Mental health awareness workshop
Welcome and introductions
Evidence informed practice combines the best available research with the experience and judgment of service providers, children, youth and families to deliver measureable outcomes.
Developed in collaboration with

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Participants will:

• achieve a better understanding of child and youth mental health

• learn to recognize some of the common signs of child and youth mental health issues

• increase confidence to engage with children, youth and families around mental health
What is mental health?
Discussion

What does mental health mean to you?
What is mental health?

The capacity to feel, think and act in ways that enhance one’s ability to enjoy life and deal with challenges.

Public Health Agency of Canada
A model of mental health

**Optimal mental wellbeing (flourishing)**

- **Example**: a person who experiences a high level of mental wellbeing despite being diagnosed with a mental illness.

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**Minimal mental wellbeing (languishing)**

- **Example**: a person who has no diagnosable mental illness who has a low level of mental wellbeing.

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**Maximum mental illness**

- **Example**: a person experiencing mental illness who has a low level of mental wellbeing.

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**Minimal mental illness**

- **Example**: a person who has a high level of mental wellbeing and who has no mental illness.
Mental health as an iceberg

Behaviours

What are these behaviours telling me?

Thoughts

Feelings

Image by Uwe Kils
Mental health

- includes all aspects of human development and well-being that affect a person’s:
  - thoughts
  - feelings
  - behaviours

(Health and Welfare Canada, 1988; Ontario’s Policy Framework for Child and Youth Mental Health)
Why is child and youth mental health important?

• 1 in 5 children and youth live with a mental illness.
• Mental health issues often develop during adolescence.
• Suicide is the second leading cause of death in Canada in ages 16-25.
• Certain populations face rates of suicide that are 4 to 6 times higher than the national average due to their circumstances.
• Child and youth mental health issues can persist through adulthood.

(Health Canada, 2006; Public Health Agency of Canada, 2002)
What contributes to our mental health and wellbeing?
Determinants of health: factors that impact our health

- Biological factors
- General socioeconomic, cultural and environmental
- Family/social and community networks
- Individual/lifestyle factors
Social determinants in Canada

(Mikkonen & Raphael, 2010)
“Could someone help me with these? I’m late for math class.”
Stigma of mental health

**Definition:** Labeling or discrimination against an individual or group of individuals on the basis of observed or presumed mental health difficulties.

(Source: Ontario Centre of Excellence for Child and Youth Mental Health, 2006)
Stigma of mental health

The stigma of mental health is often seen as a barrier and reason that children, youth and their caregivers may avoid, delay or prevent accessing mental health services.

Only 1 in 6 children and youth get the help they need.

(Davison & Manion, 2006)
“When I was depressed, it was the stigma and being rejected by others that was even worse than having depression. I would rather have had cancer than depression...”

- Anonymous
We can work to reduce stigma

Don’t make me a book mark in your book of labels!

Anonymous youth, 16-years old
Video:
Children's Mental Health Ontario: Change the View 2013 Winner
Discussion

How does stigma impact your ability to reach youth in your community?

How can you work to reduce stigma?
Protective and risk factors

**Protective factors**
Factors that encourage mental health and improve resistance to mental illness.

**Risk factors**
Factors that put a young person at risk for mental health problems.

(World Health Organization, 2004)
Examples of risk factors

- insecure attachment in an infant or child
- family violence and conflict
- poor attachment to school
- neighborhood violence and crime

Examples of protective factors

- secure attachment
- stable family
- sense of belonging
- positive school climate
- strong cultural identity and ethnic pride
- effective problem-solving and coping skills
- optimism
- economic security
Resiliency

• Resiliency is the ability to adapt and successfully cope with adversity.

• Adversities can range from a single incident (e.g. car accident) to repeated exposure (e.g. continued abuse or neglect)

• **Relationships** are vital to building resilience.

(Schwartz et al., 2008)
What we can do!
What we can do!

- Influence determinants of health (advocate!).
- Build on protective factors.
- Reduce risk factors and stigma by:
  - building caring relationships
  - engaging youth
  - engaging families

(Schwartz et al., 2008)
Building positive relationships

- Provide safety, consistency, stability and nurturing
- Ask for permission
- Listen non-judgmentally
- Validate and normalize
- Focus on the person not the problem
- Build on strengths and what’s going well
- Repair mistakes
Youth engagement: Be an ally

“Empowering all youth as valuable partners in addressing and making decisions about issues that affect them personally and/or that they believe to be important.”

- The New Mentality
Benefits of youth engagement

- Lower rates of substance use
- Lower levels of depression
- Increased skill sets for employment
- Improved decision-making abilities
- Feeling empowered
- Increased self confidence
- Higher academic performance
- Building healthier and safer communities
- Connection to resources and other people

(Catalano, 1999; Mahoney et al., 2002; Pancer et al., 2002; Youniss et al., 1999)
Youth engagement at the Centre

- Dare to Dream is a unique youth-led funding program that helps young people create and implement project ideas that promote mental health and well-being.
- In partnership with an adult mentor and a child and youth organization, youth can receive up $5,000.
Family engagement

• An active partnership between families and service providers.
• A relationship building process focused on listening and engaging in two-way communication.
• Engaging family members as essential allies in decision-making so that their involvement is meaningful and has purpose.

(Ontario Centre of Excellence, 2012)
Benefits of family engagement

- More successful treatment outcomes
- More service use with engagement in first contact
- Match between family’s preferences for service leads to longer involvement in service
- Becoming accepted as a best practice in community child and youth mental health services

(Bannon & Mackay, 2005; Chovil, 2009; Hoagwood, 2005; McKay et al., 2004)
Discussion

What are the opportunities for youth to be involved or engaged in your community?
Mental health issues
Youth development

• Most adolescents will pass through this time without significant or prolonged difficulties

• However, between 15% and 25% will experience significant mental health issues
Youth development

Common experiences:

- Mood swings/temper tantrums
- Low tolerance for frustration
- Emotions before logical thinking
- Risk-taking behaviours
- Need more sleep
When to be concerned

A youth’s thoughts, feelings or behaviours:
• get in the way of daily life
• differ from the person’s baseline
• are intense
• are not age-appropriate
• persist over time
Every experience is different

• Remember, mental health is a continuum
• Red flags, not checklists
• Not black and white
• Sometimes there are no visible signs
Development of mental health challenges

Stressor(s)

Innate vulnerability

Support

Coping skills
Anxiety and Mood Disorders
What is anxiety?

**Definition:** a physical sensation, thought, behaviour or feeling. It is an adaptive response to a real or perceived danger that keeps us safe.

(Manassis, 2007)
Continuum of mental health issues

- Anxiety occurs on a continuum.
- Anxiety usually decreases over time and it can even help us function.
- Impairment is a product of avoiding anxious situations → facing fears is crucial.
What to look for

**Feelings**
- Panic attacks/hyperventilation
- Stomachaches/ headaches
- Sleep difficulties
- Tears

**Thoughts**
- Worries
- Upsetting and intrusive thoughts
- “The world is a scary place and/or “I am not competent”

**Behaviours**
- Clinginess
- Avoidance
- Tantrums
- Freezing /mutism
- Repetitive rituals

(Manassis, 2012)
Video: Building on strengths and providing support

Getting Unstuck
Mood disorders
What is mood?

**Definition:** mood is the ongoing inner feeling experienced by an individual.

- depression
- mania

(Kutcher, 2009; Carr, 2007)
Continuum of mood

(American Psychiatric Association, 2000 taken from Lack & Green, 2009)
What to look for (depressive disorders)

**Feelings**
- Sadness and excessive crying
- Irritability, anger, guilt, hopelessness
- Disproportionate worry

**Thoughts**
- Unhelpful thoughts
- Difficulty concentrating
- Suicidal ideation or attempts
- Losing touch with reality

**Behaviours**
- Social withdrawal
- Avoidance
- Loss of interest/pleasure
- Difficulty completing tasks
- Restlessness

(Manassis, 2012)
What to look for (mania)

Thoughts
- Inflated self-esteem
- Racing thoughts
- Grandiose or illogical ideas about personal abilities

Feelings
- Persistently elevated, expansive or irritable mood
- High energy levels

Behaviours
- Decreased need for sleep
- Increased activity levels
- Risk-taking behaviours
- Distractibility

(Manassis, 2012)
How do youth feel?

High school student sample size = 19,996

(Youth Net, 2009)
Who do youth talk to?

**Males**
- Friends: 31.9%
- No One: 47.8%
- Family: 9.8%
- Prof.: 1.0%
- >1: 6.5%
- Other: 3.0%

**Females**
- Friends: 46.3%
- No One: 30.7%
- Family: 10.6%
- Prof.: 1.8%
- >1: 8.0%
- Other: 2.6%

*Davidson & Manion, 1996*
Non-suicidal self-injury
What is non-suicidal self-injury?

A deliberate attempt to cause direct injury to one’s body *without the conscious intent* to die.

Non-suicidal self-injury can signal underlying mental health challenges.

(Nock & Favazza, 2013; Skegg, 2005; Andover et al., 2012)
Discussion

What are some of the reasons young people self-harm?

(Muehlenkamp et al., 2012; Brent, 2011; Whitlock, 2009; Klonsky, 2007)
What to look for

Behaviours
- Uncharacteristic dress for the weather
- Unexplainable paraphernalia (e.g. sharp objects)
- Social withdrawal
- “Accident-prone”
- Frequently worn bandages or wristbands

Physical
- Grouped scars
- Fresh cuts or bruises
- Burns or other damage

Feelings
- Emotional absence
- Difficulty with strong emotions
- Self-loathing, shame, worthlessness

(Whitlock, 2009)
Suicide
Definitions

Suicide behaviours

• any purposeful self-inflicted acts, including suicide attempts, self-harm and self-injury, that may lead to death regardless of the intent of those behaviors and actions

Suicidal ideation

• Thoughts, images or fantasies of harming or killing oneself

Suicide intent

• The conscious decision to take one’s life
Definitions

Death by suicide
• *Intentional*, self-inflicted death

Suicide attempt
• Purposeful self-inflicted act that is non-fatal and is associated with the implicit or explicit intent to die

Non-suicidal self-injury
• A deliberate attempt to cause injury to one’s body without the conscious intent to die
What you need to know

• Suicide is the second leading cause of death in Canada in ages 16-25. Rates in vulnerable populations in youth are 4 to 6 times higher.

• Childhood suicide is underreported, as suicidal intent is unlikely to be attributed to children. Under the age of 14, one to two suicide deaths in 100,000 (50 children each year).

• Males die by suicide at a higher rate than females. Females attempt suicide at a higher rate than males.

(Hawton, Saunders & O’Connor, 2012; Health Canada, 2006; Madge & Harvey, 1999; Skinner & McFaull, 2012)
Youth suicide in vulnerable populations

• In some Aboriginal communities, rates are 5 to 6 times higher. 1/3 of Aboriginal youth deaths are suicides.

• LGBTQ+ youth are 4 times as likely to attempt suicide than their non-LGBTQ+ peers. Half of LGBTQ+ youth have thought about suicide.

• Rural youth are at higher risk of thinking about, attempting, and dying by suicide. Rural male youth are at a higher risk for death by suicide than urban youth.

• It’s important not to over-generalize, but to think about risk and protective factors in each individual’s circumstances.

(Armstrong & Manion, 2006; Baume & Clinton, 1997; Eisenberg & Resnick, 2006; Kirmayer et al., 2007; Scanlon et al., 2010; Staple, 2008)
Highest predictors of risk

1. Psychiatric diagnosis (depressive disorders, mood disorders, substance abuse)

2. Family history of suicide

3. Previous suicide attempt

(Kutcher & Szumilas, 2008)
Other predictors

- Poor physical health or disability
- History of trauma
- Family disintegration
- Transient lifestyle
- Impulsivity
- Contagion effect

(Chehil & Kutcher, 2012; Hawton, Saunders & O’Connor, 2012)
Factors increasing risk in vulnerable populations

<table>
<thead>
<tr>
<th>First Nations, Métis and Inuit youth</th>
<th>LGBTQ youth</th>
<th>Newcomer youth</th>
<th>Rural youth</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acculturation stress</td>
<td>• Social isolation</td>
<td>• Histories of trauma and violence</td>
<td>• Distance from mental health services and school</td>
</tr>
<tr>
<td>• Social marginalization</td>
<td>• Violent victimization</td>
<td>• Income inequality</td>
<td>• Increased access to lethal means</td>
</tr>
<tr>
<td>• Lack of community self-determination</td>
<td>• Separation from family</td>
<td>• Cultural conceptions of mental illness</td>
<td>• Cultural ideals</td>
</tr>
</tbody>
</table>

(Armstrong & Manion, 1997; Forrest, 1998; Hirsch, 2006; Kirmayer et al., 2007; Simon Fraser University, 2009)
Contagion

Self-injury

• Happens when an individual self-injures and it is copied by others.
• Can be contagious in schools and institutions.

Suicide

• Youth with suicidal thoughts/behaviours can be at greater risk if a peer or loved one dies by suicide.

(Lahad & Cohen, 2006 Walsh, 2006; Nixon & Heath, 2009; Whitlock, 2009)
What to look for

**Thoughts**
- Life is meaningless
- What’s the use of it all?
- I won’t be a problem much longer

**Feelings**
- Sadness, emptiness and hopelessness
- Rage, anger and revenge-seeking

**Behaviours**
- Give away favourite things
- Increased use of drugs/alcohol
- Looking to hurt themself
- Verbal/written threats
- Cheerfulness after depression
- Impulsivity
- Sleep disturbances
- Decreased quality of school work
- Loss of interest in activities
- Difficulty concentrating

(Doan, et al., 2012; Miller & Eckert 2009; Rudd et al., 2006)
Reducing suicidality

↑ Hope
↑ Problem-solving skills
↑ Communication
↑ Ability to tolerate psychological pain
↑ Connectedness
↑ Belonging
↑ Sense of support
Ensuring safety

• Remain calm.
• Remember this person has disclosed this to you for a reason.
• Be attentive to warning signs:
  • Physical
  • Verbal
  • Written

Chehil & Kutcher, 2012
Discussion

• What can you do to help?
• What would engaging a child, youth or family member look like?

(Whitlock, 2009)
Ensuring safety

• Establish an alliance.
  • Be empathetic and non-judgmental.
  • Be prepared to listen.
  • Paraphrase to check understanding.
• Don’t make promises (confidentiality).
• Assume all threats are real. The primary goal is the preservation of life: “save the friend, not the friendship”

(Cehil & Kutcher, 2012; White, 2013)
Assessing suicidal risk

• Consider risk factors
• Determine:
  - Current plan: ideation, intention
  - Prior behaviour: any previous suicidal behaviour or models
  - Resources: physical and emotional systems which the person at risk feels are helping, caring or supportive

Chehil & Kutcher, 2012
Eating disorders
What are eating disorders?

• an obsession with food, weight or body image that can interfere with everyday life

• a way to cope with deeper problems that are painful or difficult; not always just about food

• can signal difficulties with identity, self-concept, self-esteem and loss of control

(Canadian Mental Health Association, 2013; CYMHIN-MAD, 2011)
Preoccupation with body shape, size, exercise and eating

Distress about body shape, size, exercise and eating

Body image confidence with flexible eating and exercise

Eating disorders

(Scarano & Kalodner-Martin, 1994)
Types of eating disorders

There are three chronic eating disorders:

- Anorexia nervosa
- Bulimia nervosa
- Binge-eating

(Canadian Mental Health Association, 2013; Treasure, 2010)
What to look for

Feelings
- Feeling fat when weight is normal/low
- Low self-esteem
- Mood changes

Thoughts
- Weight becomes prime focus
- Wanting to be perfect

Behaviours
- Extreme or unusual eating habits
- Denial of a problem
- Vomiting/frequent washroom trips
- Episodes of overeating
- Excessive exercising
- Eating in isolation

Physical
- Fainting or dizziness
- Heart palpitations
- Blood in vomit
- Weight fluctuations

(Canadian Mental Health Association, 2013; CYMHIN-MAD, 2011)
Behaviour disorders
What are behaviour disorders?

Patterns of negative, non-compliant or harmful behaviour that impact home, school or social functioning.

(Loeber et al., 2000)
Continuum

<table>
<thead>
<tr>
<th>Healthy</th>
<th>Unhealthy</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Testing limits through occasional misbehaving</td>
<td>• Negative behaviour that persists or is not related to particular stresses</td>
</tr>
<tr>
<td>• Exploring different opinions</td>
<td>• Behaviour that is not age-appropriate</td>
</tr>
</tbody>
</table>

(Offord Centre for Child Studies, 2007; Campbell, 1995)
What to look for

**Feelings**
- Easily annoyed
- Angry or resentful
- Spiteful or vindictive
- Lack of empathy, or remorse

**Thoughts**
- Thinks others wish to harm them
- Difficulty understanding others
- Needs power and control

**Behaviours**
- Defiance
- Frequent tantrums
- Limit testing and/or rule breaking
- Violence towards others and/or property
- Lying and conning

(APA 2000; McMahon & Frick, 2007; Offord Centre for Child Studies, 2007)
Attention deficit hyperactivity disorder
What is ADHD?

Attention deficit hyperactivity disorder (ADHD) is characterized by a persistent and developmentally inappropriate levels of inattention, impulsivity and hyperactivity.

(Wehmeier, Schacht, & Barkley, 2010; Barkley, 2004; WGBH Educational Foundation, 2002)
<table>
<thead>
<tr>
<th>Healthy</th>
<th>Unhealthy</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Some degree of inattention, impulsivity</td>
<td>• When inattention and impulsivity become more severe and get in the way of daily life</td>
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<tr>
<td>and hyperactivity is to be expected in most young people</td>
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(Brock, 2002; Lubke et al., 2009; WGBH Educational Foundation, 2002)
Types of ADHD

(American Psychiatric Association, 2000; Eiraldi et al., 2012)
What to look for

Inattention
- Little attention to detail
- Difficulty sustaining attention
- Seems to not listen when spoken to directly
- Does not follow instructions
- Difficulty with organization
- Avoids/dislikes/reluctant to tasks requiring mental effort
- Loses things
- Easily distracted
- Forgetful

Hyperactivity
- Fidgets or squirms in seat
- Leaves seat when sitting is expected
- Runs around or climbs excessively
- Difficulty playing or engaging in activities quietly
- On the go or acts as if driven by a motor
- Talks excessively

Impulsivity
- Blurs out answers
- Difficulty waiting for their turn
- Interrupts or intrudes on others

(Barkley, 2003; American Psychiatric Association, 2000)
Strategies for ADHD: Self-regulation

Q. When you are driving a car on a long, boring road trip, and you are falling asleep from boredom, what (sensory) strategies do you use to stay awake?

Photo taken by Lindsey Turner
Substance use disorders
What are substance use disorders?

Recurrent use of substances that are associated with a loss of control and harmful consequences.

(Centre for Addictions and Mental Health, 2010)
Continuum

- Experimental use
- Irregular use
- Regular use
- Dependent use

(Centre for Addictions and Mental Health, 2004)
Types of substances

Alcohol (59%): booze

Cannabis (26%): weed, Mary Jane, pot, grass

Tobacco (22%): cigarettes, smokes

Prescription medication (16%): T3s, oxy, percs

Cold medicines (10%): robos, triple c

(Paglia-Boak, Adlaf & Mann, 2011; National Institute on Drug Abuse, 2011)
Types of substances

Inhalants (9%): huff, glue, spray, poppers

Chewing tobacco (6%): chew

Stimulants (5%): molly, blow

Mushrooms (5%): shrooms, magic mushrooms

Salvia (4%): Sally-D, magic mint

(Paglia-Boak, Adlaf & Mann, 2011; National Institute on Drug Abuse, 2011)
Other types

• Gambling
• Internet
• Gaming
• Sex/pornography

(Sussman, Lisha & Griffiths, 2011)
What to look for

**Thoughts**
- Positive attitudes toward substances and their effects

**Feelings**
- Negative moods that seem out of nowhere
- Anger towards family and friends

**Behaviours**
- Increased need for money
- Secrecy about activities
- Loss of interest in personal care
- Substance paraphernalia
- Sudden drop in academic performance or apathy about school
- New friends that are known to use substances or are older

(Sussman, Skara & Ames, 2008; Englund & Siebenbruner, 2012; Ketcham & Pace, 2008)
What you can do to help!

• Be aware of signs and symptoms of addiction

• Model appropriate substance use behaviour and attitudes

• Connect youth with supports

• Engage youth in substance use prevention/reduction initiatives

(Griffin & Botvin, 2010; Hawkins, 2009; Ketcham & Pace, 2008; Mayer & Blome, 2010; Sussman et al., 2004; YouthNet/ReseauAdo, n.d.)
What you can do to help!

• Don’t enable substance using behaviour: avoid focusing on fixing problems, providing money or placing blame on others

• Don’t label the youth: avoid jumping to judgments or assumptions

• Focus on the youth: recognize and address underlying mental health concerns

(Hawkins, 2009; Ketcham & Pace, 2008; Sussman, Skara & Ames, 2008)
Where do we go from here?
We can all make a difference

- counselling
- medication
- community support services
- education
- informal supports
- evidence informed approaches
How can you make a difference?

• Connect
• Recognize the signs
• Think about how you can make a difference in the moment
• Build on strengths
• Identify next steps
• Know your role and your limits
• Engage youth in the plan
Get help!

- What resources are available in your community?
- How can you get to know your community resources?
- Who can you connect with when you need support?
Video:
Building positive spaces in mental health services
Nexus Youth Services
Oolagen
Know where to go for help

- Addictions sector
- Friends, family, colleagues
- Schools / education sector
- Hospital, mental health agencies
- Child/youth/family
- Private practitioners (e.g. psychologists, counsellors)
- Justice / policing sector
- Self-help, mutual aid, peer supports
- Child welfare sector
Provincial and local resources

When you don’t know where to turn.™

Quand tu ne sais pas vers qui te tourner.™

Children's Mental Health Ontario
Santé mentale pour enfants Ontario
About the Centre

We bring people and knowledge together to strengthen the quality and effectiveness of mental health services for children, youth and their families and caregivers.

Three strategic goals:

- **Learning**: Foster a culture of organizational learning to support agencies in using evidence to improve client outcomes.
- **Collaboration**: Build and develop collaborative partnerships to sustain capacity within mental health services.
- **Leadership**: Be a true learning organization and lead by example.
Take away discussion

What are three things that you will do differently once you leave today?
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