Practical support in everyday care

When someone's body won't settle

Understand what may be happening

Restlessness, tension and difficulty settling can have physical, emotional, environmental or medication-related causes. Ask about discomfort and what feels difficult now; do not assume anxiety is the explanation.

Consider what can be changed

Check noise, lighting, temperature, crowding, interruptions, privacy, seating and opportunities to move. Ask whether a different space or familiar supporter would feel better. Address avoidable restrictions or confusing routines where possible. Consider whether staff proximity, repeated instructions or frustrated responses are adding pressure; seek colleague support or reflection where needed.

Offer practical support

Help the person find a comfortable place, obtain water or other necessities, or communicate a concern to the appropriate clinician. Listen and provide space without requiring an explanation. Quiet, attentive presence can be useful without adding an activity.

Explore something together

If wanted, offer a comfortable walk or accessible movement, personally chosen music, a familiar hands-on activity, or an optional relaxation exercise. Ask what has helped before. Any sensory resource should be chosen with the person, not imposed.

Choice and safety

Avoid unwanted touch, forced breathing, or using activities to secure compliance. New, severe or unusual physical symptoms, significant changes in behaviour, or possible medication-related restlessness warrant appropriate assessment; urgent symptoms require urgent care.

Possible invitation: “Would changing the space help, or would you prefer me to stay here with you?”

Evidence note: Environmental and relational de-escalation is supported by professional guidance (NICE NG10; Helsedirektoratet; NHS England). Sensory modulation has practice guidance (Te Pou), but specific informal activities have

variable and often indirect evidence. Do not claim they prevent aggression or restraint.

When someone is caught in thoughts or worries

Understand what may be happening

Ask whether there is an unanswered question, a practical uncertainty, something the person wants to discuss, or something they would rather not discuss. Repetitive thoughts are not always ordinary worry.

Consider what can be changed

Reduce conflicting messages, unnecessary interruptions and uncertain arrangements. Identify whether a clear answer, a predictable follow-up or a change in the care process would address a real concern.

Offer practical support

Listen without immediately correcting or challenging thoughts. Help obtain accurate information, note a question for a professional, or work through one solvable concern. Explain information in manageable parts and check understanding respectfully. Build on what the person has already shared and avoid asking them to repeat their story unnecessarily.

Explore something together

If the person wishes, write down one concern they want remembered, tackle one practical task, or spend time on a familiar activity. A later conversation can be agreed where appropriate; do not use postponement to dismiss urgent needs.

Choice and safety

Do not insist on distraction, offer blanket reassurance, or attempt psychotherapy without the appropriate role and competence. Significant confusion, changes in thinking, severe distress, impaired functioning or safety concerns require appropriate assessment. Repeated reassurance may be unhelpful in some compulsive patterns, but ordinary comfort and accurate information should not be withheld automatically.

Possible invitation: “Would it help to talk, find an answer to something, or do something else together for a while?”

Evidence note: NICE CG113 and CG31 support structured clinical interventions and caution around compulsive reassurance; AHRQ guidance supports checking that healthcare information has been explained clearly; Canadian recovery-oriented guidance supports partnership. None establishes informal distraction as treatment for rumination.

When everything feels too much

Understand what may be happening

Find out which demands, uncertainties or responsibilities are pressing now. Overload may reflect practical hardship, inaccessible services, illness or institutional pressures—not a lack of coping skills.

Consider what can be changed

Reduce avoidable interruptions, conflicting instructions and unnecessary decisions. Clarify priorities, adjust schedules where possible, and ask whether the service can remove or share a burden.

Offer practical support

Help with an appointment, form, transport arrangement, communication or another task the person chooses. Coordinate with colleagues so the person does not have to repeat information unnecessarily. Consider whether staff or service expectations can be changed rather than asking the person to carry the whole burden. Explain one thing at a time.

Explore something together

Sort immediate needs from things that can wait, complete one manageable part of a task, or take a break if the person wants one. A plan should reduce demands, not become another assignment.

Choice and safety

Do not take over decisions without appropriate authority or consent. Respect privacy and professional boundaries. Escalate unmet essential needs, safeguarding concerns or serious risks through the relevant pathway. Do not frame structural problems as individual failure.

Possible invitation: “What could I take care of or make easier right now?”

Evidence note: NICE NG197, Australian national healthcare standards, Canadian recovery-oriented guidance and NHS England support understandable communication, partnership and attention to service-related burdens. Specific burden-reduction actions are practical adaptations, not validated treatments for overwhelm.

When someone feels low or withdrawn

Understand what may be happening

Withdrawal, low energy and reduced participation can have many causes, including physical illness, pain, fatigue, grief, medication effects, fear and personal preference. Ask what matters to the person rather than assuming they lack motivation.

Consider what can be changed

Address barriers to participation: inaccessible activities, lack of materials, transport, pain, excessive expectations or unsuitable timing. Make room for rest and privacy. Being quietly present can be enough; do not require activity to demonstrate progress.

Offer practical support

Offer companionship, help with food and drinks or ordinary routines, and support contact with trusted people if wanted. Make familiar interests easier to access without setting participation targets. Let the person decide what is meaningful, including when they prefer rest.

Explore something together

Offer a small, personally meaningful option: preparing a drink, listening to chosen music, gardening, creative work, time outdoors or accessible movement. Participation might mean choosing, watching, helping briefly or simply being present.

Choice and safety

Do not treat refusal as failure or participation as proof of improvement. Marked changes in functioning, inability to meet basic needs, concerning physical symptoms or self-harm and suicide concerns require appropriate assessment and response.

Possible invitation: “Would you like some company, or is there something small you'd like us to do together?”

Evidence note: Structured behavioural activation has evidence for depression (NICE NG222; Cochrane Uphoff et al., 2020), but informal shared activities are not equivalent to therapy. Helsedirektoratet and Canadian recovery-oriented guidance support meaningful activity and personally defined goals.

Something has happened

Understand what may be happening

After frightening, upsetting or life-changing events, people may need different kinds of help. Do not presume a particular emotional reaction, diagnosis or wish to talk. Bereavement deserves respect for individual, cultural and spiritual practices. Never expect someone to find a positive meaning in suffering.

Consider what can be changed

Prioritise immediate safety, privacy, clear information and access to necessities. Reduce avoidable exposure to distressing circumstances or repeated retelling. Consider whether the service itself needs to change something.

Offer practical support

Help with food, transport, belongings, accommodation, appointments, contact with trusted people or other immediate needs, within your role. Provide clear information about what happens next and arrange appropriate follow-up when useful. Where possible, provide continuity through trusted people rather than repeated retelling.

Explore something together

Offer quiet company, a familiar routine, a practical task or a personally meaningful ritual if the person wants it. Someone who wishes to talk may be listened to; someone who does not should not be pressed.

Choice and safety

Do not require recounting or emotional expression. Do not offer psychologically focused debriefing to prevent or treat PTSD; this does not prohibit ordinary supportive conversations or appropriate post-incident reviews. Be clear about confidentiality limits. Injury, immediate danger, abuse, safeguarding concerns, unmet essential needs or significant mental-health risks require the appropriate emergency, clinical or safeguarding response.

Possible invitation: “Would you like company, or is there something practical I can help with now?”

Evidence note: WHO psychological first aid and NHS Scotland support practical, respectful assistance; NHS England and SAMHSA emphasise trauma-informed care. NICE NG116 advises against psychologically focused debriefing for preventing or treating PTSD, not against ordinary supportive conversations. Psychological first aid should not be claimed to prevent PTSD.