shame, and shock than spouses and children.[41] They often think "If only I had not lost my temper" or "If only I had been around more." The death of child is arguably the most difficult type of loss a person can experience,[17] particularly when the death is by suicide. Parents feel responsible for their children, especially when the deceased child is young. Indeed, age of the suicide deceased has been found to be one of the most important factors predicting intensity of grief.[42]

While guilt is not a grief response specific to death by suicide, it is not uncommon for a survivor to view the suicide as an event that can be prevented. Therefore, it is easy for survivors to get caught up in self-blame.[37] Understanding that most suicide completers were battling a psychiatric illness when they died helps some survivors make sense of the death and can decrease self-blame.

Rejection, perceived abandonment, and anger

Survivors of suicide may feel rejected or abandoned by the deceased because they see the deceased as choosing to give up and leave their loved ones behind. They are often left feeling bewildered, wondering why their relationship with the person was not enough to keep them from taking their lives.[43] One survivor told us that when she had shared her own suicidal ideation with her sister, her sister made her promise to never act upon her suicidal thoughts. When her sister took her own life, this survivor not only felt abandoned, but she also felt deceived. She felt angry about this perceived deception, she felt angry for being left behind to deal with life's stresses without her sister, and she felt angry that her sister put her and her family through the pain of dealing with her death by suicide. She was now alone.

Certain characteristics of suicide bereavement that are qualitatively different from other forms of bereavement may lead to delays in survivors' healing.

Suicide bereaved spouses often struggle because the marriage may be the most intimate relationship an individual ever experiences, and to be left by a self-inflicted death can feel like the ultimate form of

Complicated Grief *continued on next page*

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rejection.[44] Children who lose their parents to suicide are left to feel that the person whom they count on the most for the most basic needs has abandoned them.[45,46] Results of one study suggest that children whose parents completed suicide and had an alcohol-use disorder were less likely to feel guilty or abandoned, and suicide bereaved spouses whose partners had an alcohol-use disorder were more likely to react with anger than other suicide bereaved spouses.[47]

Anger is a common emotion among many survivors of suicide. It can be experienced as anger at the person who died, at themselves, at other family members or acquaintances, at providers, at God, or at the world in general. Often survivors feel angry at themselves for feeling angry, as they also recognize that the deceased was suffering greatly when deciding to die. Survivors may also feel angry towards other family members or mental health providers for not doing more to prevent the death and angry towards the deceased for not seeking help. A few survivors told us that their loved ones took their lives after a shameful behavior was revealed and/or in the midst of strained relationships. Survivors under these circumstances often feel anger at the deceased for depriving them of the opportunity to work through the difficult time or for not taking responsibility for their behavior.

Stigma

Unlike other modes of death, suicide is stigmatized, despite recent valiant strides to destigmatize mental illness and suicide. Many bereaved individuals report that it can be difficult to talk to others about their loss because others often feel uncomfortable talking about the suicide. This can leave the bereaved feeling isolated.[48] The feeling of being unable to talk about the death is often compounded by the perceived need to conceal the cause of death. At times, other people's belief systems, including that of the survivors themselves, can be a barrier to accepting the death and a deterrent to talking about it. When coping with a loss, people often turn to religion for comfort and guidance. A challenge for some survivors is that several religions impose shameful restrictions on the grief rituals for those who have been bereaved by suicide. Suicide survivors face additional logistical barriers when handling the deceased's business after a suicide, as most insurance policies even have clauses with built-in stigma.[49] Despite alarmingly high rates of suicides in the United States military, it was only until very recently (July 6, 2011) that the United States Government began to honorably acknowledge the bereaved after a military suicide, as is done for other deaths that occur in combat zones. For many people, talking about their loved ones is vital for their recovery from their loss. The stigma of suicide poses a barrier to the healing process.[37]

Trauma

Survivors of suicide are more likely than other bereaved individuals to develop symptoms of PTSD.[50] The majority of suicide methods involve considerable bodily damage. Occasionally, survivors are witnesses to the final act, or the first to discover the dead body. Those left to find the deceased's body struggle to get the gruesome images of out of their minds.[51] In such circumstances, traumatic distress, marked by fear, horror, vulnerability,

For many people, talking about their loved ones is vital for their recovery from their loss. The stigma of suicide poses a barrier to the healing process.

and disintegration of cognitive assumptions ensues. One survivor told us the poignant story of her boyfriend, who immediately after a breakup, climbed to a nearby bridge and leaped to his death while she looked on in horror. Not unexpectedly, her grief was replete with such trauma symptoms as preoccupation with reminders, terror-filled recollections, avoidance of high places, and other reminders. After a death by suicide, themes of violence, victimization, and volition (i.e., the choice of death over life, as in the case of suicide) are common and may be intermixed with other aspects of grief. Disbelief, despair, anxiety symptoms, preoccupation with the deceased and the circumstances of the death, withdrawal, hyper arousal, and dysphoria are more intense and more prolonged than they are under nontraumatic circumstances.[52]

Suicide risk in survivors

Suicide and mental illness runs in families, likely a result of both heritability and environmental factors.[7,8] Survivors of suicide may be left to struggle with their

own suicidal ideation, while seeing that the deceased escaped the anguish and put an end to their suffering. Despite the fact that the suicide bereaved intimately understand the intense pain and suffering experienced by all those who survive a suicide loss, survivors are at higher risk themselves for suicidal ideation and behavior than are other bereaved individuals.[53,54] Crosby and Sacks[55] reported that people who had known someone who died by suicide in the last year were 1.6 times more likely to have suicidal thoughts, 2.9 times more likely to have a plan for suicide, and 3.7 times more likely to have made a suicide attempt themselves. The pain of dealing with the loss of a loved one by suicide coupled with shame, rejection, anger, perceived responsibility, and other risk factors, can be too much to bear, and to some, suicide seems like the only way to end the pain. Some may feel closer to their loved one by taking their life in the same way. Indeed, a survivor told us of how her mother's death by suicide was so difficult to bear for her sister who, like her father, also struggled with bipolar disorder, that her sister completed suicide in the exact same way the following year, on the same date, at the same time. Finally, as with other types of losses, yearning for a loved one can be so intense, that the desire to join the loved one in death can be overwhelming.

Complicated grief in survivors of suicide

While research results are mixed regarding whether grief differs by mode of death,[43] data suggest that the incidence of CG is high among survivors of suicide, as survivors of suicide loss are at higher risk of developing CG.[11,19] Specifically, Mitchell and colleagues[57] reported that the rate of CG was 43% among their pilot study population of 60 Caucasian, Christian, employed, mostly female suicide bereaved participants grieving a total of 16 deaths collectively. This is at least double the rates of up to 10% to 20% of CG reported in the general population.[17,18] Further, Mitchell and colleagues report that suicide survivors closely related to the deceased experience rates of complicated grief at twice the level as friends, coworkers, and relatives (57% to 80% vs 14% to 28%).

Individuals from that same sample who developed CG were almost 10 times more likely to have reported suicidal ideation one month after the death of their loved ones, controlling for depression.[30] In another sample of participants with CG, suicide bereaved participants reported twice the rate of recurrent and current depression compared with other bereaved individuals, reported higher rates of suicidal ideation before the death, and were at least as likely to report suicidal ideation since the death as other bereaved participants suffering from complicated grief.[58] Finally, Latham and Prigerson found that CG is associated with higher levels of suicidal ideation independent of PTSD and depression.[29]

One study[49] suggests that three to five years is the time point at which grief after a suicide loss begins to integrate, raising the question of how the time frame used in discussions of normal and integrated grief applies to grief after suicide, and therefore what is the "normal" timeline for grief after suicide. That said, in at least one sample studied,[59] symptoms of traumatic grief six months after a peer suicide predicted the onset of depression or PTSD at subsequent timepoints. Therefore, it is important for clinicians to know how to identify traumatic grief in order to provide appropriate support and treatment when needed.

TREATMENT

Considering that grief is a normal, adaptive response to loss, noncomplicated grief that is not comorbid with depression does not warrant any formal intervention in most circumstances. However, in light of the above delineated stigma, anger, and guilt associated with suicide loss, reassurance, support, and information provided by family, friends, and, sometimes, clergy is often not available or sufficient for survivors of suicide

A complete listing of references is available online

Complicated Grief *continued on next page*

Complicated Grief *continued from previous page*

loss. Although there exists a paucity of treatment studies in survivors of suicide,[60] most experts agree that: (i) initial attention should be focused on traumatic distress; (ii) self-help support groups can be beneficial; and (iii) there is a role for both pharmacotherapy and psychotherapy in those already showing adverse mental health effects or at high risk for severe and persistent difficulties.[37,61]

Support groups

While few survivors seek help,[62] many survivors who attend support groups find them to be at least moderately helpful,[63] particularly survivors who either do not have adequate social support in the family or immediate community, or who are unable to access friends or acquaintances because of stigma or other roadblocks.[64] For many survivors, participation in support groups is felt to be their only access to people who they feel can understand them, or the only place where their feelings are acceptable, thus providing them with their only means of catharsis. The universality of their experiences provides great reassurance that they are not alone in their feelings and that others have faced similar experiences and have come out not only intact but often stronger. The bonds that develop among people can be very strong as they join a club whose "dues" are high and as they offer each other mutual support. Through such supports, individuals may receive helpful suggestions for taking care of real-life obligations such as dealing with estates and legal issues: talking to others, including children; developing fitting memorials for the deceased; coping with holidays and special events; and setting realistic goals for one's new life which now has such a huge and unfillable void.

Common components of successful support groups include providing accurate information, permission to grieve, normalization of affects and behaviors that may be totally out of keeping with the person's usual state, and most important, conveying to survivors that they are not alone. Often it is helpful to see others who have "survived" the suicides of their own loved ones, and eventually it may even be helpful to have the opportunity to help others. Support groups that are relatively homogeneous (e.g., suicide survivors rather than any bereaved, or those who have lost children rather than other losses) are often the most helpful.[35] Survivors of suicide loss groups may also be particularly effective for children who have lost a parent or family member by suicide.[61]

Survivors can locate support groups on Web sites belonging to groups such as the American Foundation for Suicide Prevention (AFSP) and the American Association of Suicidology (AAS) which host directories of over 400 suicide support groups throughout the United States. To locate support groups worldwide, survivors can visit the Web site of the the International Association for Suicide Prevention (IASP), an organization officially affiliated with the World Health Organization. With membership in over 50 countries across the globe, the IASP postvention (suicide bereavement) taskforce offers a multitude of resources to survivors including survivor guides, 24/7 helplines for people of all age groups including child survivors, and does so in multiple languages. Some survivors are wary of groups and may prefer individual counseling or family therapy, indeed suicide has a profound effect on the entire family,[11,37] or even Web-based support groups or

Often it is helpful to see others who have "survived" the suicides of their own loved ones, and eventually it may even be helpful to have the opportunity to help others.

A complete listing of references is available online

bibliotherapy.[64-67] These same organizations also sponsor organized survivors' events such as suicide prevention walks and survivors of suicide days, but too few people know about the events and some may find it difficult to go to their first event unless they go with support of a friend of a family member. Many survivors who attend these events extol their benefits and comment on the sense of belonging, of being part of a larger community, and of non judgmental acceptance that they experience.

Suicide bereavement comorbid with depression or post-traumatic disorder

For survivors whose loss has triggered a depressive episode or PTSD, support groups often are not enough. Many clinicians avoid prescribing medication or formal psychotherapy even in the face of a full major depressive syndrome or PTSD, falsely rationalizing that depressive and trauma symptoms are normal in the face of loss and that treatment might "interfere" with the grieving process. But studies have shown that appropriate treatment for these symptoms is indicated and efficacious.[68-70] Thus, if a suicide survivor is experiencing a Major Depressive Disorder (MDD) or PTSD, the clinician should consider medications and/or psychotherapy as indicated for these clinical conditions.

Clinicians often are unclear as to both if, and when, to initiate treatment. As in other, non-bereavement instances of MDD, the decision rests on various factors, including the severity, intensity, and pervasiveness of symptoms, comorbidities, past history of MDD, previous outcomes to treatments, safety, and patient preferences. A second decision point regards how to treat comorbid psychiatric conditions. At present, there is no single form of psychotherapy and/or antidepressant medication ready to be hailed as the treatment of first choice for MDD or PTSD in the context of suicide bereavement.[15] However, there is no reason to suspect that psychotherapy should not be as effective, either alone or in combination with medications, as it is in other, non-bereavement or non-suicide-related instances of MDD or PTSD. Meanwhile, several studies document the effectiveness of antidepressant medications for bereavement-related depression.[68-74] All classes of antidepressant medications are about equally effective, but differences in their side effect profiles usually dictate which medication is best suited for an individual patient. The authors recommend following American Psychiatric Association Treatment Guidelines[75] for the treatment of depression and PTSD and providing an integrative approach based on the individual's needs, resources and availability of treatment, that incorporates support, education, cognitive and interpersonal techniques, psychodynamic principles, grief-specific strategies, bright light, exercise, and cutting-edge medication management.[76]

Suicide bereavement and complicated grief

As previously outlined, survivors of suicide loss are at increased risk of developing CG. Without treatment, CG symptoms follow an unrelenting course. The effectiveness and role of pharmacologic management of CG are not yet established, but the literature suggests preliminary promise for the use of bupropion[69] and escitalopram.[77,78]

Although not specific to suicide bereavement, studies support the use of cognitive behavioral therapy (CBT),[79,80] time-limited interpretive group therapy,[81,82] and complicated grief therapy[83] for the treatment of CG. Complicated grief treatment (CGT) is a modification of interpersonal psychotherapy, adding elements of cognitive behavioral therapy, exposure, gestalt, and motivational interviewing. The basic principle underlying CGT is that acute grief will transition instinctively to integrated grief if the complications of the grief are addressed and the natural mourning process is supported. Each session includes loss-focused grief work as well as restoration-focused attention. The loss-focused grief work aids the bereaved in accepting the loss, talking about the death and surrounding events, starting to take pleasure and comfort in memories of the loved one, and feeling a deep sense of connection with the deceased. It uses imagery and other exercises that resemble exposure techniques coupled with cognitive restructuring. The restoration-focused work helps the person become free to pursue personal goals, engage in meaningful relationships with others, and experience satisfaction and enjoyment. Studies support the robust efficacy of CGT for the treatment of complicated grief, even in situations of great severity, chronicity, and comorbidity.[83-85]

When complicated grief occurs in the context of suicide bereavement, the psychiatric and psychological literature provide few, if any, empirically based guidelines.[62,86] It is not unlikely that the CGT described above may be beneficial for many suicide survivors with CG, but the therapy may need to be modified to provide more emphasis on the recurrent themes of suicide bereavement: the quest to understand why, guilt,

Complicated Grief *continued on next page*

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rejection, shame, anger, and stigma. The role of medications is not at all clear, but since there is some evidence that medications may be of benefit in non-suicide-related CG, pharmacotherapy may also be helpful to suicide survivors with CG. Since CG often co-occurs with MDD and PTSD, attention to these disorders may also be necessary; for example, depression focused psychotherapy, antidepressant medication, and prolonged exposure[51] may be indicated in specific situations as an adjunct to CGT, as an alternative to CGT, or if therapy does not result in an optimal outcome. While research suggests that it is the exposure component of CGT that is the essence of its effectiveness,[87] whether or not this level of exposure therapy is sufficient to treat suicide survivors with or without CG and/or PTSD remains to be explored. More research on the needs of suicide survivors, including individualized treatment approaches for unique patient profiles, is badly needed.[60]

CONCLUSIONS

Suicide survivors face unique challenges that can impede the normal grieving process, putting survivors at increased risk for developing complicated grief, concurrent depression, PTSD, and suicidal ideation. If left untreated, these conditions can lead to prolonged suffering, impaired functioning, negative health outcomes, and can even be fatal. Because of the stigma associated with suicide, survivors may feel they are unable to secure enough support from friends or family, but may benefit from attending support groups with other survivors who uniquely share their experiences and offer a haven for survivors to feel understood. Because suicide survivors are at higher risk for developing PTSD and complicated grief and may be more susceptible to depression, it is important for survivors and clinicians to be mindful of and address troubling symptoms should they occur. Treatment should include the best combinations of education, psychotherapy, and pharmacotherapy, often with a focus on depression, guilt, and trauma. While the field of suicide bereavement research is growing, there remains a need for more knowledge on the psychological sequelae of suicide bereavement and its treatment in general, and particularly among the elderly, those with pre-existing mental illnesses, men, and minorities.[88]

A complete listing of references is available online

Community Spirit s

Mike Kymalainen and his friends chose to raise funds for the Cr by participating in a special golf tournament in Campbell River as they honoured their friend Sam.

*Emily Post and Elizabeth Newcombe joined o Pettenuzo to thank them on the occasion of presentation of its annual Disc Golf Jambore also helped increase awareness of our **Schoo** receiving a generous donation by CIBC empl portion of their wages to the Crisis Society th*

CIBC
CIBC CHILDREN'S FOUNDATION
Helping Kids Rise Above

shines despite a most challenging year!

isis Society

rganizers Alex Austin and Dave
Odd Fellows Columbia Lodge 2
e fundraising event. The Odd Fellows
l-Based Programs, resulting in our
oyees who generously contributed a
rough the CIBC Children's Foundation.

The Pacific Blue Cross Health Foundation donated very generously to 10 Crisis Line agencies in BC this year, including the Vancouver Island Crisis Society, to help increase mental health support during the pandemic.

British Columbia's #1 health benefits provider.

PACIFIC BLUE CROSS

NanaimoNews NOW Everything Nanaimo!

We can't say enough about the ongoing promotional services provided by the eight Vancouver Island radio stations of The Jim Pattison Broadcast Group, with online promotion by Nanaimo News Now this year.

The wonderful team at Intraworks continued to rise to the occasion to support the Crisis Society. This year, they ensured all went well as we worked from both our homes and our administrative office.

VANISLE 460K/100K SOULS IN MOTION 2020

Our President, Anita Rosewall Peters, thanks Virtual Race Directors Lisa and Josh and the many participants who ran the VanIsle 460 and 100 for their contribution of time, athleticism, and funds so that we can keep on "Helping People Find Their Way."

anada

The Vancouver Island Crisis Society received a much appreciated grant from the Government of Canada's Emergency Community Support Fund and Nanaimo Foundation.

ASIST
Learn suicide intervention skills

LivingWorks

safeTALK

Applied Suicide Intervention Training Skills (ASIST) is a research-based, two-day, participatory course designed to help caregivers recognize and assess persons at risk, and master a model for effective suicide intervention. ASIST remains the most widely used suicide intervention training program in the world.

Participants learn to:

- Clarify their values and beliefs about suicide
- Enhance their understanding of suicidal behaviour
- Recognize and assess the risk of suicide
- Develop the working knowledge and skills for effective suicide intervention (model presented)
- Talk about suicide and cooperate in sharing info and resources

These workshops are currently facilitated at our Training Centre, following WorkSafeBC's COVID-19 protocols, for a maximum of eight participants. January's workshop is sold out. Upcoming dates:

- **February 18 and 19, 2021**
- **March 18 and 19, 2021**
- **April 22 and 23, 2021**
- **May 20 and 21, 2021**
- **June 24 and 25, 2021**

safeTALK helps participants become alert to suicide. Suicide-alert people are better prepared to connect persons with thoughts of suicide with life-affirming help. safeTALK is designed to complement **ASIST**. Many participants include both safeTALK and ASIST in their suicide prevention kit.

safeTALK participants learn to:

- Notice and respond to situations where thoughts of suicide may be present
- Move beyond the common tendency to miss, dismiss, and avoid suicide
- Apply the TALK steps: Tell, Ask, Listen, KeepSafe

The three- to four- hour safeTALK workshop can be facilitated on its own at your site.

Our COVID-19 safety protocols protect:

Participants attending at our Training Centre

Facilitators presenting at our Training Centre

Participants attending at other locations

Facilitators at other locations

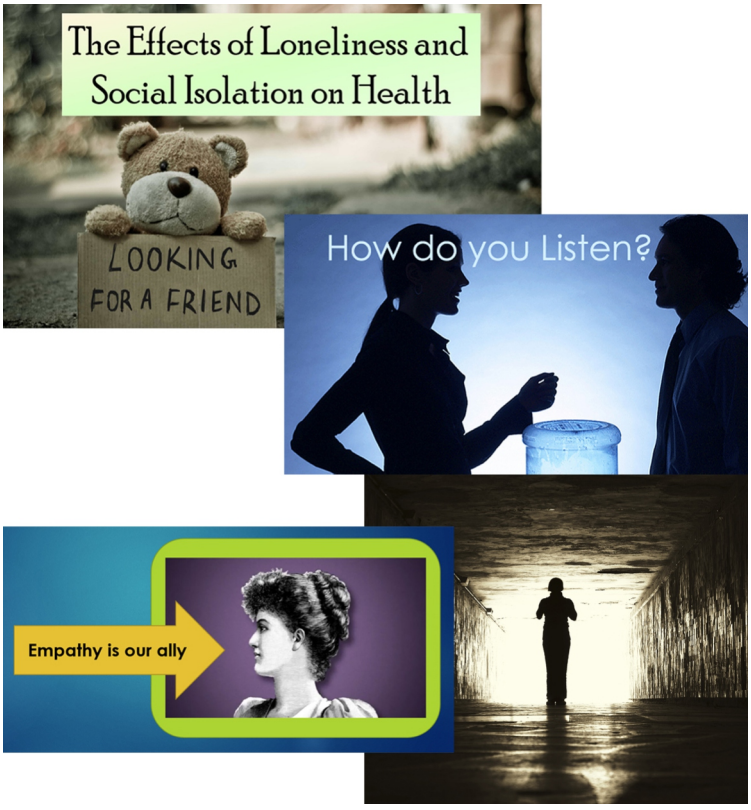
Crisis Intervention Skills Training (CIST), developed by the Vancouver Island Crisis Society, is a two-day, research-based workshop. It was developed to teach a strengths-based approach to the communication, assessment, and suicide response skills essential for crisis intervention.

Participants learn:

- The definitions of crisis
- Trauma-informed practice: How to shift focus from "At Risk" to an "At Promise" perspective
- How to effectively assess crisis situations by applying a crisis intervention model
- How to facilitate the development of a short-term coping plan for a person in crisis
- How to identify persons with thoughts of suicide and connect them to suicide first-aid resources

This workshop is currently facilitated via the Zoom platform to agencies.

It will also be facilitated via Zoom to individual participants on FEBRUARY 9 AND 10, 2021.



CIST
Crisis Intervention Skills Training
©Vancouver Island Crisis Society

We invite you to add this graphic to your website or email. Right-click on the graphic to **Save Image As...** to your hard drive. Insert thegraphic into your website or your email. You can then copy the following link and add it as a hyperlink to the graphic to help others access the community database: https://www.icarol.info/PublicResourceDirectoryFrm.aspx?org=2114

Our Series of Three-Hour Workshops

The workshops listed have been developed by the Vancouver Island Crisis Society.

- Supporting the Resilience of Suicide Loss Survivors
- Crisis, Compassion and Boundary Setting
- Brain Injury and Suicide
- Creating New Conversations: What Attempt Survivors have to say
- How to Avoid The 10 Most Common Errors in Suicide Prevention
- Communication in the Workplace
- The Effects of Loneliness and Social Isolation on Health
- Men, Mental Health, and Suicide
- Recognizing and Responding to Mental Distress

Contact us to arrange a custom workshop created specifically for your group's needs at 250-753-2495, toll free at 1-877-753-2495, or via email at info@vicrisis.ca

These workshops are currently facilitated via the Zoom online platform.

Turning "Fineness" into "Wellness"—Strengt

by Lyndsay Wells
Community Education Program Coordinator

Sometimes. it takes a medical crisis to wake up to an underlying health condition. For example, someone with a diagnosis of early diabetes will probably need to make some lifestyle changes in order to not only survive the diagnosis but also to thrive beyond it. We understand that the efforts we put into staying physically healthy give us a heightened opportunity for better health and the same need apply to our mental health. Now, with the world in the midst of a global pandemic, it becomes that much more important to understand the totality of our health—that it extends beyond the aches and pains of the body to the aches and pains of the mind.

And yet, inexplicably, there still remains a hesitancy to address these aches and pains of the mind because they are still largely invisible for a lot of people. Even in a pandemic, it seems the larger part of our community is doing just "fine."

But what if this isn't really the case? What if we looked beneath the surface of our own "fineness" and the "fineness" of others and made a determined commitment to turn "fineness" into "wellness?"

What would that look like?

An easy way to do this is to write two lists:

1. Things that negatively affect my mental health
2. Things that positively affect my mental health

The more things we can think of to add to List 2, and the more things we are ready, willing, and able to remove from List 1, will have an impact on the way we think and feel. Instead of passively going through our days in a state of hazy fineness, we can take back our own power and manage our mental health.

In our school program **COPE**, we call this "strengthening our coping muscles"—just like when you go to the gym, by actively managing our own mental health, we learn how to strengthen our resilience and find peace and contentment in the midst of life's storms. That is wellness: Understanding that we can't always quell the storms around us, but we always have the power to go within and look after ourselves. Positive self-talk, healthy relationships and connections, activities we enjoy doing, reaching out for help and support on the bad days, getting some fresh air and exercise, having a good laugh or a good cry—these are all things we can do for ourselves.

The World Health Organization has published an excellent set of guidelines for strengthening and supporting our mental health during these uncertain times. We invite you to read this and think about implementing some of the suggestions for your own mental wellness management plans.

Mental health and psychosocial considerations during the COVID-19 outbreak

18 March 2020

In January 2020 the World Health Organization (WHO) declared the outbreak of a new coronavirus disease, COVID-19, to be a Public Health Emergency of International Concern. WHO stated thatthere is a high risk of COVID-19 spreading to other countries around the world. In March 2020, WHO made the assessment that COVID-19 can be characterized as a pandemic.

WHO and public health authorities around the world are acting to contain the COVID-19 outbreak. However, this time of crisis is generating stress throughout the population. The considerations presented in this document have been developed by the WHO Department of Mental Health and Substance Use as a series of messages that can be used in communications to support mental and psychosocial well-being in different target groups during the outbreak.

Messages for the general population

1. COVID-19 has and is likely to affect people from many countries, in many geographical locations. When referring to people with COVID-19, do not attach the disease to any particular ethnicity or nationality. Be empathetic to all those who are affected, in and from any country. People who are affected by COVID-19 have not done anything wrong, and they deserve our support, compassion and kindness.

hening our mental health during times of crisis

2. Do not refer to people with the disease as "COVID-19 cases", "victims" "COVID-19 families" or "the diseased". They are "people who have COVID-19", "people who are being treated for COVID-19", or "people who are recovering from COVID-19", and after recovering from COVID-19 their life will go on with their jobs, families and loved ones. It is important to separate a person from having an identity defined by COVID-19, in order to reduce stigma.

3. Minimize watching, reading or listening to news about COVID-19 that causes you to feel anxious or distressed; seek information only from trusted sources and mainly so that you can take practical steps to prepare your plans and protect yourself and loved ones. Seek information updates at specific times during the day, once or twice. The sudden and near-constant stream of news reports about an outbreak can cause anyone to feel worried. Get the facts; not rumours and misinformation. Gather information at regular intervals from the **WHO website** and local health authority platforms in order to help you distinguish facts from rumours. Facts can help to minimize fears.

World Health Organization

4. Protect yourself and be supportive to others. Assisting others in their time of need can benefit both the person receiving support and the helper. For example, check by telephone on neighbours or people in your community who may need some extra assistance. Working together as one community can help to create solidarity in addressing COVID-19 together.

5. Find opportunities to amplify positive and hopeful stories and positive images of local people who have experienced COVID-19. For example, stories of people who have recovered or who have supported a loved one and are willing to share their experience.

6. Honour carers and healthcare workers supporting people affected with COVID-19 in your community. Acknowledge the role they play in saving lives and keeping your loved ones safe.

Messages for healthcare workers

7. Feeling under pressure is a likely experience for you and many of your colleagues. It is quite normal to be feeling this way in the current situation. Stress and the feelings associated with it are by no means a reflection that you cannot do your job or that you are weak. Managing your mental health and psychosocial well-being during this time is as important as managing your physical health.

8. Take care of yourself at this time. Try and use helpful coping strategies such as ensuring sufficient rest and respite during work or between shifts, eat sufficient and healthy food, engage in physical activity, and stay in contact with family and friends. Avoid using unhelpful coping strategies such as use of tobacco, alcohol or other drugs. In the long term, these can worsen your mental and physical well-being. The COVID-19 outbreak is a unique and unprecedented scenario for many workers, particularly if they have not been involved in similar responses. Even so, using strategies that have worked for you in the past to manage times of stress can benefit you now. You are the person most likely to know how you can de-stress and you should not be hesitant in keeping yourself psychologically well. This is not a sprint; it's a marathon.

Mental health guidelines *Continued on next page*

Mental health and psychosocial considerations during the COVID-19 outbreak

Continued from previous page

9. Some healthcare workers may unfortunately experience avoidance by their family or community owing to stigma or fear. This can make an already challenging situation far more difficult. If possible, staying connected with your loved ones, including through digital methods, is one way to maintain contact. Turn to your colleagues, your manager or other trusted persons for social support—your colleagues may be having similar experiences to you.
10. Use understandable ways to share messages with people with intellectual, cognitive and psychosocial disabilities. Where possible, include forms of communication that do not rely solely on written information.
11. Know how to provide support to people who are affected by COVID-19 and know how to link them with available resources. This is especially important for those who require mental health and psychosocial support. The stigma associated with mental health problems may cause reluctance to seek support for both COVID-19 and mental health conditions. The **mhGAP Humanitarian Intervention Guide** includes clinical guidance for addressing priority mental health conditions and is designed for use by general healthcare workers.

Messages for team leaders or managers in health facilities

12. Keeping all staff protected from chronic stress and poor mental health during this response means that they will have a better capacity to fulfil their roles. Be sure to keep in mind that the current situation will not go away overnight and you should focus on longer-term occupational capacity rather than repeated short-term crisis responses.
13. Ensure that good quality communication and accurate information updates are provided to all staff. Rotate workers from higher-stress to lower-stress functions. Partner inexperienced workers with their more experienced colleagues. The buddy system helps to provide support, monitor stress and reinforce safety procedures. Ensure that outreach personnel enter the community in pairs. Initiate, encourage and monitor work breaks. Implement flexible schedules for workers who are directly impacted or have a family member affected by a stressful event. Ensure that you build in time for colleagues to provide social support to each other.
14. Ensure that staff are aware of where and how they can access mental health and psychosocial support services and facilitate access to such services. Managers and team leaders are facing similar stresses to their staff and may experience additional pressure relating to the responsibilities of their role. It is important that the above provisions and strategies are in place for both workers and managers, and that managers can be role-models for self-care strategies to mitigate stress.
15. Orient all responders, including nurses, ambulance drivers, volunteers, case identifiers, teachers and community leaders and workers in quarantine sites, on how to provide basic emotional and practical support to affected people using **psychological first aid**.
16. Manage urgent mental health and neurological complaints (e.g. delirium, psychosis, severe anxiety or depression) within emergency or general healthcare facilities. Appropriate trained and qualified staff may need to be deployed to these locations when time permits, and the capacity of general healthcare staff capacity to provide mental health and psychosocial support should be increased (see the mhGAP Humanitarian Intervention Guide).
17. Ensure availability of essential, generic psychotropic medications at all levels of health care. People living with long-term mental health conditions or epileptic seizures will need uninterrupted access to their medication, and sudden discontinuation should be avoided.

Messages for carers of children

18. Help children find positive ways to express feelings such as fear and sadness. Every child has his or her own way of expressing emotions. Sometimes engaging in a creative activity, such as playing or drawing can facilitate this process. Children feel relieved if they can express and communicate their feelings in a safe and supportive environment.
19. Keep children close to their parents and family, if considered safe, and avoid separating children and their careers as much as possible. If a child needs to be separated from his or her primary carer, ensure that appropriate alternative care is provided and that a social worker or

equivalent will regularly follow up on the child. Further, ensure that during periods of separation, regular contact with parents and carers is maintained, such as twice-daily scheduled telephone or video calls or other age-appropriate communication (e.g. social media).

20. Maintain familiar routines in daily life as much as possible, or create new routines, especially if children must stay at home. Provide engaging age-appropriate activities for children, including activities for their learning. Where possible, encourage children to continue to play and socialize with others, even if only within the family when advised to restrict social contact.

21. During times of stress and crisis, it is common for children to seek more attachment and be more demanding on parents. Discuss COVID-19 with your children in an honest and age-appropriate way. If your children have concerns, addressing them together may ease their anxiety. Children will observe adults' behaviours and emotions for cues on how to manage their own emotions during difficult times. Additional advice is available here.

Messages for older adults, people with underlying health conditions and their carers

22. Older adults, especially in isolation and those with cognitive decline/dementia, may become more anxious, angry, stressed, agitated and withdrawn during the outbreak or while in quarantine. Provide practical and emotional support through informal networks (families) and health professionals.

23. Share simple facts about what is going on and give clear information about how to reduce risk of infection in words older people with/without cognitive impairment can understand. Repeat the information whenever necessary. Instructions need to be communicated in a clear, concise, respectful and patient way. It may also be helpful for information to be displayed in writing or pictures. Engage family members and other support networks in providing information and helping people to practise prevention measures (e.g. handwashing, etc.).

24. If you have an underlying health condition, make sure to have access to any medications that you are currently using. Activate your social contacts to provide you with assistance, if needed.

25. Be prepared and know in advance where and how to get practical help if needed, like calling a taxi, having food delivered and requesting medical care. Make sure you have up to two weeks of all your regular medicines that you may require.

26. Learn simple daily physical exercises to perform at home, in quarantine or isolation so you can maintain mobility and reduce boredom.

27. Keep regular routines and schedules as much as possible or help create new ones in a new environment, including regular exercising, cleaning, daily chores, singing, painting or other activities. Keep in regular contact with loved ones (e.g. via telephone, e-mail, social media or video conference).

Messages for people in isolation

28. Stay connected and maintain your social networks. Try as much as possible to keep your personal daily routines or create new routines if circumstances change. If health authorities have recommended limiting your physical social contact to contain the outbreak, you can stay connected via telephone, e-mail, social media or video conference.

29. During times of stress, pay attention to your own needs and feelings. Engage in healthy activities that you enjoy and find relaxing. Exercise regularly, keep regular sleep routines and eat healthy food. Keep things in perspective. Public health agencies and experts in all countries are working on the outbreak to ensure the availability of the best care to those affected.

30. A near-constant stream of news reports about an outbreak can cause anyone to feel anxious or distressed. Seek information updates and practical guidance at specific times during the day from health professionals and WHO website and avoid listening to or following rumours that make you feel uncomfortable.

Stay informed

- Find the latest information from WHO on **where COVID-19 is spreading**
- **Advice** and guidance from WHO on COVID-19
- Addressing **social stigma**
- Briefing note on **addressing mental health and psychosocial aspects of COVID-19**

WHO reference number: WHO/2019-nCoV/MentalHealth/2020.1

What it stands for

Communication: What does it mean to COPE? Becoming aware of how we speak to ourselves and the ways we think about ourselves can teach us how to be our own best friend.

Options: What are options? Exploring internal and external options. Exploring indfulness, self-care, self-compassion.

Perspective: Tools for handling overthinking, worry, and anxiety. Learning how to put things back into perspective for themselves and see the gifts in difficult times.

Enjoy Life: Finding a sense of calm or peacefulness even when one is going through a hard time. Creating intentional happiness.

COPE is available online

COPE is now offered in an optional online format. This gives families and schools across Vancouver Island access to life-affirming activities and information in support of personal resilience and mental health.

Parents, caregivers, and teachers are encouraged to participate in the program alongside young learners in order to generate further conversation. To more easily facilitate this, the Crisis Society has also created an activity booklet entitled **Action Plans for Coping (After-COPE Activity Guide)**, that students will be encouraged to work on in between sessions and after the program's conclusion. A **COPE Discussion Guide** is also available for educators and parents.

It's all in the video!

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