Breaking down barriers:

An estimated 1.2 million Canadian children and youth are affected by mental illness—yet less than 20 per cent will receive treatment

By Tania Haas

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Laura Kent* has worked for the same Toronto-based company for 28 years. She speaks in ear, and you can sense she's smiling when she answers the phone. At work, she signs off her emails with an encouraging “Cheers... Make it a great day.”

Outside the office, for the last 13 years, she’s helped her son make it through his days. He’s an addict, and earlier this year, he was suicidal.

Kent knew her son needed professional help when he was five years old. That’s when he was suspended from kindergarten. Ever since, she and her son have worked with school counselors, teachers, nurses, social workers, pediatricians, psychiatrists, psychologists, non-profit organizations, hospitals and private facilities.

Often waiting for months to be seen, some programs seemed to help, others didn’t. All was diagnosed with a learning disability in elementary school, and by his teens he was self-medicating. This year, the now 18-year-old had his first conflicts with the law. When he called his mother from the police station on his first offence, he told her he wanted to end his life.

“After all those years of therapy and programs, my kid never said something like this,” says Kent. Once informed, the Toronto court immediately set him up with additional mental health professionals eager to support him. He received targeted care he had not experienced up until then. It was a relief, Kent said, though she knew it was an emergency measure.

Kimberley Moran is another Toronto-based mother whose daughter only received suitable medical care when she became concerned. Moran told CBC Radio’s Metro Morning in Toronto that three years ago her daughter revealed she had a sadness that wasn’t going away. Moran felt perplexed because her daughter was a good student who had lots of friends. Their family doctor referred the then 11-year-old to a hospital-based children’s mental health service.

With wait times from nine to 12 months, Moran looked for other options in the community. As time passed without connection to the right program, Moran’s daughter grew so ill her life was at risk. It was only when she was admitted to an acute-care hospital that she got the right care and her condition improved.

Over the next year she received treatment in a community-based children’s mental health centre, in residential treatment, at home and a day treatment program. She returned to school two years later, where Moran says she is doing great. Even still, Moran believes her daughter’s experience did not have to unfold that way.

“The reality is, we got into those services because she became suicidal. Really we need to intervene much earlier,” says Moran, who is the new president of Children’s Mental Health Ontario. “If we weren’t stuck on wait lists, then we wouldn’t have ended up in the emergency room and such intensive and expensive services wouldn’t have been necessary. Primary care, mental health and community agencies must coordinate their efforts to create a seamless path for children and their families.”

Breaking down barriers

Cover story

Promising new program at Sunnybrook

New program at Sunnybrook Health Sciences Centre in Toronto is working to help families avoid scenarios like those experienced by Kent and Moran’s children. Launched earlier this year, the Family Navigation Project offers a call-in and email program that partners clinically-trained health professionals, known as “navigators”, with families of youth who are experiencing mental health and addiction.

The youth’s families and caregivers are connected with a professional who will guide them through the complex mental health care system, and direct them to the right services, at the right time.

“Often, the time spent talking to one of our navigators at intake is the most time parents have spent speaking with a professional about what is going on with their child,” says Dr. Anthony Levitt, medical director and co-founder of the new Family Navigation Project.

Parents or caregivers call or email in, and arrange a meeting with the navigator over the phone. The navigator encourages the parent to share information they feel comfortable sharing, and reviews the matching of the youth and the family. In all cases, the team seeks the youth’s consent to review former psychiatric evaluations, past assessments, discharge notes and other relevant background, if they are available, before making a recommendation.

When relevant, the navigators provide education about mental illness and/or addiction to the family, about how the mental health and addiction system works and about what’s reasonable to expect.

“My life is so much better,” says Kent. “When I was on the phone with one of the staff, I felt like she was hugging me. It felt like she really got in the boat with me. And when things don’t work, they say, ‘Let’s go back to the table.’ They follow up. I don’t feel alone.”

Suicide is prevalent and complex

In Canada, and around the world, suicide is the second leading cause of death in youth (aged 15 to 24) after accidents. In most western countries, youth suicide is most closely related to mental disorders – often depression. According to a 2013 study, an estimated 1.2 million Canadian children and youth are affected by mental illness – yet less than 20 per cent will receive treatment. Roughly 15 per cent of young people report thinking about attempting suicide.

Research indicates actual and attempted suicides differ between age groups, ethnicities, genders, those exposed to trauma, and socioeconomic backgrounds. And the high rates among Canada’s First Nations and LGBTQI youth are particularly concerning. But no community or region is unaffected. As the World Health Organization wrote in a recent report, every suicide is a tragedy, and its impact on families, friends and communities is far-reaching. And it’s all the more challenging because there is not one exact reason.
As Dr. Mark Sinyor, staff psychiatrist at Sunnybrook says, people often seem to be after the “one” root cause of suicide – the thing that made it happen. But suicide in youth, as in adults, is the result of a complex interplay of several factors including mental illness such as depression, an anxiety disorder, psychosis, substance misuse, stress-related life events and a person’s own coping mechanisms. Dr. Stattmar, chief of the Child and Youth Mental Health Collaborative at SickKids, Centre for Addiction and Mental Health (CAMH) and the University of Toronto, adds that impulsivity is a large risk factor. Because of these and other factors, taboo and stigma still persist and many young people do not seek help or aren’t heard when they do. Making it all the more tragic, says Sinyor, because all of these things can get better with treatment.

In recent years, Canadian businesses and community leaders have attempted to diminish the stigma and break the silence. A once-parched field now overflows with suicide and mental health awareness campaigns. As a result, resources are widely available, stigma about mental disorders may be diminishing, and more people are talking.

But according to Dr. Stan Kutcher, Dalhousie University psychiatrist and Sun Life Financial Chair in Adolescent Mental Health, Canada needs more than talk to prevent suicides and suicide attempts. “Awareness without knowledge and understanding is frankly not very useful,” says Dr. Kutcher. Other youth mental health specialists agree.

For Canada to truly address and alleviate youth suicide and suicide attempts, we need more valid and helpful research, clearly demonstrating what works to prevent suicide and what does not work; early intervention programs for youth and parents; and skill building and healthy environments for children and young people to prevent mental distress from escalating to life-threatening levels.

Researching youth and suicide

Canada’s Social Sciences and Humanities Research Council (SSHRAC) and the Canadian Institutes of Health Research (CIHR) are funding a wide breadth of suicide research. Since 2001, the CIHR funded around $32 million for research on suicide among all age groups. The SSHRC could not confirm its exact figure before Hospital News went to print, but its online database states at least $1.68 million has been dedicated to suicide and youth research since 2003.

One recipient of a CIHR grant is Researcher Anne Rhodes PhD at the Suicide Studies Research Unit and the Li Ka Shing Knowledge Institute at St. Michael’s Hospital. She’s optimistic about Canada’s progress in this area. “I feel quite hopeful about the momentum that is building on coordinating our efforts to prevent suicide in Canada,” says Rhodes, who studies sex, gender and youth suicide.

Dr. Stattmar says a national group of clinicians and scientists from across the country, led by clinical epidemiologist Kathryn Bennett at McMaster University, has recently finished a review of the world literature on suicide-prevention programs in young people set to be published in the Canadian Journal of Psychiatry. These findings may influence Canada’s national strategy, yet to be released. According to a spokesperson from the Public Health Agency of Canada, the Federal Framework for Suicide Prevention Act is set to be developed by December 2014.

The U.S., Australia and Britain have had national suicide prevention policies in place for years. More disciplined research needed

Dr. Kutcher says that despite all the work being done, the main issues regarding successful youth suicide prevention have yet to be determined. And, he is concerned that numerous, often commercial, programs that claim to “prevent suicide” have been put into place, although their effectiveness in significantly decreasing youth suicide has not been demonstrated.

“I’d like to see a study demonstrate that a specific program has significantly decreased the number of young people who have died by suicide, as well as the number who made suicide attempts and quantified the amount of health care resources put to reduced suicide attempts,” says Kutcher.

He has little patience for sub-par research that has allowed groups and organizations to sell weak or non-existent data as suicide prevention programs. He feels that these programs can then give false hope to parents and at-risk youth to think that a program is effective, thus leading policy makers off the hook when they are being held accountable for implementing suicide prevention strategies. He is also concerned that some academics hold the standard for evidence of outcomes in suicide prevention too low.

“Sometimes the wish to do something gets in the way of doing the right thing,” says Kutcher. “I would rather see money spent on evaluation to determine whether programs are effective, than money being spent on putting programs into practice that we know either do not or have no idea that they do work in prevention of suicide. The key issue here is, has the intervention been shown to significantly decrease rates of suicide? Because rates of suicidal ideation are so high, a program can decrease those rates but have no impact on decreasing rates of suicide.”

In-school nurses support teens

Dr. Stattmar says there’s good evidence that some school-based programs work by reducing suicidal thoughts and suicide attempts.

Shauna Johnston works in Mississauga Halton high schools through the Community Care Access Centre. She’s a registered nurse with extensive mental health and addictions expertise. In 2012, Ontario hired 144 nurses to work within district school boards to address the needs of students who may have mental health and addictions issues. She supports students, connects them with appropriate programs, educates parents and teachers in how they can create healthier environments and closes the gap between the hospital and the school.

Johnston has been working with adolescents for 12 years. She calls it her “dream job.” “I find that age group to have a ton of energy; they are really curious, lots of great questions, they are excited to take care of their own well-being,” says Johnston. “I see students who are having suicidal thoughts every day. We are here to be the eyes and ears asking students if they are having suicidal thoughts. We support them to get the services they need so that doesn’t become their last choice,” she adds.

Johnston says some students make remarkable changes; for others, the road to recovery can be long and difficult. “I think for students, especially in adolescence, it’s so hard to see that that’s light at the end of the tunnel. As adults, we’ve been on the Earth so much longer. So we’ve had really bad days. But we know that there are good days just behind them. But adolescents haven’t had the luxury for being here years and years to know that this period of sadness is temporary.”

Peer support: You’re not alone

Johnston says peer leaders like Hodgson can have a huge positive impact. “It’s one thing to have the nurse tell you that this is really normal. But she’s kind of old and not really cool. But when someone in your peer group says, you know what, I’ve been there, I can help you with this. That’s much better,” says Johnston.

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Warning Signs of suicide www.difd.com If you see some of the warning signs, or you fear there’s something wrong, take action and ask someone you trust for help. Loss of control in friendships, school, hobbies or part-time job

• Not doing well in class, skipping classes or having problems concentrating
• Taking more risks
• Using more drugs or alcohol
• New or increased self-harm behaviour
• Are more angry, their mood changes quickly or they’re in a “flat” mood
• More fighting with family or friends
• Giving away (or throwing away) their favourite things
• Dark art, poetry or writing
• Saying things like “Everyone will be better without me”, “I wish I were dead” or “I just can’t take it any more”
• They eat or sleep a lot more or a lot less. They don’t take as much time to do things good, do their hair or dress nicely
• Complaining about not feeling well, such as stomach aches, headaches, fatigue, etc.
• Putting themselves down or having a hard time accepting compliments
• Talking about death or suicide, making jokes about suicide like “You’ll miss me when I’m gone”
Next generation of intervention

Dr. Kwame McKenzie, president of the Canadian Mental Health Association Toronto, believes the best approach to changing youth suicide outcomes has three components: changing attitudes, understanding through knowledge, and building skills.

“If you want to make a change, you have to get everyone on the same page and destigmatize this topic. You need to be given enough knowledge about the subject but if you actually want to change things, you have to give them skills. The information is interesting but unless they know what to do with it, you don’t actually change an outcome,” says Dr. McKenzie, who is also the medical director responsible for dual diagnosis, child youth and family and geriatric services and director health equity at CAMH.

Dr. McKenzie would like to see cognitive behavioral therapy (CBT) taught by grade 10 as a coping and life skill, which can help students substantially in later years. He also suggests schools offer the Mental Health Commission of Canada’s mental health first aid course (http://www.mental-healthfirstaid.ca/) as an option for volunteer credit. Or encourage parents to invest in the training course for their teens much like they do with swimming lessons.

He believes youth mental health is greatly influenced by the environment in which teens live and learn. Some of his strategies strive to stabilize: smaller class sizes; school days that start later in the morning to coincide with when the teen brain wakes up; and education that focuses less on grades and more on producing well-rounded human beings.

“There’s also a reasonable amount of evidence that vulnerability to developing mental health illnesses is linked with levels of adversity and material deprivation in childhood,” says Dr. McKenzie.

“Whatever we can do in Canada to reduce that vulnerability is likely to drastically improve those outcomes.”

Hospital News’ ethicist examines how health professionals can navigate patient confidentiality with suicidal youth on page 8.

Echocing Dr. McKenzie, Sinyor adds that “CBT, and a related therapy dialectical behaviour therapy (DBT), can help to prevent and treat mood and anxiety disorders as well as accompanying suicidal thinking and behaviour. These treatments are relatively straightforward and, in my opinion, we should be using them broadly like vaccines rather than waiting until children become ill to provide them.”

Dr. Sinyor’s reference to early stressors opens up an important area about adverse childhood experience (ACE) and their linear relationship with suicidality, notes Dr. Melyn Leszcz, psychiatrist-in-chief at Mount Sinai Hospital and the interim department of psychiatry at University of Toronto. “Two themes emerge — adversity is more common than we recognize and we need early prevention to reduce future, such as reducing the social determinants of health. We also need to help young people with the management of emotional distress like emotional literacy, shame and coping strategies,” says Dr. Leszcz.

Behaviour change certainly strengthens a teen’s resilience, but being in tune with our physical environment can also help. Studies show that plants and trees near work or study areas help to restore the mind from mental fatigue, contributing to improved work performance and satisfaction.

In Japan, a popular practice known as forest bathing involves people going into forests and parks to simply observe and be with nature.

“We seem hard wired to need access to green space,” says Dr. McKenzie. Drs. McKenzie and Sinyor both say that none of these preventative measures on their own will solve the problem completely, but put together they could be very powerful.”

Kitcher agrees that mental health literacy that involves better understanding of many mental health concerns is very important. He and his team have developed a mental health literacy resource (the Guide) that can be easily embedded into existing curriculum taught by usual classroom teachers in junior high or high schools. Research studies in three different Canadian locations have shown that this simple intervention improves knowledge, attitudes and help seeking efficacy for teachers and students alike.

“This is such a simple intervention and it works very well. Giving teens, parents and educators the skills and knowledge they need is the foundation to improving mental health and the care for mental disorders,” says Kitcher.

Dr. McKenzie urges young people to recognize that depression can be manageable, and most people that have had depression go on to live fulfilling lives.

“If you have a serious depression, you are going to have a better prognosis than someone with diabetes. You’ll have a better prognosis than someone with asthma. People with mild depression do not need medication, changes in their life and decreasing stress is effective. People with moderate depression may need medication or therapy. But if you have a serious depression, the most likely scenario is that you are going to have to take either therapy or pills for a period of time which could be a few months to a year on average; you are going to take it for a while; then you will stop it and you’ll be okay. You may have vulnerability for another depressive episode and you will be treated for that. That’s the most likely outcome,” says Dr. McKenzie.

Family affair, sticking together

Lynda Kent and her son are now connected to appropriate services. The Family Navigation Project recently linked Kent up with a weekly support group after she told them she was crashing and needed to recharge. While her son copes with all the new information and tools at his fingertips, his mother is urging him forward, hoping he will make the right choices.

Mental Health Resources

For kids and youth: Monarch’s Mission
http://space.aboutkidshealth.ca
An interactive video game for children aged 7 to 12 to help them understand and cope with emotions such as sadness and anger.

Ellie’s Depression
http://teenmentalhealth.org/learn/mental-disorders/depression/
An animated video produced by Teenmentalhealth.org association with the NW Health Centre in Halifax as part of a series to help explain mental health disorders to children and teens.

Transitions: The ultimate guide for the transition to higher education
http://teenmentalhealth.org/
toolbox/ This guide speaks to how to incorporate healthy life habits during the transition from high school to life after high school.

Australia’s MoodGYM
https://moodgym.anu.edu.au/ welcome and other mobile apps help the user identify and overcome problematic emotions and show you how to develop good coping skills for the future so that you can enjoy good mental health

Kids Help Phone: 1-800.668.6868
Good2Talk (Ontario-wide): 1-866-925-5454 or dial 2-1-1, from anywhere in Ontario
www.good2talk.ca

For parents and teens:


For Health-care providers:

Tool For Assessment of Suicide Risk (TASR): http://teenmentalhealth.org/toolbox/tasr/

There is a real incredible theme of parents not giving up on kids — not to say that they aren’temaughters. They are saying no matter what, I’m here for you and we’re going to figure out what to do and get past this,” says Dr. Elyse Dubo, a psychiatrist and producer of two films shown in schools that address youth and mental health.

Kent’s son, who gave permission for his story to be told, but didn’t want to be interviewed, recently told his mother that he feels he’s doing better. He also asked her not to give up on him. And he also wanted her to know he didn’t like how people use the term ‘mental health’. He says it sounds like you are going mental. And that’s not the case at all, he says. He calls it just junk in your head that you are working on getting through together.

Some names of the families mentioned in this article have changed to respect their privacy.

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