BC Partners for Mental Health and Addictions Information

Visions

BC's Mental Health and Addictions Journal

Vol. 3 No. 2 | Fall 2006

background

experiences & perspectives

alternatives & approaches

bc partners

Seven provincial mental health and addictions agencies are working together in a collective known as the BC Partners for Mental Health and Addictions Information. We represent the Anxiety Disorders Association of BC, British Columbia Schizophrenia Society, Canadian Mental Health Association's BC Division, Centre for Addictions Research of BC, FORCE Society for Kids' Mental Health Care, Jessie's Hope Society (formerly ANAD) and the Mood Disorders Association of BC. Our reason for coming together is that we recognize that a number of groups need to have access to accurate, standard and timely information on mental health, mental disorders and addictions, including information on evidence-based services, supports and self-management.

visions

Published quarterly, *Visions* is a nationally award-winning journal which provides a forum for the voices of people living with a mental disorder or substance use problem, their family and friends, and service providers in BC. Visions is written by and for people who have used mental health or addictions services (also known as consumers), family and friends, mental health and addictions service providers, providers from various other sectors, and leaders and decision-makers in the field. It creates a place where many perspectives on mental health and addictions issues can be heard. To that end, we invite readers' comments and concerns regarding the articles and opinions expressed in this journal.

The BC Partners are grateful to BC Mental Health and Addiction Services, an agency of the Provincial Health Services Authority, for providing financial support for the production of Visions

regional programs

web-only articles

available at www.heretohelp.bc.ca/articles

It is a bit hard to get your head around what to call the numerous people that are really the first on the scene when a young person is having a crisis. We settled on 'first responders' because nothing else seemed appropriate.

Really we are talking here of everyone that lives in a community. As Hilary Clinton and, in this issue, Donna Murphy point out, it is the entire village that comprises the 'first response.' Teachers, school counsellors, and youth outreach workers are first responders for many youth. But if indeed the entire village is necessary, how do we reach those villagers that have little or no understanding of distress? Numerous volunteers organize, plan and deliver multitudes of social, recreational, athletic and other types of programs—how many truly know how to respond in a way that is helpful to young people and their families?

Foremost, however, are parents. How much do we teach in parenting classes or school newsletters about what to look for when it comes to identifying anxiety, eating disorders, depression, mania, psychosis, substance use problems or, really, any form of distress?

The pay off is huge, however, for doing this work right. Think of a world where mental illness or addiction does not devastate a life. Where the social, educational, vocational, and economic challenges that have come to be associated with mental illness and addiction are barely a blip in an otherwise interesting life. In a recovery model we strive to help a person regain something that was lost: be it hope, employment, health, education, or whatever. What if it was never lost in the first place?

There are some truly innovative and exciting projects reported on in this issue. Some truly inspiring youth talk about their experience. But interestingly, most of the articles are by service providers in the field. There are fewer articles by those villagers who come into contact with our young people in the myriad of non-medical programs and services.

And there is nothing in these pages that talks of what it means to the young person once labelled. Of what an uneducated village feels, thinks, or assumes the label means. Of how those thoughts, feelings or assumptions translate into perceptions. If the response to adults with mental health issues or addictions is any indication, we are making progress but still have a long way to go.

Christina Martens

Christina is Executive Director of the Canadian Mental Health Association's Mid-Island and Cowichan Valley branches. She has an MEd in Community Rehabilitation and Disability Studies and is working towards her doctorate in Policy and Practice in the Faculty of Human and Social Development at the University of Victoria

subscriptions and advertising

If you have personal experience with mental health or substance use problems as a consumer of services or as a family member, or provide mental health or addictions services in the public or voluntary sector, and you reside in BC, you are entitled to receive *Visions* free of charge (one free copy per agency address). You may also be receiving *Visions* as a member of one of the seven provincial agencies that make up the BC Partners. For all others, subscriptions are $25 (Cdn.) for four issues. Back issues are $7 for hard copies, or are freely available from our website. Contact us to inquire about receiving, writing for, or advertising in the journal. Advertising rates and deadlines are also online. See www.heretohelp.bc.ca/publications/visions.

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A Village of First Responders

Who are they? How can they help?

Donna Murphy

Donna is the founder and the Educational Director of the FORCE Society for Kids' Mental Health Care. When her son Kelly became mentally ill at 16, she struggled to find the correct services for him. After Kelly's suicide, Donna chose to work for improved information and services for other children and their families

I feel honoured to be the guest editor of this edition of *Visions*, having been a "first responder" many times. This may seem funny to some, as the term "first responder" usually refers to emergency response workers such as police or firefighters. I have never been either. However, as a teacher, a mother, a trusted aunt and a friend who tries to be there to support and listen, I have often been the initial contact for people having worries about themselves or their child.

The expression "It takes a village to raise a child" is one that we have certainly heard many times. But as I think of first responders, I think of the various members of our society who must work together to support children and their families as our young people journey from birth to adulthood.

I was given a sad-but-interesting statistic by a colleague last week. In the most recent national mental health survey, young people were found to have the most distress from mental health or substance abuse problems, yet were the least likely to seek professional help.[1] This information puts a great responsibility on all of us to be open to our young people.

First responders do exactly that. They are the coaches, the cub leaders and the many others who work with our children, providing guidance and life skills. They are ordinary people who form caring relationships with our young people and support them through their happy and sad times. They could be church leaders, next-door neighbours, grandparents, parents or friends.

First responders can also be the prevention programs taught in our schools that give children skills to cope with many of the challenges they will encounter in life. These are the programs that help kids deal with esteem issues, bullying, friendships and sexuality issues, as well as the FRIENDS for Life program that gives children the tools to cope with their worries.

Often first responders are the professionals who come in contact with our children as they grow. They can be the grade one teacher or the police who come in contact with a troubled youth. They can be the firefighter or ambulance driver who is called for an emergency in the home.

They are the people our children trust and will go to for advice and counsel. They are also the people who will first notice when something is amiss with our children. They are able to talk with the children, and their

first responders are the people our children **trust** and will go to for **advice** and **counsel**. They are also the people who will first notice when something is **amiss**

footnote

1. Statistics Canada. (2003, September 3). *Canadian Community Health Survey: Mental health and well-being.* The Daily. www.statcan.ca/Daily/English/030903/d030903a.htm.

parents, about what they notice. They may not always be in a position to be able to help, but they certainly can support both the child and the family as help is being sought.

Professional first responders need to show understanding and compassion for what the child and family is going through. They should have a basic understanding of behaviour and mental health, and should be able to make appropriate referrals. If the first responder is the police or ambulance called to the home of a troubled youth, an understanding of youth and family dynamics is necessary.

Ultimately, we are all first responders. As such, we all have the responsibility to show support and compassion for each other. We need to step outside of our own world, with our celebrations and troubles, and take the time to notice and listen to others around us. Each of us can have a powerful impact on the lives we touch, without even noticing it.

When I think of a first responder, I think of my son Kelly. Three weeks before Kelly died by suicide, he was sitting in the hall at school feeling very despondent. A school counsellor on her way to lunch noticed Kelly by himself and stopped to ask him if he was all right. He responded no, so she spent her lunch hour with him, and at the end of it he felt much better. Kelly died three weeks later, but I have always given that school counsellor credit for giving me three extra weeks with my son. I have never met the counsellor, but I often think of the great impact she had on Kelly that day, and in turn, on my life.

It truly does take a village. I love this expression because it describes perfectly the small part we all play in caring for and supporting each other as we raise our families. And, as first responders all, we need to feel proud of the job we do as parents, grandparents, family members, volunteers and professionals. i

What a great journal! This journal is a must for everyone in mental health and for every addiction leader. Visions is the most valuable resource in terms of journals that I've ever come across. Visions is not only a journal that someone just enjoys and reads… Once you discover Visions, you feel like 'This is something to be part of.'

—Robert Louis, RM Social Care, Abbotsford

I greatly enjoyed *Visions: BC's Mental Health and Addictions Journal.* I work with the College of the Rockies in Creston, BC, teaching lifespan development and FASD. It is a great 'connector' for me to see compassionate, nonjudgmental and realistic articles about alcohol and its effects. Visions included articles citing current research, programs and brilliantly, an article authored by a young person affected by Fetal Alcohol Spectrum Disorder. This condition (FASD) is more widespread globally than is reported or talked about. I applaud you at Visions for taking us one step closer to 'normalizing' the conversation about prenatal exposure to alcohol.

—Barbara West, College of the Rockies, Creston BC

I've just finished reading through your Spring 2006 journal on Alcohol and wanted to let you know that I enjoyed reading it as well as the previous issue which focused on Suicide. Very relevant issues, with a variety of perspectives. Good job, I'm looking forward to your summer issue!

—Grace, Occupational Therapist, Adult Day Program
Burnaby Mental Health and Addictions Services

we want your feedback!

If you have a comment about something you've read in Visions *that you'd like to share, please email us at bcpartners@heretohelp.bc.ca with 'Visions Letter' in the subject line. Or fax us at 604-688-3236. Or mail your letter to the address on page 3. Letters should be no longer than 300 words and may be edited for length and/or clarity. Please include your name and city of residence. All letters are read. Your likelihood of being published will depend on the number of submissions we receive.*

For our upcoming *Visions* (vol 3 no 4)

do you have an innovative resource, program or approach?

tobacco

or a personal story to share?

send us your story ideas

email us at bcpartners@heretohelp.bc.ca or call 1.800.661.2121

School, Family and Friends Matter

Improving mental health in young people

Annie Smith

Annie is Managing Director of the McCreary Centre Society, a non-profit organization committed to improving the health of BC youth through community-based research, education and youth participation projects

The strongest protective factors in a young person's life are school, family and friends. In fact, feeling connected to school and having caring relationships can really make a difference in the health of a young person.

This was a finding of the McCreary Centre Society's *Adolescent Health Survey*.[1] The survey takes place every five years. The most recent was in 2003, and over 30,000 youth in BC schools took part.

The survey results showed that most young people are developing positively and coping well. For example, nine out of 10 teenagers reported good or excellent health. Also, today's youth are waiting longer to try drugs and alcohol, and despite all the publicity, fewer are using amphetamines like crystal meth and ecstasy compared to those surveyed in the 1990s.

Although most youth are doing well, the survey also found that for some, this can be an emotionally difficult time. Over 16% of students reported seriously thinking about suicide in the past year. Twice as many girls (10%) as boys (4%) said they made a suicide attempt.

The McCreary Centre recently published a report looking at young people in BC schools who were at high risk of emotional and mental health problems—those with difficult home lives, and those who had been abused.[2] The study found that these young people did much better when some, or all, of the following were present:

- **Feeling cared about by family**
  Having someone in the family to talk to about problems or having a parent at home at key times during the school week, such as meal times.
- **Feeling connected to school**
  Liking school and feeling safe at school helped those who had been abused or had unstable home lives.
- **Having caring adults around**
  Having supportive adults to talk to about problems was also helpful. Some of the people who can be helpful include school counsellors, teachers, doctors, nurses, social workers and youth workers.
- **Having supportive friends with healthy attitudes**
  Young people most at risk of mental health and other problems were better protected if they had friends that got upset if they did dangerous or risky things. In fact, the role of friends was even more important than that of family when it came to preventing problem substance use.

The results of the Adolescent Health Survey allow us to develop some practical ways to impact the mental health of today's youth.

- **Provide safe and caring schools:**
  Caring teachers and staff, along with policies and practices that promote safe and welcoming schools, are important and can create a sense of belonging.
- **Promote healthy attitudes about risky behaviours:** Schools and communities can help promote mental and physical health through communication, public campaigns and positive role modelling. Families who encourage open communication and are good role models can also influence the behaviour of young people.
- **Support families in parenting roles:**
  Parents may need support to develop their parenting skills and to cope if their children have problems. Family-friendly employment policies would also allow parents to be at home when they need to be.
- **Provide opportunities to get involved:**
  Opportunities to volunteer and participate in the community can help youth to reach long-term goals and improve their feelings of competence.
- **Create a youth-positive environment:**
  Seeing all young people as having resilience and strengths, rather than problems and weaknesses, can help them to develop into successful adults.

The Youth Perspective

Young people across BC were asked for their reactions to the McCreary survey results[3] and came up with some practical and dynamic ways to address the problems of mental health and suicide. Just a few of these ideas are listed below:

- Separate mental health services and resources for boys and girls—their needs are different
- Give information to parents so they can be aware of the emotional health of their kids, and notice any warning signs
- Decrease the stigma of depression and other mental health problems by talking about them

openly at school and in the community
- Have presentations in schools about unrealistic images in the media
- Have role models and mentors for youth to build positive relationships and self-esteem
- Identify safe places where youth can go "just to talk" or to receive help

footnotes

1. McCreary Centre Society. (2004). *Healthy youth development: Highlights from the 2003 Adolescent Health Survey III.* Vancouver: author.

2. Saewyc, E., Chittenden, M., & Murphy, A. (2006). *Building Resilience in Vulnerable Youth.* Vancouver: McCreary Centre Society.

3. McCreary Centre Society. (2006). *The Next Steps: BC Youths' Response to the AHS III and Ideas for Action.* Vancouver: author.

for more info More information on youth health issues, including the latest reports and skill building workshops for youth, is available on the McCreary Centre website at www.mcs.bc.ca.

Quality Child Care = Caring Family Support

Ruth Bancroft

Ruth has worked in inclusive group child care for over 30 years, with a focus on supporting children with special needs in regular child care settings. She is Head Teacher at Langara Child Development Centre and on the board of the Coalition of Child Care Advocates of BC

When we welcome a child into a high-quality child care setting, we also welcome the child's family. In the close and caring relationships we build with our families, we are sometimes the first community partners to see signs of distress. If a family is dealing with challenges—such as mental illness, addictions, family violence or abuse—trained child care providers can help the family find the supports they need. Sometimes a family arrives at a child care centre already receiving community services. In that case, the child care providers must be ready to work hand-in-hand with these services to properly support the child and family.

In one case, a single father we worked with in our inclusive group daycare centre struggled with his own physical and mental health problems as he tried to raise his young son. He loved his child, but needed help and information to figure out how to parent a very active toddler with developmental delays and emotional and behavioural problems. Every day, at drop-off or pick-up times, he and the centre staff would talk about difficulties that were coming up at home around mealtime, bathing, bedtime, toilet training, behaviour, learning and making friends.

We became partners with this father. We were a part of the team of professionals supporting him. This included a community health nurse and provincial ministry social worker. These professionals worked with him around issues such as his disabilities, housing needs and transportation, while daycare staff focused on providing parenting help and meeting the child's needs. Soon we arranged for the child to receive speech therapy, physiotherapy and help for emotional and behavioural concerns. The Supported Child Development Program,[1] which helps families with children who have special needs, was also involved.

This example shows the importance of quality child care to vulnerable children and families. Child care nurtures and stimulates young children. It supports families in their parenting role. It can provide isolated families with a sense of community. When parents are under a lot of stress, child care offers a much-needed break. For some families, the support of child care—to both children and parents—means being able to maintain the child in the home. Child care providers can support parents by listening, offering parenting suggestions, making referrals to community resources, and connecting families to other families.

Child care providers are often the first to identify early signs of difficulty in a child. If children need extra support because of developmental delays or disorders, health problems or emotional or behavioural issues, child care staff can make referrals. We often connect families to speech and language pathologists, physiotherapists, occupational therapists and mental health services, as well as the Supported Child Development Program. Child care staff experienced in including children with special needs know how to work in partnership with

child care providers are often the first to identify early signs of difficulty in a child

footnote

1. Ministry of Children and Family Development Supported Child Development: see www.mcf.gov.bc.ca/supported_childcare.

Police (and others) Facing Adolescence
'Normal'? Mental illness? Can be hard to tell . . .

Camia Weaver

Camia is Provincial Coordinator of the Canadian Mental Health Association BC Division's ongoing Mental Health and Police Project to improve police and emergency service response to persons with mental illness. After almost 20 years as a practising lawyer, she is actively committed to facilitating community empowerment and restorative practices

Historically, the police perspective has been focused on law enforcement: containment through the use of authority and physical force as the primary objective, with arrest and criminal charges following. Things have changed.

In response to social trends, police organizations these days focus more on community policing—with crime prevention, foot and bicycle patrols, and community education forming a major part of their role in the community—rather than just crime fighting. At the same time, a trend toward integrating people with mental illness into the community has led to a dramatic increase in their interactions with police—hence the term sometimes applied to police: "psychiatrists in blue."

Many police agencies have developed models of effective response to people with mental illness, especially in crisis situations. Basic education on recognizing symptoms and knowing the best way to respond form the core of most programs. This is a very positive step, and one that most police value for allowing them to provide better service and protection to the community.

Unfortunately, this response information does not address issues that may come up among those in that stage of life known as "adolescence."

Adolescence can be hard—both for teens and for those around them. Puberty and adolescence are hormonal and emotional roller coasters. This is complicated by elements of rebellion, risk-taking behaviour, poor judgment and mood swings, including anger, euphoria and depression. It was recently discovered that these elements are partly due to a spurt of brain development in the frontal lobes occurring at puberty and continuing through the early twenties. The frontal lobes—responsible for functions like self-control, judgment, emotional regulation and organization—grow and become refined during this period, developing into the mature brain at about 25 years.[1]

If hormones and normal brain development were all there is to it, it would be relatively simple to manage. But there's more. Adolescence is also when most mental disorders—including depression, bipolar disorder and schizophrenia—surface for the first time. Telling the difference between 'normal' teen behaviour and mental illness, including fetal alcohol spectrum disorder, is difficult. The behaviours may look the same. Risky behaviour (like car racing, sexual promiscuity, alcohol and drug abuse or extreme physical activity), feelings of invincibility, moodiness, aggression, withdrawal, poor

quality child care | *continued from previous page*

parents and therapists to create individual plans for children and then to carry them out.

If children have very complex needs, child care programs can arrange for extra staffing support through the Supported Child Development Program. Every time a new child with extra needs enters a child care program, the staff must learn the specific skills required to support the child.

Child care offers children the security of stable, ongoing care and consistent routines in lives that may, at times, be chaotic. It provides children with caring and supportive adults they can trust. Children make friends with other children. They learn how to share, solve problems and get along. They learn how to accept differences in themselves and in others. The social lessons of respect, empathy and tolerance that happen at child care can last a lifetime. And while they are busy learning, they are also having fun.

Like families, child care programs also need support. When child care programs have strong, well-trained staff, and when they are properly funded and connected in their communities, they fit naturally into a range of services that can work together to support the families who need them. But the reality is that child care does not have enough public funding and support. It is a fragmented and fragile system. There is not enough high quality, affordable child care for all the families who need it. It is enormously stressful for families to run into poor quality, lack of space, long wait-lists and high fees when they are looking for child care.

We fail our most vulnerable families when we do not consistently provide a service that brings so many benefits. For all children and families, we must press for a universal, high quality, publicly funded, accessible and affordable child care system.

for more info For more information, visit the Coalition of Child Care Advocates of BC at www.cccabc.bc.ca

Telling the difference between 'normal' teen behaviour and mental illness, is difficult

impulse control, defiance and excitability, for example, all fall within the normal range of teenage behaviour—and are also symptomatic of mental illnesses.

Why is it important to discern between normal teen behaviour and signs of mental illness? Because mental illness should not be punished or criminalized. More importantly, early diagnosis and treatment of mental illness dramatically improves the chance for recovery.

Properly discovering and responding to youth mental illness can seem like an impossible task. The stigma of mental illness—especially in the emotional and social vulnerability of adolescence—can cause a youth to desperately conceal or deny symptoms, choosing the criminal label and consequences over the label of "mental illness." To a teen, this label means social death, teasing, bullying and rejection—the last thing any kid needs.

The most important tool for effectively addressing youth mental illness is knowledge. Awareness of the rate of mental illness among youth and its effect on behaviour is essential. For example, four out of five runaway youth suffer from depression, and suicide is the third leading cause of death for 15- to 24-year-olds. BC statistics indicate that more than 140,000 of the 580,000 children and youth in BC over the age of six are estimated to have mental disorders that impair functioning.[2] Most of these are teens, since mental illnesses become symptomatic during adolescence. At the same time, 3,000 youth were in custody—and again, it is reasonable to conclude that many of these youth have some form of mental illness.

Not making assumptions about the reasons for adolescent behaviour is a necessity—not just for police, but also for parents, teachers, school counsellors, youth corrections staff, and other professionals who interact with troubled teens daily. Many adults are still inclined to label difficult youth. They may feel that young people need punishment to deter further bad behaviour. Suspension from school and incarceration in youth detention centres are all too common.

Patience, an open mind and the drive to make many efforts to discover underlying issues are also necessary. It is not always appropriate to just give youth the chance and incentive to correct behaviour. If the behaviour is a symptom of mental illness, youth will not be able to correct it through willpower alone.

Finally, increasing public awareness of mental illness—especially among youth—is an important step. If we can all recognize that mental illness is just that—an illness—the stigma fades and it is easier for youth to seek and get help at an early stage.

footnotes

1. Wallis, C. & Dell, K. (2004, May 10). What makes teens tick? Time, 163(19).

2. Ministry of Children and Family Development. (n.d.). 2003/04 Annual Service Plan Report. Victoria, BC: author.

related resources

Resources for parents on how to respond to youth in crisis with mental health needs can be found on the Parent/Professional Advocacy League website at www.ppal.net

Bridge Over Troubled Waters

Meeting the needs of youth with concurrent disorders

Erin Toews

Erin is a communications specialist with BC Children's Hospital

It is not an unfamiliar story: a 16-year-old student who had previously been doing well in school is now struggling. Once friendly and open with her family, she has become withdrawn. She has been staying away from home, preferring to spend time alone or with friends. Her parents, already frustrated with her slipping grades, are outraged when they find a marijuana cigarette in her coat pocket. They consider this another example of her increasingly bad behaviour. They are angry and disappointed, and their relationship with their daughter deteriorates.

But at the crux of this story is a missing piece of information—this young woman has been experiencing a serious episode of depression for most of the year. She is self-medicating with marijuana and alcohol, which has resulted in spiralling drug use and depression.

Bridging the divide between mental health and addictions is the role of addictions psychiatry, an increasing subspecialty in the field of mental health.

Help for youth with concurrent disorders

BC Children's Hospital and BC Mental Health and Addiction Services, agencies of the Provincial Health Services Authority, have a program to assist children and youth facing concurrent disorders (the combination of mental health issues and substance use). It is estimated that about half of individuals facing either mental health or substance use issues, actually have both.[1] This is especially true of youth.

Dr. Shimi Kang is director of the Provincial Youth Mental Health and Substance Use Program. She started the clinic three years ago after growing tired of watching some patients fall between the cracks in traditional treatment. Initially, the clinic did one patient assessment per week. In October 2005 the program received additional funding from the Provincial Health Services Authority and is now operating as a full-time clinic based at BC Children's.

Often mental health treatment services are not prepared to treat individuals for substance use, and addiction treatment facilities are often not equipped to address the specific needs of those with mental illness.

"None of that matters at 3 am when you are working in the emergency department and have someone in front of you who desperately needs help," explains Dr. Kang. "Most programs don't look at addictions and mental health in an integrated way—even though we know that most often the two are strongly correlated and affect each other's presentation, treatment and prognosis. I saw these issues coming up again and again. Mental illness and substance use touch so many families, it would be difficult to find someone who hasn't had their life directly or indirectly affected by one or the other."

Problematic substance use by youth is a very real problem in BC

Recent research evidence and surveys of drug use by high school students indicate that nicotine, alcohol and marijuana are still the main drugs of choice. However, the use of ecstasy and crystal meth is on the rise, ranging from experimental to more chronic patterns of use.[2]

For youth with mental health issues, even experimental use of alcohol and drugs can create or exacerbate symptoms. For example, the use of methamphetamines increases the risk of psychosis. Youth with disordered eating can worsen their disorder through stimulant use. Those with anxiety problems may find the intoxicating effects of alcohol and/or marijuana leads them to escalating and eventually dangerous use.

"Studies and clinical practice demonstrate that youth experiencing higher levels of distress will turn to more potent drugs, thus putting the youth with untreated mental health issues at risk," says Dr. Kang.

Many youth use substances, but some are at increased risk of concurrent disorders. Those with mental illness, learning disabilities or street involvement are at increased risk, along with gay and lesbian youth. Compared to those with either condition alone, youth with concurrent disorders face potentially serious negative outcomes, such as homelessness, hospitalization, trauma, prison or suicide.

First responders face a complex situation

Identifying and treating children and youth with mental health problems becomes much more challenging when they are also using substances. A distinct change in temperament and behaviour is often the first sign. Other warning signals include

related resources

To find a youth addictions team in your area, check the Mental Health and Addiction Services listings in the "Health Authorities" section of your telephone book blue pages or call 1-800-661-2121

irritability, sleep disturbance, lack of interest in school or other activities, and finding drug paraphernalia—such as bottles, pills, needles and pipes—among a youth's personal items. These signs are usually flagged by a teacher, friend or parent.

Beginning substance use may be the result of peer pressure or an adolescent desire to explore boundaries. After time and depending on underlying reasons, this use may become misuse and may be causing the young person harm—however, they may still not necessarily be self-treating a mental health issue. Beyond understanding the symptoms, it is important for first responders such as parents or teachers to appreciate the complexities at hand when trying to determine the severity of the issue.

The first step for the first responder is to talk to the youth in an open and nonjudgmental manner. The first responder may suggest that the youth see their family doctor or contact a youth addiction team through community health centres. This is the first step required in order to get an appointment with the Provincial Youth Mental Health and Substance Use Program. Given the natural state of denial and resistance to treatment that sometimes occurs with addictions, the first responder may need to contact the doctor or youth addiction team themselves to discuss an appointment and referral for the youth.

Complex conditions need an integrated approach

These are complex conditions that cross over biological, psychological and social issues. Effective treatment requires an integrated approach. The program at BC Children's works with the entire care continuum—psychologist, psychiatrist, nurse clinician, nurse practitioner, social worker—and consults with teachers, mental health and addiction counsellors, youth care workers, street nurses, probation officers and the family. The program treats youth up to age 24.

The program aims to disseminate as much knowledge as possible. During the past year it has conducted 12 workshops with a variety of professionals, including youth forensics workers, mental health and addiction clinicians, nurses, teachers and social workers.

Dr. Kang's advice for helping professionals is to communicate that people do get better, but they must be prepared for a rocky road ahead. These are challenging cases, and even if a youth is well motivated, there can be multiple relapses for both substance use and mental illness.

"You need to engage youth as much as possible. This often requires small steps. My goal in the first appointment is often to see the person return for a second appointment. These can be difficult cases to treat, but it is so worthwhile to see a youth turn their life around or reconnect with their family and friends," says Dr. Kang. She suggests that any time one condition has been identified, the other be asked about in an open, non-judgmental way.

There are no silver bullets when dealing with concurrent disorders and treatment—the cases are much too individualized for a blanket solution. However, if first responders know about symptoms and resources, and if they understand the continuum between use, misuse and self-medication, they will better be able to deal with these issues. The program at Children's Hospital will be holding special information nights for parents, who so often find themselves in the role of first responder.

> "The first step for the first responder is to **talk** to the youth in an **open** and **nonjudgmental** manner."

footnotes

1. Bradizza, C.M., Stasiewicz, P.R. & Paas, N.D. (2006). Relapse to alcohol and drug use among individuals diagnosed with co-occurring mental health and substance use disorders: A review. *Clinical Psychology Review, 26*(2), 162-178.

2. Lapinen, T.M., McGhee, D. & Martin, I. (2006). Use of crystal methamphetamine and other club drugs among high school students in Vancouver and Victoria. *BC Medical Journal, 48*(1):22-27.

for more info For more information about the Provincial Youth Mental Health and Substance Use Program, call 604-875-2010 to be directed to clinic staff.

Responding to Teen Drug and Alcohol Use
A guide for parents

Robb McGirr

Robb is a retired police officer who now works as a school-based drug and alcohol prevention counsellor for Alouette Addictions Services in Maple Ridge. For 16 years he has presented drug prevention and early intervention workshops throughout BC. Robb has also developed prevention resources for parents, teens and teachers

As parents, we all seem destined to come to grips with the role drugs and alcohol may play in our teens' lives. Most of us will experience one of three scenarios:

- Anticipation… Your son or daughter is entering senior high school, or is coming of an age where their territory and social groups are expanding. It is likely they are going to come into contact with drugs or alcohol. They need more information so they can make well-informed choices.
- Suspecting… Your teen has a new group of friends who are making your radar go off. They are moodier and more distant. Your teen's school performance is slipping. You're hearing fragments of suspicious conversations.
- Knowing… Your teen has openly admitted using drugs, or you've otherwise confirmed that they are using.

Parents who suspect or know will probably be filled with questions like, What should we do? or How should we do it?

While some parents end up dragging their teen—willingly or otherwise—to the nearest counselling office, the fact is that the majority of parents try to deal with the issue within the family. This is an undertaking that can be filled with stress and conflict.

Understanding and following some simple strategic guidelines, however, will help parents send needed messages in a way that their teen can benefit from.

How do you move from confusion to a clearer understanding of what is going on and how to respond to it? Simply put, you need to stop and take the time to do what is often referred to as a "risk assessment." Gathering information before you react will help reduce the conflict that would likely arise from premature conversations with your teen.

Risk assessment

Two primary pieces of information you may want to gather are your teen's level of use and what drug or drugs they are taking. Triggers for use is another important piece of information.

Escalating levels of use

- *Curiosity:* A healthy state—and one that invites you to help provide accurate information on drugs and alcohol. Listen to your teen's opinions and help them search out the answers to their questions.
- *Experimental use:* First- or second-time use to satisfy their curiosity or to find out if using the drug helps them in a social setting.
- *Recreational use:* Using drugs or alcohol, mostly on weekends, and almost always in a social setting.
- *Coping tool:* Drug use has escalated beyond recreational use. Some typical signs are use at or during school, or when alone.
- *Dependence/Addiction:* Drugs or alcohol are now a part of your teen's daily life. Social groups and activities are almost completely associated with drug-related activity.

"Hard-core" vs. "soft-core" drugs

While I think these terms are overly simplistic, they do provide a framework for understanding about the drugs of choice for teens.

Early intervention with teens beginning to use "hard-core" drugs such as cocaine, methamphetamine, ecstasy and heroin, for example, is far more challenging than for so-called "soft-core" drugs such as alcohol, marijuana and 'magic' mushrooms. The time frame for effective early intervention with hard core drugs can be measured in weeks, as opposed to perhaps months with the softer drugs. Also, the escalating levels of use don't really apply to harder drugs, because the poten-

Two primary pieces of information you may want to gather are your teen's level of use and what drug or drugs they are taking

tial for addiction develops so quickly, and the potential for serious harm from even single use is so high.

Triggers

"Triggers" are not the things that make your teen use, but rather the circumstances in which they are more likely to use. People, places, days of the week, times of the day, state of mind or even special events—these can all be triggers.

The most common trigger that parents first identify is people—a group or crowd that your teen is now hanging out with. Other common triggers for teens are boredom, social stress and particular hangout locations. Understanding your teen's unique triggers helps to forecast high-risk moments for your teen and to provide alternatives for them.

Don't make assumptions about what your teen's triggers are. It will require close scrutiny and lots of conversations with your teen, their friends, teachers and others in their lives to get a sense of what their triggers may be.

Risk assessment to response

Doing a risk assessment helps you focus your energies and respond in an appropriate manner. Your response will probably fall into one of three categories:

- *Education/Prevention:* For dealing with curiosity, experimentation and perhaps even recreational use of so-called soft drugs
- *Early intervention:* To help your teen make some modest changes before their use becomes more problematic
- *Treatment/Rehabilitation:* To address serious problematic use, consider resources outside the family

This evaluation process will give parents a clearer perspective on what their teen needs to hear in order to make better choices. More importantly, it can reduce the fear and anxiety that all parents feel as their teens begin to make lifestyle choices beyond their parents' control.

related resources

Robb McGirr has produced a film documentary called *Rewind:A film about choices* for use in school-based prevention. He has also developed and published *Teen Drug Trends*, a parent guide, and *Thru Your Own Eyes*, a youth self-assessment guide called—both available free of charge through Alouette Addictions Services. Visit www.alouetteaddictions.org.

Marijuana Use by Youth
When is it a problem?

Marijuana use by youth is far from a new phenomenon. Many adults likely recall their own experiences with marijuana as teenagers; some may still use marijuana today. Because of their experiences, adults may have a tendency to brush aside the issue, or to accept it as a rite of passage.

How is marijuana use different for youth today?

More youth in British Columbia are now using marijuana than two decades ago. Based on the Canadian Community Health Survey, marijuana use by Canadians ages 15 years and older almost doubled between 1989 and 2002.[1] The highest rate of marijuana use in the country is in BC, with use most prevalent among youth. Moreover, youth are starting to use marijuana at a younger age.[2] Our recent research on tobacco use among teens in BC suggests that young people in BC are now more likely to be recent users of marijuana than recent users of tobacco.[3] Higher rates of frequent use have been noted among boys than among girls.[4]

British Columbia holds a reputation for having high quality "BC Bud" that is inexpensive and readily available at school, according to many youth. Some marijuana grown in this province contains record levels of delta-9-tetrahydrocannabinol (THC).[5]

Although most teens in BC report they are recreational marijuana smokers, some say they use marijuana frequently. Our survey of BC youth shows there is a subpopulation of teens using marijuana at least five times a day.[3] Youth refer to this pattern as "wake and bake," and they apply the terms "stoner," "chronic" and "lifer" to themselves and others who use marijuana often. There is now strong evidence that a subset of marijuana users develop dependency.[6]

What do teens say about frequent use of marijuana?

The TRACE (Teens Report on Adolescent Cannabis Experiences) project is a research study in which teens are being asked to reflect on their experiences with frequent marijuana use. The insights are revealing. They tell us they use marijuana because:

"It gets me going"

For some teens, marijuana use is a strategy to help them function with day-to-day activities. These teens report smoking pot as soon as they wake up in

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Joy is BC Site Director of the Centre for Addictions Research. She is also Professor and Associate Director of Graduate Programs and Research in the School of Nursing at the University of BC

the morning so they can get out of bed and get to school. As a result, some link their use of marijuana use with "staying in school."

"It keeps me cool"

Many teens report they use pot to relieve stress and to help cope with life's frustrations, such as challenges at school and difficulties at home. These teens say that using marijuana allows them to relax and calm down.

"It makes me feel better"

Marijuana use is sometimes credited as a way to improve mood and forget "bad things." Some teens living with depression believe that marijuana use is preferred to prescription medication, and they suggest that nothing else has worked. These youth also note they can control the amount they use, and know when they have had "enough."

"It helps me focus"

Some teens link their marijuana use to improved concentration with certain school activities, such as task-oriented subjects such as math. They report that using marijuana helps them "function" their best and complete their school work. In the case of teens living with attention deficit/hyperactivity disorder, there is some belief that marijuana is more effective than medications like Ritalin.

"It lets me fall asleep"

Marijuana use is a tool that some teens use to fall asleep. Some teens describe their "busy minds" at night and believe that marijuana allows them to close their eyes and "stop thinking" at the end of the day. According to some, marijuana is better than taking sleeping pills.

"It lets me be me"

A number of teens attribute their frequent marijuana use with being able to get in touch with their feelings. Thus, they claim that marijuana allows them to be more open and intimate in their discussions with friends. Some youth equate using marijuana with being a "nicer" person.

As noted, teens use marijuana to manage the difficulties in their lives. Often, youth smoke marijuana because they feel there are no other options. However, frequent use can affect teenagers' school performance and their relationships with family members.[7] Earlier and greater involvement with marijuana has also been associated with increased risk of poor mental health.[8] Frequent use is a concern for some youth; they acknowledge the difficulties they have cutting back or quitting. Frequent use may well be a sign of other distress in their lives.

> "Earlier and greater involvement with marijuana has also been associated with increased risk of poor mental health"

Connecting with teens who use marijuana often

To begin, we need to open a dialogue with teens about marijuana use. It is vital that we continue to learn from youth about their experiences with, and reasons for using, marijuana. Parents, educators, counsellors and health care providers need to talk to teens about the role marijuana is playing in their lives. This conversation must be informed by accurate information and educational materials. It is time to create opportunities to expand this dialogue about marijuana use among, and with, youth today.

footnotes

1. Tjepkema, M. (2004). Use of cannabis and other illicit drugs. *Health Reports, 15*(4), 43-47.

2. Dennis, M., Babor, T.F., Roebuck, M.C. et al. (2002). Changing the focus: The case for recognizing and treating cannabis use disorders. *Addiction, 97* (Suppl. 1), 4-15.

3. Tu, A.W., Ratner, P.A., & Johnson, J.L. (2006). *Gender differences in the correlates of adolescents' cannabis use.* Manuscript submitted for publication.

4. McCreary Centre Society. (2004). *Healthy youth development: Highlights from the 2003 Adolescent Health Survey III.* Vancouver, BC: author.

5. Mulgrew, I. (2005). *Bud Inc.: Inside Canada's marijuana industry.* Toronto, ON: Random House.

6. Coffey, C., Carlin, J.B., Lynskey, M. et al. (2003). Adolescent precursors of cannabis dependence: Findings from the Victorian Adolescent Health Cohort Study. *British Journal of Psychiatry, 182*(4), 330-336.

7. Butters, J. (2002). Family stressors and adolescent cannabis use: A pathway to problem use. *Journal of Adolescence, 25*(6), 645-654.

8. Fergusson, D.M., Horwood, L.J. & Swain-Campbell, N. (2002). Cannabis use and psychosocial adjustment in adolescence and young adulthood. *Addiction, 97*(9), 1123-1135.

Social Work
Strengthening Systems Youth Live Within

Autumn Jenkinson, BSW

Autumn is a social worker on a Youth Team within the Ministry of Children and Family Development, and a registered member of the BC Association of Social Workers

Deneen Jensen, BA, BSW

Deneen is a mental health support worker for Child and Youth Mental Health, Abbotsford Ministry of Children and Family Development. She previously worked for the Maples Adolescent Treatment Centre in Burnaby

Social work is a profession that operates from the belief that people experience life as individuals that are in relationship with the world around them. When social workers come into contact with youth and their families, they respond to the needs of the youth and family individually and look at the systems of support that surround them. Social workers recognize that providing supports to young people when needs arise—including mental health concerns—can either prevent a crisis or support a youth through a crisis.

When young people, their families or community members become concerned about the mental health and well-being of a youth, it is critical that they trust their instincts and reach out for information and support. It is not only when child protection concerns arise that a social worker can be of benefit. It is not only in times of crisis that a social worker can respond and assist. When youth and their families need information, support services and assistance connecting with relevant community resources, a social worker will connect them with the resources they need.

Social workers focus on strengthening the system a young person lives within. A youth's system of supports could include their school, family, peers, church, youth worker, mental health clinician and a variety of other service providers. Social workers build respectful relationships with the youth and their families in the interest of developing plans and goals that meet that youth's unique needs. From a social work perspective, building an effective "care team" that includes meaningful people for that youth and their family ensures that they get the support they need. Meeting regularly as a team allows all individuals involved with a family to come together and brainstorm what needs to be done, what is working and what needs to change.

Social workers can provide assistance in exploring resources that may be available for a youth experiencing mental health concerns—including, but not limited to, anxiety, depression, trauma, suicidal tendencies, substance misuse, psychosis and the variety of other mental health experiences that can arise during adolescence.

When social workers suspect a mental health concern, one of the supports they may refer the child to is Child and Youth Mental Health (CYMH), a service of the provincial Ministry of Children and Family Development. Child and Youth Mental Health operates similarly to social workers in many areas. One role a CYMH clinician can play is that of a case manager in the child's life. As such, the clinician can help orchestrate and work as part of a larger team of professionals and lay people supporting—or struggling to support—the child who has a mental health concern. While a mental health clinician directly assesses and treats mental health conditions, unlike the social worker, the overlap between the two roles is considerable. Both work with the family. A multitude of research in children's healthy development indicates the importance of educating and supporting caregivers to provide "best" care for a child with mental health issues. Mental health clinicians also frequently refer their clients to community resources as part of a belief that the child is healthiest when supported by the larger systems around them.

Children, youth and/or their caregivers and other supportive people in their lives can reach out for support in a variety of ways if they suspect a mental health concern. The first contact with a social worker or mental health worker could occur through a variety of "gates" (see sidebar). It is important that the youth, or someone concerned about him or her, knock on and enter one of these gates.

"gates" to social work or mental health clinician support

Any concern or doubt about the health and welfare of a child or youth is worth mentioning. A broad spectrum of people who work with children are trained to have some familiarity with mental health issues and can provide direction to the right care. Some of these people include:

- Physicians
- Hospital staff
- School personnel
- Early childhood educators/Day care providers
- Youth workers
- Recreation workers
- Clergy members
- Police
- Emergency services
- Children's helplines
- Crisis/Suicide hotlines
- BC Nurse Line

Journey to Recovery From First-Episode Psychosis
don't wait. get help early.

Tara and Terry-Lee Marttinen

The Marttinens live in Northern Ontario and are the mother-daughter force behind the early intervention website www.gethelpearly.ca. A new version of the site, developed in partnership with the Ontario Working Group on Early Intervention in Psychosis, launched this fall

Tara's Story

Ten years ago, when I was just 15 years old, I began having very strange experiences. I started to hear murmuring and whispering in places where these sounds were very unlikely. I would hear them while riding the bus, walking outside and sometimes in a quiet classroom. I really didn't know what was going on, but I didn't think anything of it at the time.

Then one night, out of nowhere, I heard screaming. I had been on a date with a boy I knew fairly well. We had gone to a hockey game and then went back to his house to watch a movie. After the movie, I went to catch the bus, but it didn't come. I had to find my way back to my date's house, which was in an unfamiliar area of town. I became extremely anxious. I remember the dark sky, the bright snow and the biting January wind. But what I remember most about that night were the screams I heard coming from the wooded area as I passed. The screams were awful—like many people being tortured all at once; like in a movie scene from hell.

I looked around, trying to find an explanation for the sounds I was hearing. I checked to see if any houses had windows open, hoping someone was playing a trick on me—the doors and windows of the houses around me were all closed. I did find my way back to my date's house and called my mom to pick me up. But there was no explanation for what I heard.

The voices weren't the only new thing I experienced early on during my first episode of psychosis. I began to isolate myself from family and friends, staying in my room a lot, eating my meals there and staying up all hours of the night. I felt my friends didn't like me, and I thought some of them were using and abusing my friendship. I felt profoundly alone.

I often thought about telling people about the things that were happening to me, but for some reason, I couldn't bring myself to do it. I didn't know how to begin talking about what I was going through. I was 16 when I finally told my mom. Telling her wasn't something I had planned—but one sunny afternoon I was sitting on our living room couch and noticed a pamphlet about narcolepsy on the coffee table. Being curious, I read the pamphlet and noticed that one of the symptoms described in it was auditory hallucinations. I used that as an opportunity to tell my mom what I was going through.

Terry's Story

Tara told me, in May 1997, about the strange noises she was hearing. Her father had taken his own life after a long battle with schizophrenia several years earlier, so when she told me she was "hearing things," I immediately looked for help from a specialist.

I heard about the Prevention and Early Intervention Program for Psychoses (PEPP) in London, Ontario, from an uncle who lived there, and I called the clinic straight away. My boyfriend Steve, Tara and I drove 800 kilometres within a week of that phone call to access the PEPP early intervention services. Until my daughter moved to London in 2001 to attend the University of Western Ontario, our family travelled there from Sault Ste. Marie twice a year.

Because the program was so far away, we didn't have access to all the resources

We found that it was possible to manage brain disease that wasn't out of control—like Tara's father's had been.

contribute
your art, poetry and stories to gethelpearly.ca

young people from across Canada who are recovering from their first episode of psychosis are invited to send in their art, poetry and personal stories. Parents, partners, siblings and friends are also invited to e-mail their stories for online posting. Submissions are welcome at goldencrumb@gmail.com

at PEPP. To make up for any losses, I learned everything I could about psychosis from the Internet. Our entire family applied what I learned online to navigate Tara's recovery. Together, we prioritized responsibilities to help keep stress in check. Tara and I began doing arts and crafts, we signed up for fitness classes, and we got involved in early intervention volunteer projects as a means of support. We found that it was possible to manage brain disease that wasn't out of control—like Tara's father's had been.

Nine years after her diagnosis, my daughter has finished university and is set to pursue a career in early psychosis intervention. She is currently teaching overseas, where she'll spend a year before settling into the mental health care field.

Before Tara headed overseas, she and I worked on an early intervention youth and family website with the help of other first-episode psychosis youth and families. We hope *www.gethelpearly.ca* will be a place where young people experiencing their first episodes of psychosis—and their loved ones—can share their personal triumphs.

Tara and I understand first-hand that youth and families who have experienced early intervention themselves can be a great source of knowledge, comfort and support.

bc psychosis websites

- psychosissucks.ca
- hopevancouver.com
- reachoutpsychosis.com
- psychosissupport.com

A Conversation Between a Mother and Son

Annie and Scott*

**pseudonym*

Annie has a PhD in Education from the University of British Columbia. She is also a theatre maker and has employed people with mental illnesses in her theatre company

Scott was diagnosed with paranoid schizophrenia in 1996, at the age of 24. He has been living successfully on his own for five years

Annie: It took me a long time to understand that Scott was struggling with getting by.
I had moved to Edmonton to attend university, and he was working in British Columbia. When the place where he was working closed, he moved into a shelter—and began spending more time on the street.

Finally I got him to come to Edmonton. Scott was angry and threatening. Even though I knew he wouldn't hurt me, I became exhausted from my emotional reactions. After a few months I realized that our relationship was getting worse, and I made him leave.

Once Scott was gone, I realized that the things he had said to me were not rational. I had taken a course in abnormal psychology and began to understand that his problems were not just emotional—he must have a mental illness. I was leery of the mental health system in Alberta because I had heard stories of enforced sterilization of mentally ill patients. Also, I had no medical coverage so couldn't get help there.

I tried to get help for Scott back in BC. This was the most frustrating time, because all the people I talked to long distance—at the shelter, or social workers—said he would have to agree to get help. And he wouldn't do that. The only other way they could intervene was if he did something to hurt himself or someone else.

Scott: I was afraid of what I would say if I talked to a doctor. Any time I feel manipulated, I get hostile about it because I realize that totalitarianism is a true evil.

Annie: When I finished my degree, I moved back to the coast, determined to come to terms with what was troubling my son.
This time, when he came to stay with me, I sought help from the local mental health centre. I had come to believe that Scott had been living with a mental disorder—probably schizophrenia—for about three years. He was often terrified that people were after him, but refused to go to the hospital for help. He was struggling to survive and I felt powerless to help him.

A mental health worker told me that if I wanted to have my son committed for assessment and treatment, I would have to swear an affidavit before a judge that he was a danger to himself or others. But Scott is not a violent person and is not a danger to himself or anyone else, so I despaired of ever getting help for him. And no one in my family would support me in going through the steps to have Scott committed—we were all afraid of the system, having had the experience of giving up our rights to get welfare when we couldn't find work, or having been abused by the police.

Finally, Scott did a couple of things I thought a judge might accept as dangerous. He left a pot on the stove and it melted. Then he filled a lantern with fuel and the fuel caught fire, burning the front porch. The judge accepted my affidavit and arranged for the RCMP to pick Scott up the next day.

I will never forget how I felt that day when the police came. They were kind and respectful—but Scott looked so confused and lost.

Scott: My sense of betrayal has softened over time. I didn't know until recently that it was my mother that sentenced me to eternal hell.

Annie: When I think of all that Scott's gone through since that day, I still feel that I've betrayed him. At the same time, I am so thankful he is alive. He is not struggling on the street; he has his own apartment and friends. He is still under certification, however, and hates being injected with his medication every two weeks. His medications have negative effects and no one knows what the long-term effects are.

Scott: The doctor represents totalitarianism in my life. I'm afraid of her, how she manipulates my mind to get what she wants, which is another pay cheque out of me.

Annie: I live with a mix of fear, guilt, hope and thankfulness that Scott is alive and that we have a loving relationship. Writing about this and sharing it with Scott has been important, because we need to talk about what has happened to us. We need to respect each other's journey even though we see things differently.

Scott: The conspiracy between the drug companies, the media and government, who are colluding to bring about the destabilization of the family unit through fear mongering, is truly despicable and should be undone immediately.

They keep me certified so that I have to continue taking their drugs. There are many viable alternatives to drug 'therapy,' like better diet and vitamin therapy.

Medical Staff and Self-Injury

LM

LM is a mental health consumer recovering from borderline personality disorder and post-traumatic stress disorder. She is currently pursuing her psychology degree at Simon Fraser University and volunteers with Vancouver Coastal Health

I started self-injuring nine years ago, when I was 21. When I couldn't focus on my university coursework, self-injuring helped me concentrate and continue studying.

Self-injuring became an outlet for painful feelings. At times, I felt like I had fallen into a void that held only the present unbearable moment. I couldn't remember what it felt like to be cared about or to feel calm—though I often looked calm on the outside, despite my inner turmoil. I had no words to explain what was bothering me. Having a physical injury was a way of telling other people that I was hurting.

When I self-injured, I floated away from myself. This disconnection allowed me to injure my own body. After I self-injured, I still felt bad—but in a less intense way. The physical pain distracted me from my emotional pain. The need to get medical treatment was something concrete to focus on.

Because I have received effective therapy and have learned other coping skills, I now self-injure less often and less severely. However, coping without self-injury is an ongoing struggle.

I have had some difficult experiences receiving medical treatment for my self-inflicted injuries. A doctor at the emergency room told me that the other patients were there for reasons that weren't their fault, but I was there because it was my own fault. He said that he would treat all the other patients in the treatment area first—I would have to wait until he was finished. He was very rough in cleaning my injury, causing more physical pain. I felt unsafe being treated by this doctor, so I left the hospital and found treatment elsewhere.

A doctor at a burn clinic told the medical students he was supervising that I was "obviously a very bitter young woman." Another doctor at the burn clinic ordered me to not self-injure again. When I came back with a new injury, he got angry with me for not following his order. At times, I was given inferior medical treatment—I think that, because I had so many scars, doctors reckoned that it no longer mattered how well my injuries healed.

I believe that the doctors' unhelpful responses came from their lack of understanding about self-injury. Unfortunately, their responses hurt me deeply, which ultimately contributed to more self-injury—and increased my fear and shame when seeking medical treatment.

Not all my experiences with medical staff

Self-injury refers to causing minor or moderate injuries to one's own body. Common methods are cutting, burning, scratching or hitting oneself. Sometimes it is also called **self-harm** or **self-mutilation.**[1] Self-injury is **not a suicide attempt.** It is a way of surviving by reducing emotional pain.[2]

have been negative. My family doctor has been a consistent source of support. If I need treatment for an injury now, I usually visit a walk-in clinic where the doctors treat me with respect. It was helpful for me when one of them encouraged me to come and talk to her before self-injuring. Clearly, the way medical staff treat people who self-injure can either help or hinder the recovery process.

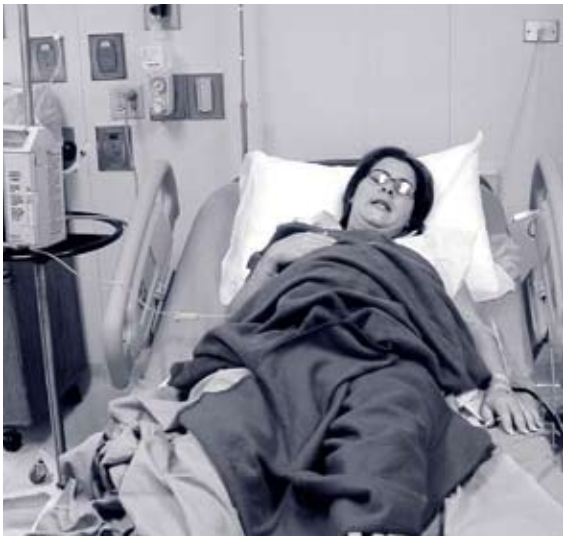
Self-Injury—Unhelpful Responses

- Telling the person to stop self-injuring. People need to learn other ways to cope before they are ready to stop.[3]
- Calling self-injury (or the person) manipulative or attention-seeking.
- Trying to deter the person from self-injuring again by making the medical treatment experience as bad as possible. Doing this may cause him or her to feel angry or ashamed. These feelings can contribute to more self-injury and to avoiding medical treatment in the future.[4]
- Forcing a person to remove his or her clothes when it isn't necessary for medical reasons. Many people who self-injure are survivors of sexual abuse and find it traumatic being forced to undress.
- Punishing the person by giving stitches without anesthetic or treating his or her injuries in a way that causes unnecessary pain.[5]

Helpful Responses

Educating yourself about self-injury.

- Understanding that even if the person looks calm or capable, he or she may be feeling quite upset inside.[6]
- Acknowledging the person's distress, even if you don't understand why he or she is distressed.
- Offering the same quality of medical treatment for self-inflicted injuries as for accidental injuries.
- Interacting with the person respectfully and avoiding judgments.
- Being aware of your emotions when dealing with self-injury (fear, anger and shock) and not communicating them to the person who self-injures. Finding support for yourself if you need it.[5]



footnotes

1. Sutton, J. (2005, May 11). *Terminology: Establishing the most appropriate term to describe the act of hurting oneself.* siari.co.uk/self-injury_terminology.htm.

2. Martinson, D. (1998). *Self-injury: A quick guide to the basics.* selfharm.net/guide.html.

3 Jeffrey, D. & Warm, A. (2002). A study of service providers' understanding of self-harm. *Journal of Mental Health, 11*(3), 295-303.

4. Martinson, D. (1998). *Emergency-room personnel and self-injury.* selfharm.net/erworker.html.

5. Martinson, D. (1998-2001). *Bill of rights for people who self-harm.* selfharm.net/brights.html.

6. Bristol Crisis Service for Women. (1997). *Helpful responses to self-injury.* [Brochure]. www.users.zetnet.co.uk/BCSW/pdfleafs/Helpful%20responses.pdf.

FRIENDS—has been a friend

First I feel nauseous; then I think I'm going to throw up. That's usually what triggers my anxiety attack. I get so worried that I will throw up. Then I feel hot and dizzy and get a really bad stomach ache. I feel like I need to escape; like I'm trapped in this closed room.

I began to leave school between classes so often that my friends started wondering what was going on. They thought I was a faker, and that I was missing way too much school. They would confront me the next day and ask, "Why did you leave?" or, "Why did you go home?" I'd tell them it was because I wasn't feeling well. I could tell by their expressions they thought I was lying. And then I would worry about how much work I missed or if the teachers were not going to be nice to me anymore.

I can usually only control my anxiety attacks at home or when I'm with my parents. They happen almost anywhere, except at home.

I always think there is something wrong with me. I have gone to doctors about my stomach and they basically throw pills at

Michelle Anderson

Michelle is 15 years old and started feeling worried when she was 10. At 10, she took the FRIENDS for Life program in Maple Ridge. She currently lives in North Vancouver and enjoys cooking and swimming

for more info For information on the Australian program FRIENDS for Life visit www.friendsinfo.net, and for FRIENDS in Canada, www.friendsinfo.net/ca.htm.

Aboriginal Superhero

Saving lives one comic book at a time

Shirley Muir

Principal, The Media Bank, Selkirk, Manitoba, themediabank@shaw.ca

Comic books and health are not words you normally hear in the same sentence.

In fact, some people may think comic books are an unhealthy pastime. But the Healthy Aboriginal Network (HAN) thinks they have the potential to save lives.

With that belief, and a lot of hard work, HAN published a 48-page comic book this spring on the topic of youth suicide prevention.

"It was apparent to us that youth had put up a lot of barriers to discussing suicide prevention. We needed a resource that they not only found non-threatening but actually went out of their way to find and enjoy. We needed to create an ice breaker," says Sean Muir, founder and Executive Director of the Healthy Aboriginal Network.

By July 2006, 34,000 copies of *Darkness Calls* had been sold and distributed across Canada. A large part of its success lies in the story and illustrations that Steve Sanderson had created. But HAN has also done an amazing job of self publishing

friends | *cont'd from previous page*

me for my stomach, which don't help at all.

One of my biggest fears is public speaking. Any class I go to, I'm scared that they will ask me to read something aloud—or to do those group projects where you have to present in front of the class. I have a huge social anxiety, too. I get so nervous thinking my face will go red when I'm talking to someone that it usually does. This is affecting my life, and I can't stand it. It's making me depressed and unhappy all the time.

> "I think the best way of taking worries away is to think about something else for a long period of time—chances are your worries will go away."

Because I have felt this way for a long time—and sometimes it's really bad—my mom had a therapist do the FRIENDS for Life program with me in 2000, when I was in grade four.[1] This was so I could learn how to control the thoughts that were making me feel anxious about things.

What I remember most about the FRIENDS program is the "I" in FRIENDS: Inner thoughts.[1] It's the strategy that I use the most. I make my mind think about putting all my worries in boxes—the more layers of boxes, the better—so the worries won't escape. Then I put all those boxes in one very strong metal box and put tons of locks on this box. I see it flying way across to the other side of the world and landing at the bottom of the ocean, where the worries can't escape or come back to me. By the time I finish imagining all of that, my worries are gone. I think the best way of taking worries away is to think about something else for a long period of time—chances are your worries will go away.

Another strategy is the breathing methods that are explained in the "R" of FRIENDS: Relax and feel good.[1] I try to control my breathing by breathing slowly and taking deep breaths. At the same time, I start to think something different, like, "What am I really worrying about? Is it really worth it to get all nervous? I always survive these anxiety attacks, don't I? So is it really worth worrying about?" And then I tell myself that the stomach aches always go away and that I'll be okay in a few minutes.

If I hadn't learned these strategies, I would never have been able to get through my attacks. And sometimes, my anxiety gets too big to be able to use the strategies that I learned in the FRIENDS program. But for most of my worries, FRIENDS has really helped me know what I can do, so I don't feel so awful.

footnote

1. The acrostic expansion of "FRIENDS" as used for children of Michelle's age (10 at the time) was changed in 2004. Currently, "I" stands for: I can do it! I can try my best! And "R" stands for: Remember to relax. Have quiet time.

and marketing the comic direct to Aboriginal, suicide prevention, literacy, health and education groups across Canada. HAN's mandate is the non-profit promotion of Aboriginal health, literacy and wellness.

It's also HAN's dream that tens of thousands of youth will read and open their minds to discussing suicide prevention wherever the comic is discovered.

"Government spends millions of dollars a year on brochures and booklets on health and social information. How much of that is actually being read by the target audience? I would argue very little of it. Our comics are designed to engage youth, to create literacy on suicide prevention for everyone, not just visual learners and those that have difficulty reading," says Muir.

Muir goes on to say "I remember how growing up, I used to read comic books with a buddy. But he always used to finish his much faster than mine. So I asked him one day, 'How do you read so fast?' He replied, 'I don't read everything. I just look at the pictures and get the jist of what's going on.' I remember that kid. He had a very difficult time reading in class. It occurred to me that comic books could be a terrific teaching tool for visual learners."

HAN started to explore the possibility of creating a suicide prevention comic book. Muir was lucky enough to find a funder in the BC Ministry of Health's Aboriginal Health department. So all he had to do was find a story.

Enter First Nations cartoonist Steven Sanderson, born and raised in Saskatchewan but currently living in Vancouver. Sanderson has a powerful gift for storytelling. Muir remembers: "The first day we met, he told me the story of he and his cousin who, growing up on a reserve, had struggled with visions of killing themselves. It was powerful story that left me riveted to my seat.'

In the end, this became the story line for Darkness Calls, which Steven wrote and illustrated.

The opening scene of the comic book has a teenager, Kyle, sitting in a classroom. Kyle feels socially isolated and has difficulty at school. His teacher, classmates and parents bully him. His only escape is his art and cartooning.

One day, Kyle finds life just too overwhelming and considers killing himself. Just as the thoughts of suicide seem to be winning him over, an elder enters his life. Around the kitchen table, over a cup of tea, the elder teaches Kyle about the old ways of Wesakecak and Wihtiko.

This storyline was developed into a manuscript. But getting youth and health professionals to read a nine-page, single-spaced story was not as easy as Muir had hoped. "No one wanted to make the time to read it. So we decided to create the storyboard and import the pencil drawings into a movie editing program and have Steve tell the story in his own words. Then we had no problem previewing the story in front of youth focus groups and health professionals for authentic characters and language."

Armed with feedback, Muir went about making changes to the original story. All in all, the process took nearly nine months to complete.

It was apparent to us that youth had put up a lot of barriers to discussing suicide prevention.

HAN's initial print run sold out. But Darkness Calls will go into its second print run in November of 2006. HAN sells comics every day. And everyone seems to agree: comic books are healthy.

HAN has funding to create three more comic books this year on diabetes, staying in school and women's sexual health.

for more info

For more information contact Sean Muir, Executive Director of the Healthy Aboriginal Network at sean@thehealthyaboriginal.net

Spokes, Needles and Anti-Therapy
Child and Youth Resiliency Team

Dave Ehle, Karen Larsen, Glenn Neilson, Karin Stotzer

Dave, Karen, Glenn and Karin are members of the Child and Youth Resiliency Team at the Canadian Mental Health Association in the Cowichan Valley. Dave is a family therapist and coordinator of the CYRT. Karen, Glenn and Karin are child and youth counsellors

The Child and Youth Resiliency Team (CYRT) at the Cowichan Valley branch of the Canadian Mental Health Association is a small group of child and youth care workers working 'outside the box.'

Tasked with the mission of providing outreach to youth in the community, they have developed several youth programs. The programs work hand-in-hand with each other, and aim at all—rather than just "at-risk"—young people. These features enable the CYRT to connect with youth who would not otherwise access mental health or other social services.

Two main outreach programs have been developed: the school enhancement program, and the U-Fix-It BikeWorks/Youth Craft Shop. Both programs hope to foster youth's positive assets,[1] including relationships with adults, good friends and contribution to the community.

The school enhancement program

The school enhancement program places CYRT members in two local middle schools and one elementary school. Rather than arrive at these schools with a set agenda, each school's unique needs and character determine the form and content of programming or connection.

The main goal of the school enhancement program is developing positive relationships with youth in the community, thereby helping to enrich the school environment. At the same time, the program provides school staff with a skilled mental health worker for consultation and referral purposes. At the elementary school, this has resulted in a lunchtime games and crafts program. At the middle school level, involvement leans toward youth experiencing behaviour problems at school. Team members encourage youth to pursue positive creative activities. They guide conversations on issues such as sexual health and drug use. They also strive to increase students' self-esteem, attendance and achievement—all while working to build a positive school environment.

The U-Fix-It BikeWorks / Youth Craft Shop

The U-Fix-It BikeWorks program came into being in July 2005. In November 2005 the Youth Craft Shop was added. Both shops are based on the simple idea that creative and productive activities are vital to the health and well-being of youth.

The program provides space and materials—and builds connections with the young people involved. Managing issues of power and trust are crucial in developing relationships that are enriching—and not restrictive—to young people. In many cases, the relationships that emerge are among the youth's first supportive connections with an adult. By providing the chance for adult helpers to participate in teaching bike and crafting skills, both shops support the development of positive connections with adults outside of the family.

Neither BikeWorks nor the Craft Shop are presented as mental health or other social service programs—rather, both appear as local businesses appealing to youth. The shops serve the community by recycling used bikes and craft materials. And participants learn a variety of new skills. Specific tasks are chosen for a given youth based on age, interest and skill level.

The ultimate goal of this program is to engage these young people in teaching skills to their peers. This process supports the growth and display of competency and mutual support, which results in an increased sense of self-esteem and belonging.

Throughout the program, an additional focus is placed upon giving to the community. For example, prior to creating a quilt of their own, participants at the Craft Shop create receiving blankets for the hospital maternity ward and cat blankets for use at the SPCA while learning basic quilting skills. At BikeWorks, participants help seniors and the homeless maintain their bikes.

Helping youth gain access to mental health services

Within the context of the wider child and youth mental health system, the CYRT programs can be seen as both outreach and prevention. At both the shops and school, team members have contact with a number of youth, some of whom have some form of mental health concern.

Team members have the opportunity to develop relationships with these young people and their families. This relationship can be a means of gaining access to the official intake process for mental health services, and as a support for the youth during intake and while on the wait-list. Alternately, youth who are receiving mental health support are steered back into the BikeWorks and Youth Craft Shop as a means of additional support. Similarly, the school system and other community agencies use the shops to the advantage of their clients.

Overall, the programs run by the CYRT staff make a valuable contribution to the community in the Cowichan Valley by building on youth's strengths, providing access to healthy and creative activities, and helping youth gain access to traditional mental health and other community services.

footnote

1. For more information on the Search Institute's 40 Developmental Assets visit www.search-institute.org.

My Path to 'Mental Illness First Aid'

From young adult with mental illness to facilitator

Shannon Ryan, MA

Shannon lives in Vancouver with her 15-year-old daughter. She has a master's degree in Social Anthropology focusing on population health and the social determinants of health

My first experiences living with mental illness occurred in my late teen years—but neither myself nor my family and friends recognized what was actually going on.

By the time I was 17, I would spend months with an unlimited amount of energy and countless creative ideas, which often meant I slept very little. Eventually I would become agitated and irritable with my family and friends.

Alternatively, I also experienced many severe depressions as a young woman. I would find myself unable to cope with school, friends or family obligations. At times I could barely leave my bedroom—my anxiety was so severe that I simply found it easier to stay isolated and keep activities to a minimum.

I was unable to comprehend that what I was experiencing was mania, depression and anxiety. I turned to self-medicating with alcohol and marijuana in an attempt to manage my extreme mood shifts. In 1988, just before my 19th birthday, I was hospitalized for the first time, on the psychiatric ward in a hospital in northern BC.

Many, many years went by before I was accurately diagnosed and could successfully manage my mental illness. In fact, it wasn't until March of 2003 that I was diagnosed with bipolar disorder and panic disorder.

After being diagnosed with bipolar disorder and experiencing the devastating consequences of an acute-but-unrecognized and untreated episode of mania and psychosis, I lost a lot. Not only did I lose my contract with Health Canada, my apartment and my ability to care for my then 12-year-old daughter for nine long months, but I also lost my ability to believe in myself—to believe that my life was ever going to get back on track and that I would regain my well-being over time.

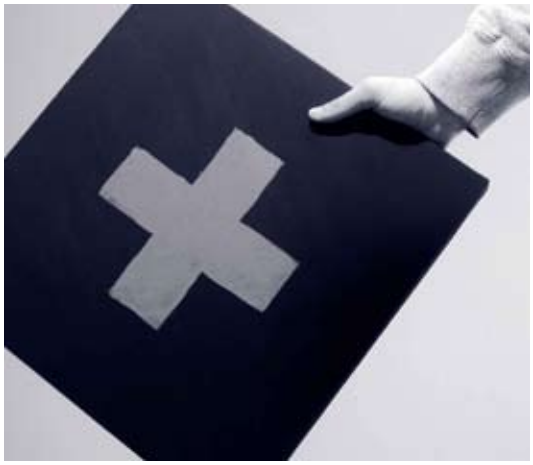
Thankfully, my family, friends and medical advisors did not give up hope. I leaned on the people around me until I was able to slowly and very painfully regain confidence in myself and the person I was—despite the psychiatric labels, which took me a long time to come to terms with.

Over the past two years, I have worked very hard at my recovery process. I have been able to stabilize my moods and enjoy and fully participate in my life—including working as a facilitator with the Vancouver-Burnaby branch of the Canadian Mental Health Association (CMHA).

In 2003 I spent a lot of my time walking through my neighbourhood in Vancouver. One day I came upon the Vancouver-Burnaby branch of CMHA on West Broadway, where I was greeted in such a warm and friendly manner that at first I wanted to turn around and run. But instead, I decided to stay and look through the amazing collection of books, videos and other publications in the resource room. Over the next few weeks, I continued to stop by CMHA to browse. I devoured the literature on bipolar disorder, anxiety disorders and psychosis.

Then, after accessing some of CMHA's services, I was encouraged to apply for training on a new and exciting course called Mental Illness First Aid (MIFA). I have been facilitating the two-day MIFA course over the past two years for government, private, education, commu-

Instead of Airway, Breathing and Circulation, however, the ABC in Mental Illness First Aid stands for Acknowledge changes, Be proactive and Check-in and follow-up.



nity, health care and not-for-profit organizations all over the Lower Mainland.

The course is designed to give the general public a better understanding of mental illnesses and the basic skills and knowledge to effectively respond to individuals who are experiencing mental distress in our communities. We teach first responder skills that increase confidence in recognizing the signs and symptoms of mental illness. Participants learn to respond in a compassionate, safe and supportive way, and to refer individuals to the appropriate resources in their communities.

MIFA follows a physical first aid model, with its "ABC" approach. Instead of Airway, Breathing and Circulation, however, the ABC in Mental Illness First Aid stands for Acknowledge changes, Be proactive and Check-in and follow-up.

The Mental Illness First Aid course will soon have a youth-specific version that will help parents, teachers, friends and mentors working with youth. Recovery is faster and more complete when intervention happens early on in the illness. Looking back, I know that when I started to experience depression and anxiety as a young woman, my family, my friends and I didn't know what was going on. None of us knew then how to effectively manage the situation. When young people have struggles with their mental health, it is important to be able to provide them with the information, support and interventions that will help them recover.

Although my recovery is ongoing, I have an amazingly full and rich life. I wouldn't change the past: sharing my personal experience of living with and effectively managing mental illness means that other individuals can learn from my experience. They, in turn, will be able to appropriately respond to others experiencing an acute or chronic mental illness. In sharing my journey, I have been able to show course participants that anyone can experience mental illness—and, with the right support from family, friends, colleagues and medical professionals, most people will recover fully. i

for more info

The Mental Illness First Aid course is currently offered in 10 communities across BC by the Canadian Mental Health Association. For more information, visit www.mifa.ca, or call the Vancouver-Burnaby Branch at 604-872-4902, or e-mail mifa@cmhavb.bc.ca

Meth An innovative addiction prevention project

David Diamond, DLitt (Hon)

David is Artistic and Managing Director, and Joker, at Headlines Theatre in Vancouver

For more information on the Meth project, go to www.headlinestheatre.com or call 604-871-0508.

Vancouver's Headlines Theatre is producing an innovative touring production about addiction called *Meth*. The play will be created at the Vancouver Aboriginal Friendship Centre in November of 2006. It will be performed at the Japanese Hall from November 29 to December 10. The production will then tour up to 28 communities around British Columbia during January and February of 2007. Everywhere the play is performed on the tour, it will be supported by teams of counsellors.

The project is designed to stimulate community dialogue that seeks grassroots solutions to addiction issues. As requested by many of the community members with whom we have consulted, addiction will be dealt with as a health issue—not a justice issue.

Meth will be created and performed by youth and adults who have struggled with crystal methamphetamine addiction. Over the course of a six-day Theatre for Living workshop, participants take part in games and exercises that help them explore issues at a deep level. They then create plays. These plays are the basis for the single play developed for performance.

Meth will be audience interactive, in the form of forum theatre. Forum theatre provides an opportunity for creative, community-based discussion. The story of the play builds to a crisis and stops, offering no solutions. The play is performed once, all the way through, so the audience can see the situation and the problems that arise. The play is then run again, with audience members able to "freeze" the action at any point where they see a character engaged in a struggle. An audience member yells "stop," comes into the playing area, replaces the struggling character and tries out a new idea. This is called an "intervention." The process is fun, profound, entertaining and full of surprises—and learning.

The Meth project has the potential to be very powerful in the community because the process digs underneath symptoms to get at root causes. It will explore family and relationships and the tiny moments in our lives that lead us to addictive behaviour. Because it is theatre, it does this at a symbolic, metaphoric level—the level at which humans articulate thought and feeling, which lead to action. i

Honoured to be a FRIENDS Trainer

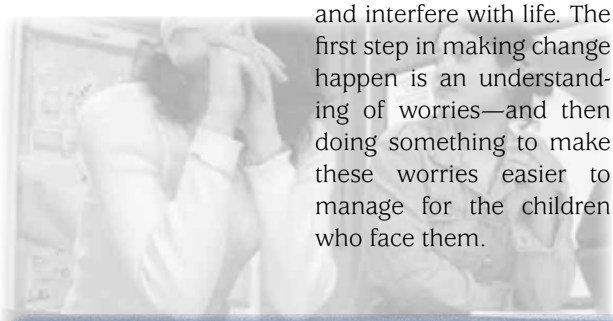
A school-based anxiety prevention program

Jonaire Bowyer-Smyth

Jonaire has been a behaviour specialist in the Surrey School District for the last 13 years. She also has a private practice as a family therapist, and is a trainer for the FRIENDS for Life program

FRIENDS is being taught in grade four and five classes across British Columbia. In the largest school district in the province, Surrey, I am amazed at the effort to make this prevention program a success—from the leaders in Student Support Services, to the principals of elementary schools who encouraged teachers to attend the day of training. I am also amazed at the energy and commitment of the teachers, counsellors, child care workers, special education assistants and mental health therapists who have been trained. There is a drive to understand anxiety and a willingness to bring about change—by offering the FRIENDS for Life program.

All of us worry, but worrying becomes a problem when the worries overcome healthy experiences and interfere with life. The first step in making change happen is an understanding of worries—and then doing something to make these worries easier to manage for the children who face them.



As a behaviour specialist and in private practice I noticed that many children were having difficulty coping with their worries. This was reflected in their behaviours—avoiding, making excuses, blaming and not taking risks. As I gained more insight into anxiety, I began to wonder if interventions were too focused on changing behaviours, rather than figuring out what the behaviours represented. Hence, FRIENDS for Life began a journey of personal philosophical change.

Last fall, through my association with FORCE Society for Kids Mental Health, I was invited to become a district trainer for FRIENDS. I felt blessed to take this journey along the universal-prevention trail—far preferable to seeing children individually in private practice, with the stigma and expense for them and their families.

The challenge was to get the program out to all grade four and five teachers in our district. Fortunately, my excitement spilled over to Student Support Services. With very little convincing, I was on the way to getting the message out, with a memo to all elementary principals and grade four and five teachers.

The first workshop was scheduled for October 14, 2005. Interest in attending was high. Principals were finding ways to get teachers there even though there was no funding. Teachers who shared classes were coming on their own time. Wow!

Teacher job action in October 2005 stopped the process, but it did not stop the interest. Once the strike was over, we scheduled another workshop. Since then, there have been more opportunities to train teachers. It is their response and the support from Student Support Services that continue to drive my commitment. More importantly, my commitment is driven by the children who learn the skills and techniques that address the experience of anxiety.

Over 66 elementary schools in the Surrey School District have at least one or more teachers trained to run the FRIENDS for Life program. My goal for the upcoming school year is to have training available that enhances those numbers and reaches all elementary schools in the district. We will also be one of the districts supported by the FORCE Society for Kids' Mental Health to offer a training component for parents.

Research confirms that universal intervention is the most practical and effective way to teach and promote resiliency for all children. The FRIENDS for Life program, when used by teachers, can effectively return a majority of clinically anxious children to a normal range without the use of other interventions, such as specialists. I'm honoured to be a trainer for this invaluable program.

FRIENDS for Life is an Australian-developed, world-leading, school-based prevention program that assists children and youth in developing life skills to effectively cope with anxiety. It addresses the mind, the body and the behaviour that results from both.

What is Team Izzat?
Police as mentors

Jet Sunner, Sgt

Jet is a police officer with the RCMP in North Vancouver. He has 14 years of service throughout the Lower Mainland. Jet has participated in many initiatives aimed at reducing violence against women and children. He founded Team Izzat in 2004

Team Izzat is a youth-targeted program driven by the volunteer efforts of 22 police officers serving in the Lower Mainland with the Royal Canadian Mounted Police (RCMP) and the Vancouver Police Department. Fifteen university students also volunteer with the team.

The police officers who are members of Team Izzat serve as role models. As mentors, they help guide kids along a positive path based on respect and they reinforce the value of "being on the good side of the law."

Team Izzat members connect with young people in non-threatening ways. Many of the outreach efforts are focused around sports and other social activities that allow adults to bond with young people.

Team Izzat is about building respect, sending positive messages to impressionable young people, and influencing them in their decision making to help prevent crime and personal tragedy.

History of Team Izzat

Team Izzat was formed in January 2004 by me and members of the RCMP. The team was an informal response to the increase of violence and crime among South Asian youth. The individual RCMP members committed their volunteer time to changing the negative portrayal and stigma associated with South Asian youth and their connection with crime.

Team Izzat targeted elementary schools with high ratios of South Asian students. They reached out to temples, mosques and other community centres. They focused on engaging youth in positive activities, and supporting community projects that pay tribute to youth or enhance youth services.

Who Does Team Izzat Work With?

Team Izzat volunteers aspire to project an intelligent, compassionate, proud-yet-humble image of South Asians. Through their focus on young South Asians, they foster pride in their culture and reinforce positive images.

Encouraged by the success of the program, the Team Izzat volunteers expanded their efforts. Reaching beyond just the South Asian community, volunteers now work with youth from all backgrounds. They counter negative stereotyping, build self-esteem, and involve youth in constructive activities—reinforcing acceptable behaviour and promoting citizenship.

Annual Youth Engagement Work Plan

- *Mentoring Program:* Bi-weekly, drop-in mentoring on site at schools or community centres in the Lower Mainland connects a Team Izzat volunteer with young people to assist with homework, participate in social activities and provide general guidance. This program began at Cambie Community Centre in Richmond this year, in partnership with Richmond Youth Services. It continues every second Thursday, targeting youth ages 12 to 19. Team Izzat plans to expand the program to other cities in the Lower Mainland.
- *Common Ground Day:* This escorted civic tour of places to worship exposed young people to community diversity. In January 2005 Team Izzat facilitated this first tour with 180 grade eight students in Richmond. They hope to make the tour an annual event.
- *Three-on-Three Youth Basketball Tournament:* Team Izzat successfully completed their third annual Three-on-Three Basketball Tournament for boys and girls ages 12 to 16. Twenty-one teams entered this free tournament hosted at McNair Secondary in Richmond on July 8, 2006.
- *Youth Leadership Awards Dinner:* The first event was held in August 2005 to recognize Richmond high school graduates for their leadership and positive achievements at school, home and within the community. Three hundred youth and their parents attended. Ten grads were presented with bursaries of $500 each.

Looking ahead

Team Izzat is planning a North American youth forum for university students ages 19 to 35 in May 2007. This forum will deal with global issues selected by the students. Team Izzat hopes to bring some fantastic speakers to this event.

'Co-ed' Parent Group

Strengthening family responders

As a therapist with the Canadian Mental Health Association's Cowichan Valley Branch, Gabriele works with young people who struggle with eating disorders. She is often approached by parents interested in meeting with other parents. Early this year, in response, she contacted mothers and fathers who had already accompanied a child through the healing process. Three parents stepped forward. One couple and another mother were willing to share their thoughts and experiences with other parents actively confronting the challenge of a young family member struggling with food, weight and body shape issues.

With its emphasis on parent-to-parent support, the initiative fit the mandate of the Strengthening Youth and Family Voices pilot project, which Gabriele coordinated at the Cowichan Valley branch of CMHA.[1] Under the umbrella of this program, space, refreshments and administrative support were provided.

Mental health issues affect the whole family. This truism was addressed by involving both parents whenever possible. To support hearing and appreciating both male and female voices within the family, Gabriele invited Björn, also a therapist, to co-facilitate the group. Providing the framework for this group as a couple highlighted the importance of mothers and fathers by emphasizing and respecting the different roles within a family. Gabriele and Björn are also parents of young adults, which strengthened the emphasis on parent-to-parent support.

Gabriele was the main therapist for many of the families and therefore was able to act as a resource for general questions regarding eating disorders. Since the young people were concerned their parents would talk about them, it was agreed that specific details of the affected youth would not be discussed and that things would be kept confidential.

Björn became the main facilitator and was particularly able to connect with the men in the group. Each meeting began with sitting in a circle and "checking-in" with our thoughts and feelings. The first round was just about listening and being heard. In another round, concerns, announcements or questions would be raised, helping to shape our agenda. A dominant topic for the evening easily emerged. Each meeting closed with "checking-out"—for sharing insights, pondering thoughts, formulating intentions, expressing wishes and giving compliments. The group quickly became an open space for heartfelt sharing.

There were many insights

- All family members have an important role, including the siblings of a young person. There is a normal developmental stage of separation between teenagers and parents, which siblings share.
- There is a fine balance between confidentiality and secrecy within a family. If no one talks about the condition, then there is secrecy and some denial. Siblings are often affected by secrecy. They generally know something is going on, but if no one talks to them, they may feel very alone. Confidentiality maintains respect for personal issues and keeps discussion of the problem within the family or therapeutic circle.
- Both parents may feel abandoned by the other. Fathers shared how they felt left out—the line of communication would often be from daughter to mother and mother to father—so they often stayed in the background. When men stay in the background, women sometimes interpret this as abandonment and think they have to do it all.
- Mothers and fathers may react differently to situations. For example, fathers tend to look for a clear path towards a goal, whereas mothers are more likely to worry or to long for emotional affirmation. When they are struggling, men tend to withdraw, whereas women often seek relationship and conversation to process things. This may send different messages to the young person and can lead to tensions within the family.
- Parents must give themselves permission to "step out" of being in charge of the eating disorder. It is the young person who has to take charge of the condition; parents can only assist. Dads found it harder to step back; they want to 'fix it.'
- Eating disorders are not just a female thing. Men or boys can also be affected by eating disorders or body image issues. And fathers need to realize the importance of their role in the healing process.
- When women heard their husbands' sharing and the responses by the other men, things shifted from being a personal difficulty between them, to being viewed more objectively as a partner's action in the context of gender roles, societal expectations and different coping mechanisms.

Benefits for all

The group showed how a challenging personal experience can be turned into an asset for helping others who

Björn Ratjen, PhD

Björn has provided individual, child and family counselling in private practice for many years. He specializes in recovery from trauma, has created psychological first aid courses for emergency responders, teaches peer support and is president of the Cowichan Men's Resource Centre

Gabriele Ratjen

Gabriele has been a clinical counsellor for 17 years. Through the Child and Youth Mental Health team of the Canadian Mental Health Association, Cowichan Valley branch, she provides therapy to young people struggling with eating disorders. Gabriele has been local coordinator for the CMHA Strengthening Family and Youth Voices project

footnote

1. For more information on the Strengthening Youth and Family Voices program of the Canadian Mental Health Association, BC Division, visit cmha.bc.ca/advocacy.

continued on page 29

Quality Info on Kids' Mental Health

New website takes a community approach

Sherry Cecil

Sherry is an independent communications consultant specializing in health and children's issues

I met Dan Offord only a few times before he died in 2004. In 2003 I was hired to build public awareness for the small—but respected—research centre that would later bear his name.

The Offord Centre for Child Studies began life in the early 1980s, and Dan Offord was one of its founders. It was known then as the Canadian Centre for Studies of Children at Risk. But its aim was the same—to study the factors that put children at risk of mental health problems and find ways to improve their lives and opportunities.

Dan—a researcher, clinician and scientist—was responsible for the landmark study that gave us the disturbing news, still true today, that one in five children has a mental health problem.[1] It was a watershed moment in children's mental health and it cemented Dan's reputation as a giant in the field of child development.

It was no surprise, then, as I travelled the country singing the praises of the Offord Centre and its dedicated team of researchers, to find people who knew Dan and admired his work. What was surprising is that it was not Dan's work as a scientist that left its greatest mark on those who met him, but rather, the impact he made as a mentor, a friend—and a human being.

You see, Dan was not a passionate advocate for children because he was a child psychiatrist. He was just passionate about children, period. As an adult, he returned every summer to the camp for disadvantaged children where he had worked as a teenager—not because it might be helpful to his research, but because he believed that the right supports delivered at any time in a child's development by anyone can make a difference to their future.

Dan Offord's philosophy continues to guide the work of the centre, now headed by Peter Szatmari, a child psychiatrist and specialist in autism.

"As scientists, we know a lot about what helps kids grow up healthy, because we've studied it in depth," says Dr. Szatmari. "Where we so often fail is in sharing that information with parents and others in the community who can use it to improve outcomes for kids."

Sharing that information has never been more important. Five out of six children who have a mental health problem will never see a mental health professional.[1] Those who do are often diagnosed quite late, when treatment is less likely to be successful.

The Offord Centre prints information pamphlets for parents. These are available to libraries, public health nurses, family doctors, teachers and other groups that deal directly with families.

But many parents turn to the Internet for help and are often overwhelmed by the quantity of information—much of it conflicting. They end up confused, frustrated and no better informed than when they started.

The Offord Centre decided it was time for something better. It created the Centre of Knowledge on Healthy Child Development—www.knowledge.offordcentre.com.

Launched earlier this year, the website gives parents, teachers and others clear, honest, practical information on all kinds of child and youth mental health problems. Visitors to the site will find out how to identify, prevent and treat behaviour problems, anxiety, depression, learning problems and more. They can read plain-language summaries of the latest research from around the world. They'll learn what's normal—and what's not—at every stage of development, and what works—

www.knowledge.offordcentre.com

sharing that information has never been more important. 5 out of 6 children who have mental health problem will never see a mental health professional

footnote

1. Offord, D.R., Boyle, M.H., Szatmari, P. et al. (1987). Ontario Child Health Study. II. Six-month prevalence of disorder and rates of service utilization. *Archives of General Psychiatry, 44*(9):832-836.

and what doesn't—to improve kids' mental health. All information is based on the latest scientific evidence and reviewed by experts in the field.

The website has won praise from parents and professionals alike. Parents get information previously denied to them, and professionals have easy access to published studies they don't have time to research themselves.

"Dan Offord believed that every person has a role to play in helping kids grow and thrive. That's what this website is all about—empowering parents, teachers and others who care about kids by giving them direct access to knowledge they've never had before, that isn't available anywhere else, and that is backed by the very best science," says Dr. Szatmari.

"With this knowledge, families and communities will be better able to help children and youth who are having problems, and to create the kind of climate that will support and encourage children at every stage of their development."

Better knowledge, better choices, better futures for kids—Dan Offord would be proud.

strengthening family responders | *continued from page 27*

are in the middle of a similar struggle. Parents who had already gone through the whole process with their child provided understanding and a kind of roadmap, enabling parents who were going through the initial stages to identify where they were in the process.

The willingness of the experienced parents to revisit painful memories of feeling at a loss or overwhelmed was appreciated. Their presence and sharing validated the issues the other parents were facing, and spread hope and encouragement to everyone. Newer parents gained confidence and said they felt compelled to "try [new] things out."

The experienced parents also benefited. All had consulted with their daughters and sons before and after meetings. They noted that revisiting and reflecting on the past provided an opportunity to appreciate the growth within their own families and to "still learn to see things that I couldn't see before."

The group stopped meeting when summer arrived; however, it is likely a similar group will be established again. If you are interested in participating in the group, or for information on setting up a similar group, contact Gabriele at CMHA Cowichan Valley, 250–746–5521.

So a Youth Enters the Door—Now What?

Approaches at Victoria's Youth Clinic

Maia Love

Maia is a medical student in the Island Medical Program in Victoria. She worked with Victoria's Cool Aid Community Health Centre as part of the Doctor, Patient and Society course at UBC, and has also volunteered in the Downtown Eastside in Vancouver

Teenaged youth who use drugs are more at risk for unprotected sex, violence, injuries, overdose and death.[1] Intervention methods to aid youth in recovering from addiction are thus in demand.

Many youth in Victoria live on the street and use drugs as part of their daily lifestyle. Their access to health care is poor, because their age disqualifies them from several services. For example, there are only five youth detox beds to service all of Vancouver Island, and beds for youth over 19 are not available to stimulant users. This is a concern, since stimulants are the most common kind of drug requiring detoxification for youth.

Several services do exist, however; I volunteered with a drop-in service over the last year as part of a project for the Cool Aid Community Health Centre. I observed doctors at the Victoria Youth Clinic and was struck by their approach once the youth makes first contact. They combine the Five Stages of Change model and motivational interviewing to build understanding between the care provider and patient, and to assess and treat a patient at the same time. When applying some of these skills as a medical student, I was again impressed by the clarity and trust with which young patients and I could talk about the addiction issues in their lives.

Five Stages of Change model

Prochaska and DiClemente found that people who recover from addiction move through five stages of change.[2] These five stages of change are:

- *Precontemplation:* a person denies having an addiction problem
- *Contemplation:* a person considers that he or she may have an addiction
- *Preparation:* the person starts to cut down on addictive behaviour
- *Action:* the person actively abstains from the addictive substance
- *Maintenance:* a state of abstinence is actively maintained

The Five Stages of Change model is a powerful tool, because once a stage of change is recognized, certain methods can be used to help a person change. These methods are specific for each different stage. For example, educating a client about the risks of his or her addiction using statistics and scientific facts is useful in beginning stages, but is counterproductive in later stages, where action rather than information gathering is needed.

continued on page 36

footnotes

visit www.heretohelp.bc.ca/publications/visions for Maia's complete footnotes or contact us by phone, fax or email (see page 3)

Changing With the Times

Online youth crisis services in real time

Robin Shantz

Robin is Communications Coordinator at the Crisis Intervention and Suicide Prevention Centre of BC

A quick glance at the number and variety of distress lines and other services available across BC shows there are a lot of crisis services available for youth who need support—everything from drop-in centres to crisis lines. But the challenge for support and wellness groups, as with every other sector focused on youth, is to remain relevant and keep up with changing youth trends and demands.

This issue confronted the Crisis Intervention and Suicide Prevention Centre of BC a few years ago. Despite successfully running a distress line that has served people of all ages and all communities for a number of decades, we began to notice that the number of youth callers was dropping off. Drastically.

We knew the problems youth are facing weren't just going away. And it's not like youth don't have access to phones—anyone who walks past a high school or university can see cell phones in the hands of youth of all ages and backgrounds. So why weren't they calling any more?

We consulted youth through focus groups to try to find the answer. They told us overwhelmingly that they wanted crisis support services available online. They pointed out that more and more youth are spending more time on the Internet and are using it as a first point of contact for information gathering and communication. To provide services that youth would actually use, they said, we'd have to adapt to their new way of communicating.

That's when the Crisis Centre decided to create its web-based hotline for youth in distress: YouthInBC.com.

Admittedly, there are other types of youth-oriented support services on the Internet: webpages listing resources, sites offering open forums with group discussions, and services offering help via e-mail.

But what makes YouthInBC.com different is its live chat function. This service allows youth on our site to get confidential, nonjudgmental help one-on-one from our trained volunteers in real time. It's the only service of its kind in Canada.

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Sites that offer help on an e-mail basis, by their nature, are delayed in reaching the person in need. But experience has shown that people in distress who reach out for help need to receive it right away.

Open discussion forums can make it difficult to control content and a youth might not feel safe discussing their problems in front of a group. YouthInBC.com provides the safety and immediacy of a telephone distress line using the technology of today.

Youth are using the site's chat function to get support for a whole range of issues. For example:

- One youth wanted to know how to distance himself from friends who call him stupid all the time.
- Another was on for nearly an hour, saying she'd been in a bad mood for no reason and was feeling the urge to take drugs and cut herself. She said she was suicidal most of the time and feared she was manic depressive.
- Another was looking for help for her brother who had made a suicide attempt in the past. She was afraid her brother was going to kill himself that night.

Our data indicates youth like these are coming to the service in greater numbers. When YouthInBC.com was launched in 2004, there were about 40 chats per month. That number has increased to more than 100 chats per month.

On top of that, youth are also sending e-mails requesting help during the hours of the day when the chat function is inactive.

And we've also noticed youth calls to our distress phone line have increased since YouthInBC.com began. This indicates to our staff that through the Internet channel provided by YouthInBC.com, young people are becoming comfortable with crisis services and are more willing to use other options like telephone distress lines.

Beyond the usage numbers and positive feedback from other agencies, we also know the website is

working because of the response we've been getting from youth themselves. On average, YouthInBC.com receives one to two "thank-you" chats or e-mails every month from youth who have come to the service for support. We're also regularly contacted by youth wanting to know if they can help with our service.

But running a live, web-based hotline also has its challenges. We know we need to increase our capacity to conduct more chats, because youth are being turned away due to limited resources. That means we need to add more volunteers and terminals to open more chats. We also are working on expanding the service from its current eight hours a day to 24. The Crisis Centre is also exploring the idea of making the YouthInBC.com software available to other crisis lines and support agencies to offer their own online services in their unique communities.

Another challenge is for volunteers to adapt to facilitating help by typing instead of talking over the phone. Some volunteers are initially concerned they won't be able to read the youth's tone from words on a screen. But they quickly learn to understand a chatter's tone through the choice of words and the presentation of the text.

It is this ability of the volunteers to adapt to the changing realities of technology that best illustrates what the web-based hotline YouthInBC.com is about. It's about seeing our way past the perceived obstacles of a new technology and realizing we have an opportunity to enhance the way we offer help. Evolving our methods of support to keep pace with the type of communication used by youth allows us to remain not only relevant to them, but accessible when they need us—now and into the future.

other youth websites

- www.mindyourmind.ca
- www.kidshelpphone.ca
- www.cyberisle.org
- www.griponlife.ca
- www.zoot2.com
- www.facetheissue.com
- www.there4me.com
- www.talktofrank.com
- www.beyondblue.org.au/ybblue
- www.checkyourself.com
- www.lifebytes.gov.uk

The Youth Net Model

Gemma Fletcher and Sophia Khan

Gemma and Sophia are Youth Net program coordinators working out of the Canadian Mental Health Association, Delta Branch

John's story

"I developed severe obsessive-compulsive disorder (OCD) soon after we came to Canada. My family and I have kept this a secret because of our fears. What does having OCD mean for my career and relationships? What will happen to me? For a long time, I suffered in silence."

Many young people can identify with John,* a former Youth Net facilitator. They understand the fear, loneliness—and, often, the silence that comes with struggling with a mental illness. An estimated 20% of Canadians will be affected by a mental illness in their lifetimes.[1]

What is Youth Net?

Youth Net is a mental health program designed to address the mental health needs of young people. It aims at removing the stigma of mental illness and making professional help more youth friendly. Youth Net facilitators who have personal experience dealing with mental illness deliver 90-minute sessions to groups in high schools.

The Youth Net model was established in Ottawa in 1994. It arose from a Canadian Psychiatric Association study involving youth discussion groups. The study showed that these young people were more willing to talk to peers about their stresses than they were to professionals. Young people often don't feel comfortable communicating with authority figures about their mental health. They feel awkward and don't think adults will understand them. Youth Net facilitators are able to connect with youth on a personal level. The facilitators are university/college students in their early twenties who can relate to experiences that young people are dealing with.

The purpose of the Youth Net program is threefold: education, prevention and follow-up. The "older youth leading younger youth" focus group model creates a supportive climate for young people to access help for mental health concerns.

Ending the silent struggle

Youth Net provides students with an open forum to discuss and debunk myths surrounding mental illness. These myths may be preventing them and their peers from asking for professional help. Young people have the opportunity to learn more about mental health, discuss their stressors and find out about the youth-friendly help

* *pseudonym*

footnote

1. Health Canada. (2002). *A Report on Mental Illnesses in Canada.* Ottawa, ON: Author.

available in their community.

Some youth may be struggling with a dormant mental illness that becomes active as a result of stress. Often, these youth are unaware that they are experiencing symptoms of mental illness and continue to struggle without professional intervention. Others have been living with mental illness and are currently receiving professional support. The program tries to catch those students who are going without help and struggling in silence.

To help with follow-up, Youth Net screens for suicidality, using a self-report screening form. The screening form is a tool that is completed by students and viewed by Youth Net facilitators halfway through presentations. The screening form allows facilitators to identify and follow-up with any young person showing signs of a mental health problem. The Youth Net experience in classrooms has shown that at-risk youth don't always show typical suicidal risks or signs. Monitoring youth disclosure during discussion groups, together with assessing the screening forms, allows facilitators to identify youth who are struggling with their mental health. If needed, the facilitator will link the youth with professional help in the community.

supporting young people with a mental illness: tips

- Be honest and direct
- Actively listen to what they have to say, and describe what kind of changes you have been seeing in them lately, without sounding judgmental
- Assure them that they can get help and that they are not alone
- Offer to accompany them to appointments
- Don't make assumptions or try to simplify their problems
- Help them identify healthy coping strategies and create a safety plan for times when they are acutely struggling

Positive impact

John describes his involvement with Youth Net as a facilitator as being an important part of his recovery. "I have received tremendous emotional support from other facilitators who were around my age group. I got a chance to hear other stories. I got a chance to work toward reducing stigma associated with mental illnesses. All this helped me vastly."

Through education, prevention and follow-up, Youth Net helps young people reach their fullest potential. As John says, "I have to live my life to the fullest. And now, thanks to Youth Net and other programs, I know that if I can overcome OCD, I can overcome anything."

for more info If you would like more information about Youth Net, please contact youthnetdelta@dccnet.com or phone 604-943-1878.

Healthy Attitudes

Youth body image and self-esteem prevention program

Sarah Thorsteinson, RN, BN

Sarah is a community health nurse and member of the Healthy Attitudes Program team, which serves Vancouver and Richmond youth ages 12 to 24

Early intervention of disordered eating behaviours during the teen years is crucial. Eating disorders are associated with serious health risks, including death and impaired psychosocial adjustment.[1] And young people who diet are seven times more likely to develop an eating disorder.[2]

The Healthy Attitudes Program (HAP) is a free, community-based eating disorder prevention program serving Vancouver and Richmond. The program is staffed by a team made up of a community health nurse, physician, dietitian and clinical counsellor.

KC's story

KC's story is typical of client participation in the program. KC, a 15-year-old 10th grade student, was referred to HAP by her school counsellor. Her friends had talked to the counsellor after noticing that KC was losing weight and not eating lunch with them any more. KC admitted to always being on a diet and expressed a desire to be thinner, even though her weight was within the healthy range.

The counsellor suggested to KC that she call the HAP team to see if they could help with her concerns around how she viewed her body and how she felt about herself. KC's friends felt like they had done the right thing by contacting the school counsellor to get help for her. They wanted KC to feel like her old self again and were willing to support her in any way they could.

After some convincing from the school counsellor, KC called HAP and spoke to the intake nurse. After asking KC a few questions about her eating habits and how she felt about herself, the nurse set up an appointment for a face-to-face visit to fully assess KC's situation.

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One Community, Our Future

Sto:lo Youth

In May 2006, the Sto:lo Nation Health Services received a grant through the provincial government Crystal Meth Program. It was proposed that the funding be used to create a youth drop-in centre for aboriginal youth between the ages of 12 and 19 who live on and off reserves.

A youth drop-in centre has been a desire for many Sto:lo youth and their families for years. As an aboriginal youth myself, I yearned for a place that I could find positive role models in a safe, comfortable environment. The creation of a youth centre is an exciting and inspiring enterprise.

StY:LES is vital to the Sto:lo Nation community for the sustainability of our youth in general, as well as for intervention and prevention with youth at risk of abusing drugs and alcohol.

A steering committee was created to plan for the success of the youth centre. Many counsellors, youth workers and others were involved with the planning of the centre. A list of potential services and programs for the youth centre was made, as well as items that would be required for the centre. A portable building near the health services building was leased to be the official youth centre.

The core planning of the youth centre was conducted throughout the month of June. Staff was hired for the summer: a project leader and two peer counsellors. The project leader and I planned and organized for the official opening of the centre—which took place in the first week of July.

StY:LES Youth Drop-in Centre became the official name. StY:LES stands for Sto:lo youth, leadership, empowerment and support—everything we hope youth will find when they come to the centre.

Events and activities were created for different days of the week. Educational, recreational and cultural activities were integrated into the schedule of events. Some days have drop-in hours, when youth can socialize with other youth and the staff.

Positive relationships are being made at the drop-in centre. I introduced one male youth to StY:LES in July. The youth's mother had been concerned about his addiction to ecstasy and had requested assistance from the health services addiction team. The youth also wanted help recovering from his addiction. He is a very intelligent young man. He realized he had a problem—and it was getting worse. The youth centre has proved to be a useful tool to intervene with his addiction. He has built a relationship with other youth and our staff members, especially one of our peer counsellors. He regularly attends the events and activities at the centre. I have noticed a big difference in his attitude and demeanour since he began attending.

There are other youth who come to the centre regularly. They are younger teens who appear to be seeking guidance and support from positive role models, and looking for a safe and comfortable place to just hang out. They don't have problems with drugs or alcohol. The youth centre is an inviting place for them to go to, and it's introducing them to fun things to do. This helps prevent them from trying drugs and alcohol or other unhealthy activities that boredom or peer pressure can sometimes lead to.

Every Thursday a field trip is held, or the peer counsellors give presentations upon request to educate youth. Each community has particular topics of concern they would like presented and discussed with their youth, although the majority of requests are for crystal meth, marijuana and alcohol. The presentation topics include information about drugs, alcohol, suicide prevention and life skills.

StY:LES is vital to the Sto:lo Nation community for the sustainability of our youth in general, as well as for intervention and prevention with youth at risk of abusing drugs and alcohol.

This initial grant by the province's crystal meth initiative only funded the youth centre for the summer months. This created great concern for the youth, communities and staff, because continuation of the centre is felt to be crucial for our young people.

Recently, a follow-up proposal was submitted to the Crystal Meth Program in the hopes of keeping the doors to the youth centre open. I am very pleased to announce that funds have been granted and the youth centre will remain open throughout the fall—and, hope-

Brenda Wallace

Brenda is a Youth Prevention Worker with Sto:lo Nation Health Services in Chilliwack

healthy attitudes | *continued from page 32*

In the one-hour face-to-face intake interview, the nurse and KC discussed KC's recent weight loss and her body image.

KC's weight was still in the healthy range, but she had lost weight on a low-carb diet. She was now counting calories to limit the amount she ate and was avoiding certain foods that were higher in fat and carbohydrates. She was also exercising more.

Most of KC's thoughts were about food and she felt guilty about eating. KC wasn't happy with her current weight and wanted to be lighter. She found it hard to relate to her friends, because they seemed to be able to eat chips and pop and chocolate bars without worrying about the consequences. As a result, she spent less time with her old friends.

she felt guilty about eating

KC was starting to spend more time with her new boyfriend and his friends. She really wanted to fit in with his more popular group of friends—and she thought the best way to fit in was to be thin.

The intake nurse listened to KC's story and recommended that she be included in the program. The nurse explained to KC that she would see the doctor from the HAP team for a thorough medical exam. KC was also asked to inform her family doctor that she was participating in HAP.

KC's next appointment was with the HAP counsellor. The counsellor was concerned that KC showed signs of anxiety and depression along with an unhealthy body image and a desire to be thin. The counsellor offered to see KC for help with these issues once a week. KC agreed to attend, and wanted to see the HAP dietitian for help with healthy meal planning.

After three months of regular attendance at HAP, KC decided she was feeling well enough to stop coming to the program for awhile. She was following her healthy eating plan and was feeling good about her body shape for the first time in years. She was still in the healthy weight range. KC was seeing more of her old friends who had helped connect her to the Healthy Attitudes Program. She realized that her friends truly cared about her, and that was why they had reached out to get her help. KC was grateful that the school counsellor was able to connect her with HAP and that her friends were so supportive.

KC was sure that her problems would've become a lot worse if she hadn't connected with HAP. The team congratulated her on her progress and invited her to return to the program at any time.

footnotes

1. Herzog, D.B., Greenwood, D.N., Dorer, D.J. et al. (2000). Mortality in eating disorders: A descriptive study. International *Journal of Eating Disorders*, *28*(1), 20-26.

2. Patton, G.C., Selzer, R., Coffey, C. et al. (1999). Onset of adolescent eating disorders: Population based cohort study over 3 years. *British Medical Journal*, *318*(7186), 765-768.

for more info For more information about the Healthy Attitudes Program, call 604-321-6151.

Fraser South
Early Psychosis Intervention Program

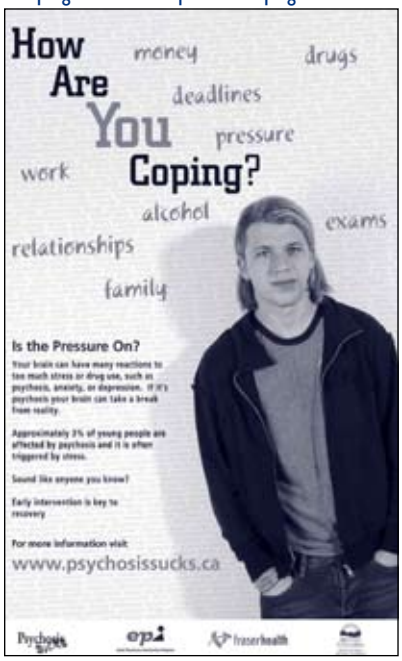
Karen Tee, PhD, RPsych

Karen is the Program Coordinator for the Fraser South Early Psychosis Intervention Program

The Early Psychosis Intervention (EPI) Program in the Fraser South region (White Rock, Delta, Surrey, Langley) serves young people ages 13 to 35 with early psychosis, and their families. The program bridges youth and adult mental health services, and links community with hospital. We are a community-based program with clinical services that include single-entry intake (one phone number to call); assessment, treatment and case management; group intervention; family intervention; and vocational rehabilitation services. We provide community education through workshops. We raise public awareness through the media, public transit, schools and other places frequented by young people. Research and evaluation are also important elements of our program.

Most people in the EPI Program are between 15 and 25. Many aspects of our programming are geared toward youth. Our clinical services include specific groups for adolescents and young adults. A strong peer support advisory is made up of young people in the program, and they sponsor most of our peer recreational activities. These range from soccer, hockey and hiking to musical jam sessions.

EPI program's newest poster campaign



He described psychosis as the brain's way of coping with overload

Last year at EPI's annual conference, several youth presented an art project that was received with great acclaim.

Families are also an integral part of our program. In addition to family support and crisis intervention, counselling and therapy provided by clinicians, we offer educational groups for families and monthly support groups.

Educating young people about psychosis is key to EPI's work. Early 2003 saw the launch of the Psychosis Sucks public awareness campaign, which promoted our program and website. The website was designed to be accessible to youth and their families. If you click on www.psychosissucks.ca, you will see information about psychosis, what causes it, treatment for psychosis, street drugs and psychosis, and more. There are downloadable information handouts, which are also available in Punjabi, Hindi and Chinese. The website also has stories from young people in our program, and links to websites developed by youth and family members.

The Psychosis Sucks campaign was extended across BC through commercial media and poster distribution. Even other provinces took an interest in the campaign and requested posters. While the campaign had four images, the one featuring the red-haired girl was most widely seen: on transit shelters, the backs of buses, on commercial vans and trucks, and in local community and youth newspapers. The result was a broad product recognition that came to be associated with early psychosis intervention.

Building on the momentum of the Psychosis Sucks campaign, a second message was designed to reach young people whose lives are affected by psychosis. The new campaign title is How Are You Coping? The goals are to improve understanding of psychosis and awareness of the EPI Program. To achieve these goals, the message informs people about risk factors, presents symptoms in a way that makes an emotional connection, and provides clear information about finding help. This campaign is being delivered through commercial advertising in restaurants, bars, educational institutions and Chilliwack Bruins hockey promotions, as well as poster distribution to schools, physicians and various health and community service agencies.

The team at Fraser South EPI hopes that this campaign will help shorten the time that psychosis is left untreated, increase the likelihood of early intervention, and directly battle stigma.

It was one very unique story from a recovering client that became the basis for the How Are You Coping? message. He described psychosis as his brain's way of coping with overload. This simple concept spoke volumes. He was absolutely right—his brain took a break from reality when the right combination of genetics and environmental stressors triggered the onset of psychosis. "Coping" is a great way to describe such a complicated process, and is much easier to accept than a word like "psychosis." It somehow makes this disorder seem less like a disability and more like something that could happen to anyone asking too much of their brain. "Coping" is something we can all relate to. "Coping" is completely normal, and if asked the question—how are you coping?—most people will be able to come up with an answer.

There is no doubt that for most people whose lives are affected by it, psychosis 'sucks.' What levels the playing field between mental illness and mental health is simply how well you cope with it. i

for more info Fraser South EPI is at 604-538-4278 or www.psychosissucks.ca

victoria youth clinic | continued from page 29

Motivational interviewing

Motivational interviewing is a technique developed by Rollnick and Miller, and is based on the stages of change.[3] The technique of motivational interviewing has two important aspects: the use of empathy, and a focus on client strengths, rather than weaknesses. The term *empathy* means that one person can understand another person's feelings or problems. To promote empathy, a counsellor tries to understand an addiction from the client's point of view. Together, the client and counsellor look at the needs that are met by the addiction, and the conflicts that are created by the addiction. The counsellor then invites the client to use his or her personal values to decide how to resolve these conflicts. A client is asked:

- How much does he or she want to change?
- How much does he or she believe in a personal ability to change?
- What strengths does he or she inherently possess that can support the process of change?

By talking with the client about their strengths, the counsellor reinforces that client's confidence in his or her ability to change. Personal strengths are often overlooked in older approaches to addictions counselling.

Evidence for motivational intervention

Combining motivational interviewing and the Five Stages of Change model can be referred to as "motivational intervention." Motivational intervention has been proven to help teenage youth reduce substance use in several research studies:

- Youth reduced their ongoing use of alcohol, cannabis and cigarettes.[4] Greater decreases were seen in heavier users, high-risk youth and those with less motivation to change.[4,5]
- Youth with risky drinking behaviour became more open to reducing their drinking, and moved more quickly through the action stage.[6]
- Five studies finding that youth reduced substance use in response to the intervention also shared two aspects: they used one-on-one sessions and feedback to determine how the youth's substance use compared to the norm. The feedback consists of comparing the addictive behaviour of the client to age-relevant statistics and to normal use of the substance.[7]

Also, 29 studies on motivational intervention were looked at carefully. In 73% of the studies, people were found to have made dramatic, positive changes in their health. The studies that involved youth with substance abuse problems were included in this 73%.[8]

Motivational intervention is gaining a large body of supportive research, especially when used for brief interventions with teenaged youth. It is exciting to see these techniques being used in the clinical setting, because they support the independence that needs to develop in adolescence.

acknowledgements

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for young people in distress

BC Helpline for Children
- 310-1234 (no area code needed)

Crisis Intervention & Suicide Prevention Centre of BC
- 1-800-SUICIDE (24/7 crisis support, no busy signal)
- Real-time chat at www.YouthInBC.com

Kids Help Phone (24-hour counselling for ages 5 to 20)
- 1-800-668-6868

for parents and others

FORCE Society for Kids' Mental Health
- 1-800-661-2121 (press 2, 3, 1) or 604-878-3400

BC Mental Health Information Line
- 1-800-661-2121 or 604-669-7600

BC Partners for Mental Health and Addictions Information
c/o 1200-1111 Melville St.,
Vancouver, BC Canada V6E 3V6

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