Who Can Use the Guide?

If your child or a child you know is experiencing a mental health issue, you may not know where to turn for information, help or support. This guide is intended to assist children and youth, families, friends or professionals in accessing information about the variety of child and youth mental health services and supports that are available in the Thompson/Cariboo. Having access to useful information is a key value of the Canadian Mental Health Association (CMHA). We believe people must have accurate information in order to be able to make personal choices about the services they wish to use. While some of the services will no doubt change over time, we hope this guide will assist you in finding the services or supports you need in a timely manner.

Who is Normal?

Struggling is part of being human, but we need not do it alone. There is support to overcome mental health issues. Children struggle too, and their needs deserve attention. Angry or elated, depressed or positive, anxious or peaceful: anyone can experience mental health issues. No one needs the stigma to go with it.

Mental health issues affect people from all walks of life at every income and age level. In Canada, one in five of us will experience a mental health issue during our lifetime and one in eight of us will require hospitalization due to a mental health issue.

Mental health issues have a significant impact not only on the individual directly affected but also family members, friends, employers and the public at large.

More often than not, people with a mental health issue find their opportunities limited and their recovery impaired by debilitating prejudice and rejection based on misunderstandings about mental health issues.

There is hope and opportunity for recovery for people with a mental health issue. We believe this guide is a useful tool in promoting recovery.

How to Tell if Someone is Experiencing a Mental Health Issue:

1. They breathe oxygen to survive. Using a complex respiratory system including organs known as lungs, the subject will continually inhale and exhale for survival.
2. They're usually between the ages of 5 and 100. This age range is the prime period in which mental health issues affect humans. The reasons for this are varied.
3. They live in large cities or small towns. People with mental health issues usually have a high school, college, or university education, or an education of less than high school. They often either work or don't work in their big city or small town.
4. There's a 20% chance they have read this. Or they will read it. Or they're reading it right now. This is because one in five people will experience a mental health issue.

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What are Child & Youth Mental Health Services?

Approximately 15%, or 143,000 children within BC will experience mental health issues every year. The Ministry of Children and Family Development provides a range of specific mental health services for children and youth. For youth who have become involved with the law, Youth Forensic Psychiatric Services provides a similar range of services. In addition, some residential and outreach assessment and treatment options for children and youth with mental health issues are available at the Maples Adolescent Treatment Centre, BC Children’s Hospital and the Adolescent Psychiatric Unit at the Kelowna General Hospital. Community Child and Youth Mental Health Services are available throughout the province.
Like it or not, mental health issues can affect anyone. In BC approximately 15% of children will experience mental health issues that will cause significant distress and impact their functioning at home, school and in the community.

Categories of Mental Illness and Some Common Forms They Take

These descriptions are taken from the DSM-IV (Diagnostic Statistical Manual of Mental Disorders), a resource used by professionals to diagnose mental health issues.

- **Mood disorders**, also known as affective disorders, affect how children feel about themselves, other people and life in general. They include:
  - Depression
  - Bipolar disorder (manic depression)
  - Suicidal behaviour

- **Anxiety disorders** involve an unusual degree of fearfulness, worry and even terror. Types include:
  - General anxiety disorder
  - Panic disorder
  - Phobias (overwhelming feelings of terror in response to a specific object, situation or activity)
  - Obsessive-compulsive disorder (repetitive actions are used to cope with recurring, unwanted thoughts)
  - Separation anxiety disorder

- **Behaviour disorders** reduce a child’s ability to direct and control his or her actions. Included in this category are:
  - Attention deficit hyperactivity disorder (ADHD)
  - Oppositional defiant disorder (ODD)
  - Conduct disorder (CD)

- **Schizophrenia and psychotic disorders** involve changes in the chemistry and structure of the brain, which may cause lethargy, hallucinations (e.g. hearing “voices”) and delusions (e.g. having supernatural powers):
  - Schizophrenia
  - Schizoaffective disorder
  - Delusional disorder

- **Psychosis**: A medical condition that affects the brain, so that there is a loss of contact with reality. When someone becomes ill in this way, it is called a psychotic episode. A psychotic episode is characterized by extreme impairment of a person’s ability to think clearly, respond emotionally, communicate effectively, understand reality, and behave appropriately. An individual experiencing a psychotic episode may have delusions or hallucinations.

- **Eating disorders** involve distorted body images that make it difficult for people to nourish themselves in a healthy way:
  - Anorexia nervosa (dramatic weight loss combined with an intense fear of gaining weight)
  - Bulimia nervosa (bouts of uncontrollable eating followed by purging, e.g. vomiting)
  - Binge or compulsive eating disorder
  - Disordered eating is when a person’s attitudes about food, weight, and body size lead to very rigid eating and exercise habits that jeopardize one’s health, happiness, and safety. Disordered eating may begin as a way to lose a few pounds or get in shape, but these behaviors can quickly get out of control, become obsessions, and may even turn into an eating disorder.

- **Substance use disorders** refer to excess use of alcohol and/or legal and illegal drugs, leading to significant home, school and medical problems:
  - Alcohol addiction
  - Drug use (illicit drugs or prescription medication)
  - Co-existing mental health issues and addiction
  - Tobacco

**Prevention**

Mental health is not just the absence of mental health issues. Positive mental health involves emotional and psychological wellness, a positive and confident self-perception, healthy relationships and an ability to take control of actions and feelings on a daily basis. By being aware, we can take positive steps toward mental health when the balance is disrupted.

**Information Lines**

- **Kid’s Help Phone**
  - 1-800-668-6868

- **Abuse and Neglect of Children**
  - 310-1234 (toll-free)
  - www.safekidsbc.ca/helpline.htm

- **Mental Health Information Line**
  - 1-800-661-2121
  - www.heretohelp.bc.ca

- **Dietician**
  - 1-800-667-3438

- **Youth Against Violence**
  - 1-800-680-4264

- **BC Poison Control**
  - 1-800-567-8911
  - www.bccdc.org

- **BC Nurse Line**
  - 1-866-215-4700

- **Victim LINK Information Service**
  - 1-800-563-0808
  - www.vcn.bc.ca

- **Crisis Intervention & Suicide Prevention Centre of BC**
  - 1-866-661-3311
  - www.youthinBC.com

- **Jessie’s Hope**
  - 1-877-288-0877
  - www.jessieshope.org

- **Centre for Addictions Research of BC**
  - 1-866-677-LINK (5465)
  - www.carbc.ca

- **FORCe Society for Kids’ Mental Health**
  - (604) 878-3400
  - www.bckidsmentalhealth.org

- **Mood Disorders Association of BC**
  - (604) 873-0103
  - www.mdabc.net

**The BC Partners are:**

- **Anxiety Disorders Association of BC**
  - (604) 681-3400
  - www.anxietybc.com

- **BC Schizophrenia Society**
  - 1-888-888-0029
  - www.bcss.org

- **Canadian Mental Health Association, BC Division**
  - 1-800-555-8222
  - www.cmha.bc.ca

- **Jessie’s Hope**
  - 1-877-288-0877
  - www.jessieshope.org

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  - (604) 873-0103
  - www.mdabc.net
As of November 1, 2008 there will be a province-wide number for the Crisis Line, and you will be transferred to the nearest available line. The new number is 310-6789

**Suicide Line**
1-800-SUICIDE (784-2433)

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**Thompson**

Kamloops Urgent Response Team (KURT)  
(250) 377-0088

Parkview (crisis intervention/mental health assessment)  
(250) 376-7855

Child & Youth Mental Health  
Child Protection Intake  
(250) 371-3600

**Cariboo**

Canadian Mental Health Association Williams Lake Branch  
(250) 398-8224

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**Clinical Services**

**Services for children and youth**  
under 19 years of age are offered through the Child and Youth Mental Health Services  
- 100 Mile House (250) 395-5633  
- Ashcroft (250) 453-2109  
- Clearwater (250) 674-6810  
- Kamloops (250) 371-3648  
- Lillooet (250) 256-2710  
- Merritt (250) 378-1476  
- Williams Lake (250) 398-4963

**Youth Forensic Psychiatric Services**  
(by referral only)  
Youth Forensic Psychiatric Services (YFPS) is a provincial program of the Ministry of Children and Family Development that provides court-ordered and court-related assessment and treatment services for troubled youth. We provide services to:  
- Young persons in conflict with the law pursuant to the Youth Criminal Justice Act (YCJA),  
- Young persons found unfit to stand trial or not criminally responsible due to mental disorder.

**Maples Adolescent Treatment Centre**  
The Maples provides a number of programs and services to address the needs of troubled youth aged 12 to 17 with significant psychiatric and behavioural difficulties. All programs and services are holistic in their approach and include participation of the family or alternate caregivers as well as the professionals in their home community. In most programs, there are both residential and non-residential options.  
These programs provide a period of stabilization and intensive intervention followed by support for families/caregivers to implement a long-term community-based care plan. The programs and services are staffed with a multidisciplinary team of social workers, psychiatrists, psychologists, nurses, and child and youth counsellors. The Maples uses a relational or attachment approach to promote individual and family functioning and development. Your child needs a referral to this service by the Child & Youth Mental Health Team Leader.

For more information go to the Maples website:  
www.mct.gov.bc.ca/maples/index.htm

**Mental Health Line**

To get contact information for the services closest to your community please call 1-800-661-2121 or visit www.heretohelp.bc.ca
When seeking mental health help for your child, it isn’t always easy to find out what’s available and where to go. Learning about the vast array of services can seem like an overwhelming task. Providing comprehensive care and support for a child often involves a number of professionals and services. To help you on your journey, we have provided a roadmap of the main sources for help for families.

### Ministry of Children and Family Development (MCFD)

**Child and Youth Mental Health Services:**
- Cognitive behaviour therapy
- Other best practices therapies (i.e. dialectical behavioural therapy, interpersonal therapy, early psychosis intervention)
- Family therapy and education
- Referral to day treatment programs
- Case management services
- Maples Adolescent Treatment Centre
- Community services (e.g. in-home support)

Learn more about the mental health services offered by the Ministry of Children and Family Development at [www.mcf.gov.bc.ca/mental_health](http://www.mcf.gov.bc.ca/mental_health), or by contacting your local Child and Youth Mental Health Office, listed in the blue pages of your local telephone directory.

### School

**Teachers:**
- Adapted or modified lesson plans
- Seating alternatives
- Test alternatives
- Homework alternatives
- Oral presentation alternatives
- Silent reading alternatives

**School Counsellor:**
- Referral to mental health services
- Counselling
- Assessment
- Referral to student support services
- Class or program placement assistance

**Student Support Services:**
- Program placement
- Assessment and psycho-educational testing
- Referral to mental health services
- Designation for funding
- Assignment of support time

### Doctors

**General Practitioner:**
- Assessment
- Medication
- Ordering diagnostic tests
- Referral to specialists
- Blood workup
- Monitoring
- Referral to hospital in-patient units

**Specialists (e.g., psychiatrists, pediatricians):**
- Assessment
- Medication
- Order diagnostic tests
- Referral to other specialists
- Blood workup

**Psychologists:**
- Assessment
- Therapy
### Community Child & Youth Mental Health Services

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<tr>
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<tr>
<td><strong>100 Mile House Child &amp; Youth Mental Health Services</strong>&lt;br&gt;(250) 395-5633</td>
<td><strong>Lillooet Child &amp; Youth Mental Health Services</strong>&lt;br&gt;(250) 558-2775</td>
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<tr>
<td><strong>100 Mile District Hospital</strong>&lt;br&gt;(250) 395-7600</td>
<td><strong>Lillooet District Hospital</strong>&lt;br&gt;(250) 256-1300</td>
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<tr>
<td><strong>Ashcroft Child &amp; Youth Mental Health Services</strong>&lt;br&gt;(250) 453-2109</td>
<td><strong>Williams Lake Child &amp; Youth Mental Health Services</strong>&lt;br&gt;(250) 398-4963</td>
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<tr>
<td><strong>Clearwater Child &amp; Youth Mental Health Services</strong>&lt;br&gt;(250) 674-6810</td>
<td><strong>Cariboo Memorial Hospital</strong>&lt;br&gt;(250) 392-4411</td>
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<td><strong>Dr. Helmcken Memorial Hospital</strong>&lt;br&gt;(250) 674-2244</td>
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**Answers to Your Questions About Getting Help**

**For Children with Mental Health Concerns**

**Where do I start if I think my child is having difficulties?**

A good place to begin is with your child’s doctor. Many physical illnesses can mimic the symptoms of mental health issues. A physical exam can help to rule out certain illnesses. Children who have brain disorders can be very difficult to diagnose because often the symptoms of the disorder in children are different from the symptoms experienced by adults. It is important that your child receive an accurate diagnosis, especially before considering medication.

If you feel uncomfortable talking to your doctor about this, contact your local Child & Youth Mental Health Services office or talk to a school counselor.

**Where should parents look when searching for a mental health professional?**

Mental health therapists and clinicians are available by contacting your local Child and Youth Mental Health services which is part of the Ministry of Children and Family Development. Ask for the mental health intake worker. A listing of community offices can be found online at [www.mcf.gov.bc.ca/mental_health/pdf/services.pdf](http://www.mcf.gov.bc.ca/mental_health/pdf/services.pdf). It is best if a family member or the youth themselves make this call, as only they are able to know when they are ready to seek help. In addition to government services, families can also check the College of Psychologists of BC website for listings of registered psychologists at [www.psychologists.bc.ca](http://www.psychologists.bc.ca); the BC Association of Clinical Counsellors at [www.bc-counsellors.org](http://www.bc-counsellors.org); or the BC Association of Social Workers at [www.bcasw.org](http://www.bcasw.org). These are user-pay services and may be covered by your extended health plan or check with your employer to see if you are covered by your Employment Assistance Program.

**What can I do while I’m waiting to see a specialist?**

Educate yourself. Search the library or Internet for information on child and youth mental health to gain as much information as possible. There are some good tips from books like *The Explosive Child* by Dr. Ross Greene. Parents have indicated that his practical advice really helped them to learn how to minimize their children’s emotional explosions. In addition, look for family support agencies such as the F.O.R.C.E. Society for Kids’ Mental Health that may be able to assist in answering any questions you may have and locating support groups for parents.

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Taken from the F.O.R.C.E. Answers to Your Questions About Getting Help for Children with Mental Health Concerns tip sheet [www.bckidsmentalhealth.org](http://www.bckidsmentalhealth.org) 
(For a list of resources check out the McMaster Children’s Hospital Family Resource Centres at [www.mcmasterchildrenshospital.ca](http://www.mcmasterchildrenshospital.ca))
# Child & Youth Mental Health Guide

## Thompson Community Resources

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<tr>
<td>Kamloops</td>
<td>Big Brothers &amp; Big Sisters</td>
<td>(250) 374-6134</td>
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<td>Kamloops</td>
<td>Boys &amp; Girls Club</td>
<td>(250) 554-KIDS (5437)</td>
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<td>Kamloops</td>
<td>CMHA Youth Clubhouse</td>
<td>(250) 374-0440</td>
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<td>Kamloops</td>
<td>Kamloops Youth Resources Society</td>
<td>(250) 374-7135</td>
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<tr>
<td>Kamloops</td>
<td>Kamloops YMCA-YWCA</td>
<td>(250) 372-7725</td>
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<td>Kamloops</td>
<td>United Way</td>
<td>(250) 372-9933</td>
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<tr>
<td>Kamloops</td>
<td>Phoenix Centre</td>
<td>(250) 374-4634 or 1-877-318-1177</td>
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<tr>
<td>Kamloops</td>
<td>Aboriginal Family Development Centre</td>
<td>(250) 554-5823</td>
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<td>Kamloops</td>
<td>Interior Metis Child &amp; Family Services</td>
<td>(250) 554-9486</td>
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<td>Kamloops</td>
<td>Interior Community Services</td>
<td>(250) 376-3660</td>
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<td>Kamloops</td>
<td>White Buffalo Aboriginal Health</td>
<td>(250) 554-1176</td>
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<td>Kamloops</td>
<td>Secwepemc Family Services</td>
<td>(250) 314-9669</td>
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<td>Kamloops</td>
<td>Children Who Witness Abuse</td>
<td>(250) 374-2111</td>
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<td>Kamloops</td>
<td>Children's Therapy &amp; Family Resource Centre</td>
<td>(250) 371-4100</td>
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<td>Kamloops</td>
<td>Indian Friendship Centre</td>
<td>(250) 376-1296</td>
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<td>Kamloops</td>
<td>Insight Support Services</td>
<td>(250) 554-0085</td>
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<td>Kamloops</td>
<td>Kamloops Sexual Assault Counselling Centre</td>
<td>(250) 372-0179</td>
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<tr>
<td>Kamloops</td>
<td>Kamloops Youth Clinic</td>
<td>(250) 851-7954</td>
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<td>Kamloops</td>
<td>Parents Anonymous, Inc.</td>
<td>(250) 376-6800</td>
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<tr>
<td>Kamloops</td>
<td>Autism Parent Partners</td>
<td>(250) 376-5495</td>
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<tr>
<td>Kamloops</td>
<td>T.R.A.A.C. (Treatment and Recovery of Early Psychosis Through Awareness &amp; Assertive Case coordination)</td>
<td>(250) 851-7450</td>
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<tr>
<td>Kamloops</td>
<td>BC Schizophrenia Society (Williams Lake Chapter)</td>
<td>(250) 392-5553</td>
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<td>Canadian Mental Health Association</td>
<td>(250) 398-8220</td>
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<td>Child Development Centre</td>
<td>(250) 398-5658</td>
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<td>Choices for Youth</td>
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<td>Desniqi Services Society</td>
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<td>Salvation Army Family Emergency Services</td>
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<td>Three Corners Health Services</td>
<td>(250) 398-9814</td>
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<td>Women's Contact Society</td>
<td>(250) 392-4118</td>
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<td>Youth for Christ</td>
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<td>Aboriginal Victim Services</td>
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<td>Kamloops</td>
<td>Axis Family Resources</td>
<td>(250) 392-1000</td>
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<td>Kamloops</td>
<td>Kamloops Training &amp; Information Center (KTIC)</td>
<td>(250) 392-1000</td>
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<td>Parent-Teen Counseling Program</td>
<td>(250) 398-8220</td>
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<td>Kamloops</td>
<td>RCMP Victim's Services</td>
<td>(250) 392-8709</td>
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<td>United Way</td>
<td>(250) 395-3838</td>
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<td>100 Mile House</td>
<td>Youth Centre</td>
<td>(250) 395-3636</td>
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<td>100 Mile House</td>
<td>Family Enrichment Centre</td>
<td>(250) 395-5155</td>
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<td>Ashcroft</td>
<td>Elizabeth Fry Office Ashcroft</td>
<td>(250) 453-9656</td>
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<td>Barriere</td>
<td>United Way</td>
<td>(250) 672-0014</td>
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<td>Barriere</td>
<td>Yellowhead Community Services</td>
<td>(250) 672-9773</td>
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<tr>
<td>Clearwater</td>
<td>United Way</td>
<td>(250) 674-2600 local 227</td>
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<td>Clearwater</td>
<td>Williams Lake</td>
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<td>Big Brothers &amp; Big Sisters</td>
<td>(250) 398-8391</td>
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<td>Cariboo Brain Injury Society</td>
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<td>Clearwater</td>
<td>Children's Therapy &amp; Family Resource Centre</td>
<td>(250) 371-4100</td>
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<tr>
<td>Clearwater</td>
<td>Community Based Victim Services</td>
<td>(250) 305-2513</td>
</tr>
<tr>
<td>Clearwater</td>
<td>Crisis &amp; Counselling Centre</td>
<td>(250) 398-8224</td>
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<tr>
<td>Clearwater</td>
<td>Parent-Teen Counseling Program</td>
<td>(250) 398-8220</td>
</tr>
<tr>
<td>Clearwater</td>
<td>RCMP Victim's Services</td>
<td>(250) 392-8709</td>
</tr>
</tbody>
</table>
Therapy is a dynamic exchange of thoughts, ideas and feelings between an individual and a mental health professional. The therapeutic relationship is meant to promote positive change in a person’s life within an open, non-judgmental environment. This atmosphere of trust enables clients to discuss, in confidence, issues and emotions that impact their lives.

Therapists may be a helpful resource in examining why children and youth think, act, and respond the way they do. They can also help clients to understand their feelings, to consider possible changes, and to examine how they relate to others. Cognitive-behavioural and interpersonal therapies have been shown to be the most helpful kinds of psychotherapy.

Preparing for the First Visit
You may be concerned that your child will become upset when told of an upcoming visit with a therapist. Although this is sometimes the case, it’s essential to be honest about the session and why your child (or family) will be going. The issue will come up during the session, but it’s important for you to prepare your child for it.

Explain to young kids that this type of visit doesn’t involve a physical exam or shots. You may also want to stress that this type of therapist talks and plays with kids and families to help them solve problems and feel better. Kids might feel reassured to learn that the therapist will be helping the parents and other family members too.

Older kids and teens may be reassured to hear that anything they say to the therapist is confidential and cannot be shared with anyone else, including parents or other doctors, without their permission—the exception is if they indicate that they’re having thoughts of suicide or otherwise hurting themselves or others.

Giving kids this kind of information before the first appointment can help set the tone, prevent your child from feeling singled out or isolated, and provide reassurance that the family will be working together on the problem.

(From www.kidshealth.org Taking a Child to a Therapist)

Parents are always the experts on their own child—you are not giving up control. If you have issues with your child’s therapist, talk with them to try to work out your differences.

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Finding a Therapist

How to Find a Therapist
- Recommendations from other people whose children have received mental health services
- Referral from your child’s family doctor or psychiatrist
- Recommendations from other mental health organizations
- Recommendation from Employee Assistance Program (EAP) or Extended Health Program
- Yellow Pages

Places to Access Counselling
- Psychiatrists are physicians with specialized training in mental illness. They are able to prescribe medications. Available on referral from a family doctor or GP.
- Psychologists have a PhD in psychology and provide assessment and counselling but do not prescribe medications.
- BC Psychological Association Referral Line: 1-800-730-0522 or www.psychologists.bc.ca
- Clinical Counsellors should have a Masters degree and provide assessment and counselling but do not prescribe medications.
- BC Association of Clinical Counsellors Referral Line: 1-800-909-6303 or www.bc-counsellors.org
- Board of Registration for Social Workers in BC: www.brswnow.ca
- Employee Assistance Programs may be available through your workplace
- Child and Youth Mental Health Services (see page 5)
- Universities, Family Services, social workers, nurses, clergy Contact your local CMHA branch for other types of counselling

Self-Help Resource Association of BC
SHRA is an organization that provides resources and supports to individuals and organizations that are involved in self help/peer support. (604) 733-6186 or www.selfhelpresource.bc.ca

Alternative Treatments

When there is a relatively mild anxiety disorder, sometimes parents will look at these alternative treatment methods. For more serious mental health issues consult a mental health professional.

BC Art Therapy Association
(604) 878-6393 www.bcarttherapy.com

BC Naturopathic Association
1-800-277-1128 or www.bcna.ca

Music Therapy Association of BC
(604) 924-0046 www.mtabc.com

BC Therapeutic Recreation Association
(604) 462-0070 www.bctra.org

BC Association for Play Therapy
(604) 682-8122 www.bcapt.org

Canadian Society of Clinical Hypnosis
(604) 688-1714 www.hypnosis.bc.ca

BC Clinic of Traditional Chinese Medicine
(604) 872-6833

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(604) 872-6833
Is ‘Bad Parenting’ the Chicken or the Egg?

After years of resisting referral to a mental health professional for her son’s difficulties, the child psychiatrist uttered the very words she was avoiding: “Mrs. Johnson, I think your son is suffering from a mental illness and I want to refer you and your husband to a local parenting class.”

The ‘mental illness’ part was not a surprise. She and her husband had known all along that there was something unique about their son’s struggles. It was the ‘parenting class’ part that twisted the knife she had felt sitting in her heart for years.

These innocent words may not have been felt so strongly by others. For Mrs. Johnson, however, they only served to confirm the shaming opinions of friends, family and the countless strangers in grocery stores that her inadequate parenting skills were the cause of her son’s mood problems and disruptive behaviour.

We’ve all seen it: an angry, tight-jawed mother yanking on the arm of a screaming, flailing child in the grocery store. We scurry to the next aisle out of social embarrassment. And then, we’ve all thought it: “No wonder the child is like that, look at that stressed-out mother.”

Sadly the experience of Mrs. Johnston in the professional’s office is played out many times every day in the offices of mental health professionals across North America. The parenting class recommendation itself is not necessarily the problem. It’s the implied message: the suggestion that ‘bad kids’ are made by ‘bad parents,’ that flattens the hopes of parents already struggling to preserve slivers of self-esteem. Yes, I know, the suggestion is very consistent with our cultural beliefs and very consistent with clinical lore. But does it have scientific merit?

To be sure, parenting patterns can have a significant impact on children’s functioning and well-being. There is no scientific doubt here. But what do we make of the strong resilience literature that demonstrates most kids survive bad parenting with little significant pathology.

This seems to fly in the face of the unsubstantiated, often assumed, and all too-commonly implied theory that any child in the presence of a bad parent (Mrs. Johnson hears “your parenting”) will develop mental illness. This is simply not true.

The clinical implications are clear then. What are the chances that the mental illness-related problems being experienced by this child in my office were ‘caused’ by this parent? Possible—but unlikely! The corollary follows. What are the chances, therefore, that fixing the parent will fix the child? Don’t bet the farm.

So what do we do with parenting skills then? Why would we spend precious limited resources on family assessments and family therapy? Why include expensive family interventions in our toolbox? Should we ignore the family and focus on the child as an isolated individual? We’ll get to that later, but first let’s discuss the relationship between child dysfunction and parental distress further.

Common clinical lore suggests that parents who are stressed by life circumstances (finances, life events, low education, family size, etc.) bring that stress to the parenting role and inflict psychological harm on their children through dysfunctional interactions and poor parenting styles. Good theory. It’s just not true.

For example, Vitanza (1999) demonstrated that the strongest predictor of parental stress in mothers of children with mental illness was not the environmental stressors but the level of challenging behaviours in their children. So it does not seem to be the case that stressed parents bring their stress to the parenting role. Rather, it is the parenting of challenging children itself that causes parents’ stress. Bad parents don’t cause bad kids. It’s the other way around. Challenging children bring out the worst in their caregivers, teachers, doctors and nurses.

Interestingly, other factors that predicted mother’s stress more than environmental stressors included her level of self esteem, the presence of depressive symptoms and interpersonal sensitivity (being more easily hurt than the average person).

Interpersonal sensitivity is an important factor for professionals to keep in mind. Parents’ historic experiences with blame and shame will make it easier for them to misunderstand our communication. Extra care must therefore be taken to ensure we are just as clear about what we are not saying as we are about what we are saying.

Excerpted from Visions: BC’s Mental Health and Addictions Journal Vol. 2, No. 3 (Summer 2004); to read the full article, visit www.HereToHelp.bc.ca
What to Expect from Your Child's School in Children's Mental Health

Mental health conditions can interfere with a child's learning. The role of the school is to ensure that all students, including children with mental health issues, have equitable access to learning opportunities, and to help them succeed educationally to the best of their abilities. Parents can play a vital role in the educational approach by working in partnership with the professionals to develop a plan that maximizes their child's abilities to succeed in school.

What parents can do

- Try to establish regular ongoing contact and not just when a crisis arises. Expect you will have regular contact. Be proactive and let the school know your preferences for how you will communicate with them.
- When you meet with the school to review your child's progress, begin the meeting with things that are going well, as well as the concerns. It is important to look at what has been working. Put together some notes (positive feedback) and bring to the meeting. This will relieve some anxiety and help you be prepared going into the meeting.
- If you have noticed something in your child's behaviour that is troubling, it is a good idea to contact the school to find out whether their school work or social interaction with the other children is also being affected.
- It is best if you can start by contacting your child's teacher, as they are the one who knows your child the best. The school counsellor is also a good contact and parents can request to meet with them. The school principal is a good resource and may be able to pull together appropriate staff members to talk with you about your child, but is usually not the person who knows your child the best.
- Be aware of everything that is in your child's file. If there is anything you do not have a copy of and which you would like, do ask the school if they could please provide one. Offer to pick up the copy at a later date, so it can be copied during a quiet part of the day. This is especially important if you would like copies of more than one report or if the reports are long.
- Get to know and understand your rights and all the terms and conditions that apply to the services your child and family use. Read everything carefully. Be sure you understand and fully agree to everything before you commit to, or sign anything.
- Once a child has involvement with a service provider outside of the school, an integrated case management (ICM) meeting is often required and parents, as well as schools, can request an ICM meeting. These meetings bring together everyone involved in assisting your child.

What parents need from schools

- To be treated with courtesy, consideration and respect for the job they are attempting to do.
- Appreciation for the expertise that parents have gained from bringing up their child and living with them.
- To be fully involved in the assessment and planning; the goal being to develop a plan for the day-to-day management of the child and to prevent situations from reaching a crisis point.
- Information that is explained in plain language that doesn't cause parents more stress by needing to ask what things mean.

What schools can do

- Because of different stressors and expectations at school, the child will often behave differently at school. The school may contact the parents because they are seeing a problem that may not be evident at home. This is an opportunity for both school and parents to work together on the child's behalf.
- When teachers first notice a problem, they will often consult with the parents and attempt strategies to manage the behaviour or support the student in the classroom. If these prove unsuccessful, the teacher may seek assistance from other school-based services.
- If a classroom teacher finds effective ways to help a student, it may not be necessary to investigate further. However, if your child continues to experience significant academic, social, or emotional difficulties that interfere with learning, it is a good idea for the family and school to meet to discuss next steps.
- A behavioural assessment may be administered which will provide a better understanding of the function and the patterns of your child's behaviour. You may be asked to contribute information about your child's behaviour at home. This provides important information needed for developing an appropriate plan of support.
- If there is a meeting required with the school, it may include the teacher, principal, school counsellor, and possibly other school personnel such as the special education assistant, etc. to discuss the difficulties they are experiencing with the child. These meetings sometimes result in recommendations being made for the child to be referred to a specialist and/or the local Child and Youth Mental Health Centre for assessment. It may also be appropriate at this stage to have families involve their physician or pediatrician to rule out any other health problems.

What schools need from parents

- To be treated with courtesy, consideration, and respect for the job they are attempting to do.
- A description of the child's personality, strengths, likes, dislikes, struggles, etc. Information on what the child is saying about school, their friends, things they are struggling with, things they are happy with and enjoying. Strategies used at home for setting limits, for encouraging the child, for giving the child safe time. A common message and approach at home and school are very important for the child.
- To ensure privacy when talking about a child's difficulties, teachers can be more helpful if parents make an appointment or give the teacher a note. This helps to prevent other children or parents from overhearing any conversations you need to have with the teacher.
- A team effort where everyone is respectful and mindful of the need to agree on a plan of action and agree to adjust the plan if necessary.
- Access to other reports, assessments, and information that parents have that may help the school in understanding and managing the child.

The teachers at your child's school can provide you with valuable information about how your child behaves at school and about his or her academic performance. With this information, families are able to develop a more complete understanding of their child.

A recommendation for psycho-educational testing may be made to help identify any learning expectations or read the social cues that can create a lot of anxiety, a lot of stress on the child.

If your child is given a special education designation, the school will work with you to develop an individualized education plan (IEP) that will provide accommodations and interventions designed specifically around your child's needs. All schools have access to Support Services (or Special Education) teacher who can help with the case management for the IEP.

Developed by the FORCE Society for Kids’ Mental Health. For more information please visit our website: www.bckidsmentalhealth.org

CanCanadian Mental Health Association Pour la santé mentale

Thompson/Cariboo
BC Mental Health Act

All Canadian provinces and territories have varying legislation about the treatment and protection of people with severe mental disorders. BC’s Mental Health Act (Bill 22) provides guidelines for those working in the mental health system and safeguards for securing the dignity of individuals, whether they are voluntarily or involuntarily admitted to a psychiatric facility.

<table>
<thead>
<tr>
<th>Voluntary</th>
<th>Involuntary</th>
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</thead>
<tbody>
<tr>
<td><strong>What is it?</strong></td>
<td><strong>What is it?</strong></td>
</tr>
<tr>
<td>• Person admits themselves into a facility by their own free will</td>
<td>• Person is admitted, not by their free will, into a facility by a doctor, police officer, or court</td>
</tr>
<tr>
<td>• If a person has been examined by a doctor and has a mental disorder, the director may admit them if asked by the person, or a parent/guardian on their behalf if they are under 16 years</td>
<td>• The director may admit a person for up to 48 hours with 1 Medical Certificate (valid for 14 days following date of examination)</td>
</tr>
<tr>
<td>• When a person is under 16 years is admitted, they must be examined by a doctor once a month for the first 2 months, then within 3 months after the second exam, then within 6 months of the third exam and every 6 months thereafter</td>
<td>• Once admitted, the second doctor’s examination, and certificate must be issued within 48 hours</td>
</tr>
<tr>
<td>• Voluntary admission is described in the Act under section 20</td>
<td>• A police officer may take a person into custody for a doctor’s examination if s/he believes the person may put at risk her/his/ someone else’s safety</td>
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<tr>
<td><strong>Discharge</strong></td>
<td><strong>Discharge</strong></td>
</tr>
<tr>
<td>• A patient under 16 years must be discharged if the parent/guardian requests it, or if the patient does not have a mental disorder</td>
<td>• A request for discharge will go through Review Panel hearing</td>
</tr>
<tr>
<td>• If the patient is under 16, without consent from the parents for discharge, the request will go to a Review Panel hearing</td>
<td>• Obtain application Form 7 for a Review Panel hearing only after second Medical Certificate is completed</td>
</tr>
<tr>
<td>• The Act provides for compulsory treatment of all involuntary patients</td>
<td>• A person is entitled to representation at the hearing by a lawyer, advocate or person of choice</td>
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<tr>
<td>• The patient or someone on their behalf may ask for a second opinion on diagnosis</td>
<td><strong>Consent to treatment</strong></td>
</tr>
<tr>
<td>• Patients must consent before treatment is administered</td>
<td>• The Act provides for compulsory treatment of all involuntary patients</td>
</tr>
<tr>
<td>• The physician must inform the patient of the nature of their condition and the reasons for and consequences of the treatment</td>
<td>• The patient or someone on their behalf may ask for a second opinion on diagnosis</td>
</tr>
<tr>
<td><strong>Application to court for discharge</strong></td>
<td><strong>Application to court for discharge</strong></td>
</tr>
<tr>
<td>See section, Discharge above</td>
<td>If the patient or their representative do not agree with the order of admission into a facility, then an application may be made to the court to reverse the involuntary committal certificate</td>
</tr>
<tr>
<td><strong>Access to medical certificates</strong></td>
<td><strong>Access to medical certificates</strong></td>
</tr>
<tr>
<td>N/A</td>
<td>All patients are allowed access to their Medical Certificates</td>
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</tbody>
</table>

For more information about the Mental Health Act in plain language, visit www.kelowna.cmha.bc.ca/files/kelowna/mha_pdf. Make sure you speak to a qualified advocate or legal professional for more specific information about how the Mental Health Act applies to your individual situation.

Legal Resources

**Community Legal Assistance Society (CLAS)**
Litigates test cases and seeks reform laws in all areas of law relating to economically, socially, physically, and mentally disadvantaged.
1-888-685-6222
www2.povnet.org/clas

**Legal Aid**
This legal Services Society (LSS) will pay for a lawyer to represent you in court; if you have a legal problem covered by their legal aid guidelines; your income and the value of your property is below a certain limit; you have no other way of getting legal help; and you can pay a contribution to the Legal Services Society.
1-866-577-2525
www.lss.bc.ca

**Mental Health Law Program (part of CLAS)**
Provides free legal representation of patients at review panels under the Mental Health Act and Review Boards under the Criminal Code.
1-888-685-6222

**Legal Services Society’s Law Line**
Provides general information, education, and referral services (Note: not specific to mental health law issues; line is staffed by librarians, not lawyers).
1-866-577-2525
www.lss.bc.ca

**Law Students Legal Advice Program**
UBC student-operated program supervised by lawyers, giving free legal advice to low-income people. (604) 822-5791

**Lawyer Referral Service**
If referred through this service, you only have to pay $10 for the first half-hour of consultation, with regular rates thereafter. 1-800-633-1919

**Dial-a-Law**
Library of pre-recorded messages prepared by lawyers to provide practical information on aspects of law. 1-888-365-5297
www.dialalaw.org

**Legal Aid**
This legal Services Society (LSS) will pay for a lawyer to represent you in court; if you have a legal problem covered by their legal aid guidelines; your income and the value of your property is below a certain limit; you have no other way of getting legal help; and you can pay a contribution to the Legal Services Society.
1-866-577-2525
www.lss.bc.ca
Advocacy is a way of raising concerns you have, changing the status quo, and standing up for what you believe in. The mental health of children and youth is very involved and requires support from the Ministry of Children and Family Development, Ministry of Education and the Ministry of Health to ensure the best possible results. At some point you may want to advocate for yourself or your child, or on behalf of a friend, to raise concerns, to ask for a policy change, to request new or enhanced services, or to help dispel stigma and prejudice.

What Can I Do?
There are four major steps to effective self-advocacy:
- Be organized
- Develop a plan of action
- Take action
- Don’t be afraid to ask for help

There are a number of simple and quick ways you can get your concern heard by people in decision-making positions, including:
- Writing a letter
- Making a phone call
- Visiting your elected representative

Where Do I Go?
- If you have a concern about a specific service your child is receiving, ask for a copy of the organization’s complaint procedure and/or statement of service user’s rights. Find out how their complaints process works and whom you can speak to if your initial concern is not resolved to your satisfaction.
- If you are a part of a support group or other association, ask others if they have had similar experiences and what they did. If you need support, consider getting in touch with advocacy or campaigning groups who might share your concerns.
- If you have questions or concerns about government or private insurance coverage, talk to your doctor or healthcare provider so that together you can give all the reasons why the service, treatment or therapy is necessary, and ask for reasons if coverage is denied, and if necessary, how to appeal their decision. If the insurance plan is through your workplace, you can also speak to the Human Resources department to find out more details of what is covered and why.
- Consider getting in touch with your local political representative (MLA). Their role is to represent you and they have regular times when you can meet them in their constituency offices.

10 Rules of Advocacy “Etiquette”
- Start by assuming the best of others
- Plan for small wins
- Do your homework and document your findings
- Take the high ground
- Be passionate and persistent
- Be willing to compromise
- Be opportunistic and creative
- Don’t be intimidated
- Keep focus on the issues
- Make it local and keep it relevant

Stigma & Discrimination Around Mental Illness
Stigma, or shame, can take many forms and is often experienced as verbal or emotional abuse, discrimination, isolation from family and friends, and even physical violence. Stigma affects people’s self-esteem. They can feel lonely and ashamed of themselves and their illness. There are many myths that contribute to the level of stigma in society, such as considering people with mental health issues as dangerous or violent, lacking intelligence, unable to recover, not having willpower or being unpredictable, among others.

- Stigma is fueled by myths and misconceptions, which you can help reduce by educating others. If your child has a mental health issue, tell the people you care about. If you don’t but you know someone who has, remember to treat that child and their family with the same respect you would offer any friend. Research has shown that personal contact is the #1 way to dramatically decrease negative attitudes. For other ways such as media monitoring, speaking in public or volunteering, contact your local CMHA.

Useful Advocacy Contacts
BC Minister of Children and Family Development
(250) 387-9699 (or use Enquiry BC)

Representative for Children & Youth
1-800-476-3933

Enquiry BC (To contact your local MLA)
1-800-663-7867
www.leg.bc.ca

BC Pharmacare Program
1-800-663-7100
www.healthservices.gov.bc.ca/pharmace

F.O.R.C.E. Society
(604) 878-3400
www.bckidsmentalhealth.org

BC Coalition of People with Disabilities
1-800-663-1278
www.bccpd.bc.ca

BC Review Board
1-877-305-2277
www.bcrb.bc.ca

ARA Mental Health Action Research & Advocacy Association
1-866-689-7938
www.aramentalhealth.org

Advocacy Access
A Vancouver-based program that helps people with disabilities apply for BC Disability Benefits & CPP Disability Benefits; will also work on client

Family Support Institute of BC
1-800-441-5403
www.familysupportbc.com

Published by The World Health Organization
**Before recommending any medication, the psychiatrist (preferably a child and adolescent psychiatrist) should conduct a comprehensive diagnostic evaluation of the child or adolescent. Parents should be informed about known risks and/or FDA warnings before a child starts any psychiatric medication. When prescribed appropriately by an experienced psychiatrist (preferably a child and adolescent psychiatrist) medication may reduce or eliminate troubling symptoms and improve daily functioning of children and adolescents with psychiatric disorders.

Recently there has been a lot of media coverage about the possible risk of suicidal ideation (thoughts about suicide) in children who are prescribed antidepressants. If you are worried about this speak with your child’s psychiatrist.

If you are considering having your child take an herbal remedy, tell your doctor and pharmacist about your interest and what specific remedy you are considering. They can provide additional information, advice on suitability, and precautions on interference with other medication that your child may be using. If your child is having problems with a remedy, they may also provide alternatives or find solutions for the problem. Herbal remedies can have side effects and should be given with caution when used with other medication. Some examples of herbal remedies are: St. John’s Wort, Sam-E, and Ginkgo Biloba.

Establish routines:

- **Bedtime routines are especially important:** Start at least an hour before the planned bedtime, build in a story, a chat time, some warm milk or snack. A warm bath ahead of time may help. The ritual helps the child gradually relax. It is important that parents not get into the habit of sleeping with the child or having them fall asleep in the parents’ bed as this becomes a habit which is hard to break. Settle them with some quiet music or a story tape, and check in briefly at planned intervals (5 min. for young children, 10–15 min. with older children) so they don’t need to worry about where people are. A good routine can take several weeks to establish, but everyone will feel better once it is in place.

**If you have questions regarding specific medications, please consult with your pharmacist or the prescribing physician**

**No-charge Medications (Plan G)**

This no-charge psychiatric medication program assists people for whom the cost of psychiatric medication is a serious barrier but who, without medication, would suffer very serious consequences, such as hospitalization.

The program provides psychiatric and side effect medication approved by Pharmacare (except sleeping pills) at no cost to the individual. To apply, bring in a doctor’s form and your child’s prescription to your local child and youth mental health services centre (see list on page 5).

If your medical and financial situation qualifies your child, and the centre director approves the application, you can go to any pharmacy and receive your child’s medication at no cost.

Applications must be signed and delivered or faxed to the local child and youth mental health services centre for approval. The forms are available at the child and youth mental health services office or online at www.healthservices.gov.bc.ca/exforms.

**Helping Anxious Children**

In most cases, the tendency to be anxious stays with a person throughout their life. So we need to help anxious children develop coping skills to manage their own anxiety eventually. This starts with parents helping them by going through the following steps. Older children and teens can do some of this for themselves:

**Assessment:** Have a child’s general health checked by the doctor. Untreated allergies, anemia, ear infections or other problems make it harder for anxious children to cope. The doctor can also check out whether panic attacks or obsessive-compulsive disorder, which need very specific treatment, are present. For some kinds of anxiety, medicine may be suggested, but in most cases, treatment includes learning new coping skills.

**Look after the basics:** No one copes well when they are tired or hungry. Anxious children often forget to eat, don’t feel hungry and don’t get enough sleep. Establish bedtime routine (see below) and offer frequent, nutritious snacks. Anxious children rarely eat a large full meal. They are better to “graze” as long as the snacks cover the basic food groups in a day.

**Establish routines:** Routines reduce anxiety. But anxiety tends to disrupt routines. So you need to work hard to build regular patterns so life is more predictable. Have the child help plan the routine. Making an attractive schedule for the fridge gives a sense of control and order. This is not the kind of child who copes well with a disorganized, “spontaneous” family style. Help the child adjust to changes by gradually introducing them and preparing them in advance.

**Plan time for homework and projects:** This needs to be a regular part of the schedule, as anxious children tend to procrastinate. Because anxious children become overwhelmed, breaking the job up into small chunks, setting a specific time to work, and rewarding themselves for each bit done are tools they need to learn. Often the hardest part is getting started, so knowing that the TV program is on afterwards, or having computer time to look forward to can help to start.

**Firm, consistent parenting:** Anxious children feel calmer when life is predictable, when they know what is expected of them, and what the consequences will be. Setting limits is a challenge for parents, however, when the child becomes so upset. With practice, everyone can feel more secure, and children are relieved to have adults in charge.

Web resources regarding children with anxiety disorders:

- www.aacap.org/publications/factsfam/anxious.htm
- www.adaa.org/GettingHelp/FocusOn/Children&Adolescents.asp
- www.caringforkids.cps.ca/behaviour/fears.htm
- www.anxietybc.com
- www.nationaleatingdisorders.org

continued on next page
I have always felt that I’ve inherited a hypersensitive nervous system from my mother and she, from her mother. When there’s a surprising noise or explosion in a movie, we’re the ones in the theatre who will physically jump out of our seats and gasp audibly—and then shrink back in embarrassment. These days, it seems that everyone else, desensitized by the ‘action’ in daily life, is seeking bigger and bigger thrills and adrenaline rushes. Not me. I think life is far more exciting the way it is.

I first started to realize that my mind and body were prone to ‘excitability’ around the time that I was getting used to a double-digit age. I remember that I was really excited about the first day of Grade 6, so much so that I found it hard to get to sleep. When I finally did, I ended up having a nightmare and woke up with a start in the middle of the night. Wide awake now, my mind became active and I got so worked up thinking about going back to school, I had to run to the bathroom and throw up. I still remember how the next day I had asked my friends if they had thrown up too, as if my reaction was the norm. They just looked at me funny. It was then I realized I probably shouldn’t mention my vomiting incidents to anyone. Looking back now, after that day I never felt “excited” about anything because to me, excitement felt the same as nervousness.

From around age ten to age eighteen, I routinely (and secretly) experienced panic attacks whenever there was a special outing or event about which I was uncertain, or whenever I felt someone had expectations of me. I make this distinction because, for example, I never had anxiety writing exams or driving because I felt I had control over my test performance or what the car did. But all the fun things that everyone else loved to do, it seemed, I would ‘freak out’ over. These could be vacations, sleepovers, birthday parties, or even just a family meal at a restaurant. Someone would make the mistake of inviting me to these activities days or weeks in advance—way too much time for me to think about it.

My fears started out as ‘what if they don’t have a good time at my house?’ or ‘what if I sleep funny and they make fun of me?’ or ‘what if I can’t finish what’s on my plate?—someone I care about will have wasted their money.’ Soon enough though, the only fear I had was having another attack: the horrible tingles down the spine, the knot in the tummy, the heart rate and breathing accelerating, the nausea, the sweating, and that horrible feeling that the world was going to end. So why didn’t I just avoid the ‘fun’ activities that were common triggers for my panic? Because then people might suspect something was wrong and I wasn’t about to give them the satisfaction of judging me. Also, I hated “missing out”: I knew I’d regret later if I did. Besides, after a couple of hours, I’d relax enough to have fun.

So I developed a proactive campaign to prepare for an attack. For example, what frightened me most about having a panic attack was that there was the possibility—that it rarely happened—of vomiting. I could disguise a panic attack in a crowd, but throwing up is harder to hide and would have concerned my friends and family. So to tackle this foe, I had come up with two strategies:

1. Since anxiety and a full tummy don’t mix well, I made sure I didn’t overeat. Often after having a meal, I’d run and lie down on my bed for a few seconds to make sure my stomach didn’t feel too full. I never stayed hungry or anything, I’d just focus more on medium-sized meals.

2. Whenever I went on an excursion that might have triggered an attack, I made sure a bathroom was accessible in case I had to ever-so-inconspicuously run in and throw up. In cases where that wasn’t possible—like during a long drive—I’d put a plastic bag inside a paper lunch bag, fold it up, and put it in my pocket. Or if I was driving alone, I’d put an empty ice-cream pail on the passenger’s seat. God help me, I was so ridiculously over-prepared for emergency vomiting.

In senior high where I was a sociable, popular, straight-A student involved in many extracurricular activities, the panic attacks were less frequent but a kind of social anxiety combined with obsessive-compulsive-like behaviour took over. I became hyperconscientious about being made a fool of by my peers even though my peers really respected and liked me. It was bad that if someone just happened to be laughing when I walked by, I’d always assume they were laughing at me. Or I’d worry about embarrassing underarm sweat patches that people might see if I raised my hand (I’d go to the washroom during recess and lunch to make sure I didn’t have any patches—realizing, of course, that the more I thought about it, the more likely I was to sweat over it). My hand would quickly and casually check my pant zippers to make sure they were pulled up, my bra straps to make sure they weren’t showing, and the backs of my skirts to make sure they weren’t tucked into my underwear by accident. During the worst of it, I must have checked these kinds of things at least a dozen times during school hours. I hated that I kept doing it but I couldn’t help it. After school and at home, I was relaxed and fine.

In 1996—actually, for reasons totally unrelated to my anxiety—I began a battle with major depression. My depression ended up completely dissolving my anxiety. Why? Because I went from a state of hyperawareness of other people’s judgments and petty details to the exact opposite: in my depressive state, I was barely aware other people even existed; they all felt like robots or movie extras. I had no time to care about zippers and bra straps when I wasn’t eating and would spend half the day sleeping and half of it crying. All I cared about was getting through the day and surviving. Ironically, depression has given me a perspective I longed for all those years in my childhood and adolescence. I’m happier now than I’ve ever been and for almost six years now and counting, I haven’t had any anxious symptoms. Okay okay, I still jump out of my seat a little at the movie theatre, but that doesn’t count—I like to think I get more bang for my movie buck that way.

Sarah lives in Vancouver, BC
Bipolar Disorder

in children ...

Bipolar disorder involves marked changes in mood and energy. Persistent states of extreme elation or agitation accompanied by high energy are called mania. Persistent states of extreme sadness or irritability accompanied by low energy are called depression.

However, the illness may look different in children than in adults. Children usually have an ongoing, continuous mood disturbance that is a mix of mania and depression. This rapid and severe cycling between moods produces chronic irritability and few clear periods of wellness between episodes.

Diagnosis is made using the DSM-IV criteria, for which there is no lower age limit. See section below for DSM-IV criteria. However, it becomes more difficult to apply the DSM-IV criteria to very young children.

Behaviors reported by parents in children diagnosed with bipolar disorder may include:
- an expansive or irritable mood
- extreme sadness or lack of interest in play
- rapidly changing moods lasting a few hours to a few days
- explosive, lengthy, and often destructive rages
- separation anxiety
- defiance of authority
- hyperactivity, agitation, and distractibility
- sleeping little or, alternatively, sleeping too much
- bed wetting and night terrors
- strong and frequent cravings, often for carbohydrates and sweets
- excessive involvement in multiple projects and activities
- impaired judgment, impulsivity, racing thoughts, and pressure to keep talking
- dare-devil behaviors (such as jumping out of moving cars or off roofs)
- inappropriate or precocious sexual behavior
- delusions (grandiose belief in own abilities that defy the laws of logic) (ability to fly, for example) and hallucinations

Symptoms of bipolar disorder can emerge as early as infancy. Mothers often report that children later diagnosed with the disorder were extremely difficult to settle and slept erratically. They seemed extraordinarily clingy, and from a very young age often had uncontrollable, seizure-like tantrums or rages out of proportion to any event. The word “no” often triggered these rages.

Several ongoing studies are further exploring characteristics of affected children. Researchers are studying, with promising results, the effectiveness and safety of adult treatments in children.

in teens ...

In adolescents, bipolar disorder may resemble any of the following classical adult presentations of the illness.

Bipolar I. In this form of the disorder, the adolescent experiences alternating episodes of intense and sometimes psychotic mania and depression.

Symptoms of mania include:
- elevated, expansive or irritable mood
- decreased need for sleep
- racing speech and pressure to keep talking
- grandiose delusions
- excessive involvement in pleasurable but risky activities
- increased physical and mental activity
- poor judgment
- in severe cases, hallucinations

Symptoms of depression include:
- pervasive sadness and crying spells
- sleeping too much or inability to sleep
- agitation and irritability
- withdrawal from activities formerly enjoyed
- drop in grades and inability to concentrate
- thoughts of death and suicide
- low energy
- significant change in appetite

Periods of relative or complete wellness occur between the episodes.

Bipolar II. In this form of the disorder, the adolescent experiences episodes of hypomania between recurrent periods of depression. Hypomania is a markedly elevated or irritable mood accompanied by increased physical and mental energy. Hypomania can be a time of great creativity.

Cyclothymia. Adolescents with this form of the disorder experience periods of less severe, but definite, mood swings.

Bipolar Disorder NOS (Not Otherwise Specified). Doctors make this diagnosis when it is not clear which type of bipolar disorder is emerging.

For some adolescents, a loss or other traumatic event may trigger a first episode of depression or mania. Later episodes may occur independently of any obvious stresses, or may worsen with stress. Puberty is a time of risk. In girls, the onset of menses may trigger the illness, and symptoms often vary in severity with the monthly cycle.

Once the illness starts, episodes tend to recur and worsen without treatment. Studies show that after symptoms first appear, typically there is a 10-year lag until treatment begins. CABF (Child and Adolescent Bipolar Foundation) encourages parents to take their adolescent for an evaluation if four or more of the above symptoms persist for more than two weeks. Early intervention and treatment can make all the difference in the world during this critical time of development.

Excerpt taken from www.bpkids.org website

Web resources regarding mood disorders in children
- www.nationalyouth.com/mood-disorders.html
- www.bipolarchild.com
- www.bpkids.org
- www.depressedteens.com
- www.moodgym.anu.edu.au
In the beginning:
Imagine ... watching your 9-year-old son withdrawing from the world. He begins to interact with his friends less and less. He is trapped in his own house by his fear and he does not want to be alone. For no apparent reason he starts to refuse to go to school. In order to overcome this, you give up your job and attend school with him, all day, every day of his Grade 7 year because that is the only way you can keep him attending. Then one day you find your precious child curled up in your back yard crying and saying he wants to die. You have no idea what is happening and you cannot find anyone to help or provide support. If you can imagine this, then you get a glimpse of what our life was like when our son James’ mental health issues became critical.

We actually began our initial search for psychiatric help when our son was 5 years old but it took until he became suicidal at age 9 to be referred from one specialist to another, from one Ministry to another, and put on one waiting list after another. And that wasn’t the worst. The worst was being told by a mental health liaison worker at the local hospital, that they could offer me foster care for my son, AND ... after hearing what my son's difficulties were doing to our family, the worker advised me that she would have to make a report to protection services about our family. The liaison worker felt our daughter, Michelle, may be in danger because of her brother’s behavior and Michelle may need to be moved into care of the Ministry. I decided at this point I was not dealing with a typical problem and that it didn’t appear that anyone was hearing me or understanding that our son had a life-threatening illness and our family needed help. I often said I couldn’t believe that a child who was so obviously suffering from something, couldn’t get access to appropriate care and would this happen if he had any other life-threatening physical illness?

Our son is now a 19-year-old that has a full time job and a girlfriend, and he has lived with bipolar since being diagnosed at 10 years old. He is doing better than we had certainly dreamed possible, given his long struggle.

Although initially I began lobbying for services for my son, it was always in my nature to speak for other children as well. To promote awareness, I appeared on the evening news one night to share our family’s story and was later contacted by a Surrey mom, Donna Murphy, whose 18-year-old son had suffered from such depression that he had committed suicide. I had found a kindred spirit and a common bond was formed. Together, Donna and I made a commitment to provide support and facilitate change in children’s mental health.

Donna knew of three other moms who had faced similar challenges and in 2000, us five moms got together and decided to form a non-profit society, not even knowing what this meant or how to do it. Our non-profit society, The F.O.R.C.E., was created. Operating from my home, we applied for and received a small grant from VanCity Savings Credit Union (my former employer before I had to quit in order to find help for my son) and created and produced a brochure, a newsletter, and a website.

It took 3 years of full time volunteering to build our society until we received our first funding from the Ministry of Children & Family Development, Jayne Barker, the former Executive Director of Child & Youth Mental Health in the Ministry, believed that what we had to offer was of value and she provided us with a way to reach more families and provide needed support and information that families so desperately needed.

The F.O.R.C.E. is now in its eighth year and I feel that we have had some influence in raising the awareness and support for child & youth mental health in British Columbia. As important, the kids and families in BC and across the country need us to keep our diligent focus on doing more.

Although parents are often reluctant or apprehensive about attending a support group or coming out to the various presentations we do on topics related to child & youth mental health, we almost always hear from them that once they reach out to other parents like us they usually say “wow, you really do get it” and I like to think that yes, we really do get it.

Keli Anderson is the Executive Director of The F.O.R.C.E. Society for Kid’s Mental Health and has two children, aged 17 and 19.
ADHD
ADHD is a common behavioral disorder that affects an estimated 8% to 10% of school-age children. Boys are about three times more likely than girls to be diagnosed with it, though it’s not yet understood why. Children with ADHD act without thinking, are hyperactive, and have trouble focusing. They may understand what’s expected of them but have trouble following through because they can’t sit still, pay attention, or attend to details.

Of course, all children (especially younger ones) act this way at times, particularly when they’re anxious or excited. But the difference with ADHD is that symptoms are present over a longer period of time and occur in different settings. They impair a child’s ability to function socially, academically, and at home.

The good news is, with proper treatment, children with ADHD can learn to successfully live with and manage their symptoms.

What Are the Symptoms?
ADHD used to be known as attention deficit disorder, or ADD. In 1994, it was renamed ADHD and broken down into three subtypes, each with its own pattern of behaviors:

1. **an inattentive type**, with signs that include:
   - inability to pay attention to details or a tendency to make careless errors in schoolwork or other activities
   - difficulty with sustained attention in tasks or play activities
   - apparent listening problems
   - difficulty following instructions
   - problems with organization
   - avoidance or dislike of tasks that require mental effort
   - tendency to lose things like toys, notebooks, or homework
   - distractibility
   - forgetfulness in daily activities

2. **a hyperactive-impulsive type**, with signs that include:
   - fidgeting or squirming
   - difficulty remaining seated
   - excessive running or climbing
   - difficulty playing quietly
   - always seeming to be “on the go”
   - excessive talking
   - blurtling out answers before hearing the full question
   - difficulty waiting for a turn or in line
   - problems with interrupting or intruding

3. **a combined type**, which involves a combination of the other two types and is the most common

   Although it can often be challenging to raise kids with ADHD, it’s important to remember they aren’t “bad,” “acting out,” or being difficult on purpose. And children who are diagnosed with ADHD have difficulty controlling their behavior without medication or behavioral therapy.

How Is It Diagnosed?
Most cases of ADHD are treated by primary care doctors. Because there’s no test that can determine the presence of ADHD, a diagnosis depends on a complete evaluation. When the diagnosis is in doubt, or if there are other concerns, such as Tourette syndrome, a learning disability, or depression, a child may be referred to a neurologist, psychologist, or psychiatrist. Ultimately, though, the primary care doctor gathers the information, makes the diagnosis, and starts treatment.

To be considered for a diagnosis of ADHD:
- a child must display behaviors from one of the three subtypes before age 7
- these behaviors must be more severe than in other kids the same age
- the behaviors must last for at least 6 months
- the behaviors must occur in and negatively affect at least two areas of a child’s life (such as school, home, day-care settings, or friendships)

The behaviors must also not be linked to stress at home. Children who have experienced a divorce, a move, an illness, a change in school, or other significant life event may suddenly begin to act out or become forgetful. To avoid a misdiagnosis, it’s important to consider whether these factors played a role in the onset of symptoms

First, your child’s doctor will perform a physical examination of your child and ask you about any concerns and symptoms, your child’s past health, your family’s health, any medications your child is taking, any allergies your child may have, and other issues. This is called the medical history, and it’s important because research has shown that ADHD has a strong genetic link and often runs in families.

Your child’s doctor may also perform a physical exam as well as tests to check hearing and vision so other medical conditions can be ruled out. Because some emotional conditions, such as extreme stress, depression and anxiety, can also look like ADHD, you’ll probably be asked to fill out questionnaires that can help rule them out as well.

You’ll also likely be asked many questions about your child’s development and his or her behaviors at home, at school, and among friends. Other adults who see your child regularly (like teachers, who are often the first to notice ADHD symptoms) will probably be consulted, too. An educational evaluation, which usually includes a school psychologist, may also be done. It’s important for everyone involved to be as honest and thorough as possible about your child’s strengths and weaknesses.

What Causes ADHD?
ADHD is not caused by poor parenting, too much sugar, or vaccines.

ADHD has biological origins that aren’t yet clearly understood. No single cause of ADHD has been identified, but researchers have been exploring a number of possible genetic and environmental links. Studies have shown that many children with ADHD have a close relative who also has the disorder.

Although experts are unsure whether this is a cause of the disorder, they have found that certain areas of the brain are about 5% to 10% smaller in size and activity in children with ADHD. Chemical changes in the brain have been found as well.

Recent research also links smoking during pregnancy to later ADHD in a child. Other risk factors may include premature delivery, very low birth weight, and injuries to the brain at birth.

Some studies have even suggested a link between excessive early television watching and future attention problems. Parents should follow the American Academy of Pediatrics’ (AAP) guidelines, which say that children under 2 years old should not have any “screen time” (TV, DVDs or videotapes, computers, or video games) and that kids 2 years and older should be limited to 1 to 2 hours per day, or less, of quality television programming.

Taken from www.kidshealth.org

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Web resources regarding children with a behaviour disorder

- [www.aacap.org](http://www.aacap.org)
- [www.adhdinfo.com](http://www.adhdinfo.com)
- [www.cmha.ca/bins/content_page.asp?cid=3-1036](http://www.cmha.ca/bins/content_page.asp?cid=3-1036)
Eating Disorders

Anorexia nervosa is a common eating disorder that usually begins at the age of fourteen or fifteen, with another peak in incidence in eighteen year olds. It is more common in adolescent girls (affecting almost 1% of adolescent females), but it is also found in boys and its incidence has been increasing. Anorexia causes an overwhelming fear of being overweight and a drive to be thin, leading to a restriction of calories that can lead to being underweight. Teens with anorexia may also have bulimia nervosa, with a loss of control and binge eating, followed by purging behaviors.

It is not known what causes eating disorders, but it does seem to be associated with certain genetic attributes and is more common in children who have a first-degree relative with an eating disorder. Other factors that put you at risk for an eating disorders is participating in certain competitive activities (especially ballet, skating, athletics, and fashion modeling), having a perfectionist or obsessive personality, and having a parent with an eating disorder or weight problem (obesity, frequent dieting). Eating disorders are probably also more common in children with a past history of physical or sexual abuse.

Early risk factors for eating disorders include having low self esteem and being dissatisfied with their body. Some other factors that you should look for if you suspect that your child has an eating disorder include:

- recent weight loss
- a fear of gaining weight or of being overweight
- purging behaviors (vomiting or using diuretics (water pills) or laxatives to lose weight)
- having a distorted image of their body’s size or shape (for example, believing that she is overweight even though she is at a healthy weight)
- a preoccupation with thoughts of food, calories and their weight
- restrictive eating patterns, which can lead to a failure to gain weight or to being underweight and can include skipping meals, fasting, or eliminating entire food groups
- preference for eating alone
- amenorrhea (absence of menstrual cycles) or delayed onset of puberty and menarche
- being underweight, with a body mass index that is below normal. Use the body mass index calculator to see if your child is underweight.

You should have your child seen by a physician as soon as possible if you think she might have an eating disorder. At this visit, your doctor will probably perform a nutritional assessment, including taking a look at her eating patterns, daily caloric intake, measuring her height, weight and body mass index, and evaluating her for depression.

Your doctor will also try and rule out other causes of weight loss and decreased appetite, including other psychiatric disorders (depression, obsessive compulsive disorder), drug abuse, inflammatory bowel disease (which is usually accompanied by vomiting, diarrhea and abdominal pain), hyperthyroidism, diabetes (usually accompanied by frequent urination (polyuria) and excessive drinking (polydipsia)), and other medical problems. However, children with most of these medical problems don’t have a preoccupation with food or a distorted body image.

Resources for Eating Disorders

Web resources regarding children with eating disorders

- www.jessieshope.org
- www.anred.com
- www.nationaleatingdisorders.org

Cariboo

Williams Lake & 100 Mile House
(250) 392-1483

Thompson

Kamloops
(250) 851-7450
How to determine if your teen is at risk of problem substance use

**Evaluate the risk factors in your teen's life.**

Problem substance use is more common among teens who have multiple risk factors, such as:

- Problems at home
- Low academic performance
- A hard time fitting in with peers
- Personal stress
- Past or current trauma
- Lack of social support
- Parental role modeling of problem substance use
- Minimal parental supervision

If your teen has experience with several of these risk factors, their experimentation with tobacco, alcohol, and other drugs is more likely to develop into substance use problems.

**Consider the protective factors in your teen’s life.**

A teen's substance use is more likely to be a passing phase if their life is filled with protective factors, such as:

- Parental support and supervision
- A network of friends
- Involvement in extracurricular activities
- Community involvement
- Parental role modeling of low-risk substance use

The more protective factors your teen has, the less likely they are to develop problems with tobacco, alcohol, and other drugs.

**Talk to your teen.**

If you're not sure whether your child is experimenting or has a problem with substances, talk openly with them about your concerns. Begin your conversation when you're both relaxed and able to listen to one another in a meaningful way. Find out how your teen feels about the substances they've tried, how often they've indulged, when, and why. Learn as much as you can about your child's relationship with substances, as well as the people your teen is with when drinking or getting high.

**Be aware of the warning signs.**

Some of the warning signs that your teen’s experimentation with substances has become a problem include:

- Sudden changes in mood or behaviour
- A loss of interest in important activities, such as school, sports, or recreational activities
- Withdrawal from family and friends
- Attendance, performance, or discipline problems at school
- Excessive secrecy
- Money, alcohol, or cigarettes disappearing from home
- Spending time with a new peer group that you are unfamiliar with
- Fatigue, loss of appetite, or depressed behaviour
- A decline in personal hygiene or appearance

Individually, these signs may well be a normal part of your teen's adolescent development. If your teen exhibits several signs, however, they may have a problem.

**If you think your teen has a problem with alcohol or other drugs**

Don't panic. While you may feel angry or frustrated, yelling and showing anger will not help your situation.

Try to communicate in an open, supportive way. Using bribes, threats, or guilt may only make your situation worse. Let your teen know that you care about them and are concerned about their health and safety.

Get informed about what your teen's using and how often. Find out as much as you can about your teen's experiences and attitudes toward substances.

Educate yourself. Learn about the substances your teen is taking, and let your teen know that you're studying up on substance use. You can start the process by checking out the resources available at www.silink.ca.

Be honest with yourself and your teen. If you don't know something related to your teen's substance use, tell your teen the truth and suggest researching this information together. Let your child know they're not alone and can trust you to help them.

Seek help. Not all parents are able to cope with their teen's substance use issues on their own. The Alcohol and Drug Information and Referral Service provides information and referrals 24 hours a day, seven days a week. Call them toll-free at 1-800-663-1441.

From the Centre for Addictions Research of BC website at www.carbc.ca

**Web resources regarding substance use disorders:**

- www.youthondrugs.com
- www.nida.nih.gov
- www.dancesafe.org
There is wide acknowledgment that people with a developmental disability are susceptible to the full range of psychiatric illnesses. The most commonly occurring disorders—similar to those in the general population—include major depressive disorder, bipolar disorder, anxiety disorders, and schizophrenia.

When compared to the general population, individuals with developmental disability have a higher rate of mental disorders: 39 percent in children and 30 percent in adults (Emerson, 2003; Hudson C., Chan J., 2002; Smiley, 2005). Despite this, many are typically under-diagnosed, misdiagnosed, and underserved.


A helpful resource is Dual Diagnosis A Guide for Families of a Child with an Intellectual/Developmental Disability and a Mental Disorder. The guide can be found on the FORCE’s website at www.bckidsmentalhealth.org/education/tip_sheets

### Web resources regarding dual diagnosis (a developmental disability and mental illness)

- BC Association for Community Living www.bcacl.org
- The National Association for the Dually Diagnosed www.thenadd.org
- Developmental Disabilities Association of BC www.develop.bc.ca

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**Youth Resources Related to Substance Use**

Check with your local Child & Youth Mental Health Services office to find out what services they offer for substance use disorders.

### Carboo

#### 100 Mile House

- **Interior Health Alcohol & Drug Services**
  - (250) 395-7676

#### Williams Lake

- **Interior Health Alcohol & Drug Services**
  - (250) 392-1483

- **HIV Aids Awareness**
  - (250) 392-5730

- **Nenqayni Treatment Centre Society**
  - (250) 989-0301

### Thompson

#### Kamloops

- **Phoenix Centre (Raven Program)**
  - (250) 374-4634
  - 1-877-318-1177

#### Barriere

- **Alateen**
  - (250) 672-9693

- **Simpcw First Nation**
  - (250) 672-9995

- **Phoenix Centre**
  - (250) 672-9731

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**Developmental Disabilities & Mental Health (Dual Diagnosis)**

For information about services to youth 14 years or older who have a developmental disability and a mental health disorder contact:

**Developmental Disability Mental Health Services**

#309 – 1664 Richter Street, Kelowna, BC V1Y 8N3
Ph. (250) 860-5731
Depression

In the last half of the 20th century, depression has increased dramatically and is now a common problem. Research has shown that many young people (about 40% in any six month period) suffer periods of sadness or unhappiness, but this may not be depression. It is quite normal for people to feel “blue” or “down,” but it’s when they’re feeling down for a number of weeks and there are behaviour and personality changes that it is time to seek out help. When people’s moods change their usual activities and habits, it may indicate that they have some kind of depression.

Sometimes because we don’t understand our feelings or are unable to talk about them we do things to distract ourselves and this may not always be obvious. For example:

- Become more aggressive (lose their temper a lot quicker than before, or even treating everyone badly).
- Risk taking (doing things that they normally wouldn’t, for example skydiving or disregarding their own personal safety).
- Use of lots of alcohol and other drugs (trying to forget their problems through drugs and alcohol, but instead forgetting what they did the night before).
- Not going to school or work (because they don’t want to be around people that are having fun or they just can’t face their friends).
- Are doing badly at school or work (concentrating on a task may be hard due to the fact they are confused).

There are also a number of things that families and friends can do to help. Offer help and listen. Encourage your friend to talk about their feelings. Acceptance and belonging are very important, so it is important to encourage them to:

- Talk to someone they trust
- Ask for help (this could be from a parent, school counsellor or your local doctor)
- Spend time with friends
- Participate in sports and hobbies
- Ring a 24 hour telephone service
- Do things that will improve self esteem (participating in community activities).
- Encourage positive thinking by hanging around people that have a positive outlook on life and themselves.
- Developing and maintaining your social skills—by getting out and getting involved you are working on such skills as problem solving, communication and confidence—skills which will help make and keep positive friendships
- Good relationship with at least one parent or another adult who is important to you.
- Good relationships with friends and peers.
- Set goals and go for them.

Prevention of depression is also possible and there are a range of skills and activities that everyone can do that will help keep a positive state of mental health. Some of these things are:

An excellent resource is The Dealing with Depression Antidepressant Skills for Teens workbook. It can be found at: www.mcf.gov.bc.ca/mental_health/publications.htm

BC residents may order free copies of this guide at: www.gov.bc.ca.
(Look under Ministry of Children and Family Development > Child & Youth Mental Health > Publications)

This information was found at Headroom www.headroom.net.au/lounge
©2006 Children, Youth and Women’s Health Service
So what are the signs of depression then?

- About hurting yourself or acting on it
- Putting yourself down and thinking you’re no good
- Sadness or irritability
- Withdrawal from friends, family, and previously enjoyed activities
- Change in eating or sleeping patterns
- Feeling of guilt or worthlessness
- Difficulty concentrating
- Lack of energy, enthusiasm, or motivation

Thompson/Cariboo

Canadian

Suicide

Adolescence is a time of dramatic change. The journey from child to adult can be complex and challenging. Young people often feel tremendous pressure to succeed at school, at home, and in social groups. At the same time, they may lack the life experience that lets them know that difficult situations will not last forever. Mental health problems commonly associated with adults, such as depression, also affect young people. Any one of these factors, or a combination, may become such a source of pain that they seek relief in suicide. Suicide is the second leading cause of death among young people after motor vehicle accidents. Yet people are often reluctant to discuss it. This is partly due to the stigma, guilt or shame that surrounds suicide. People are often uncomfortable discussing it. Unfortunately, this tradition of silence perpetuates harmful myths and attitudes. It can also prevent people from talking openly about the pain they feel or the help they need.

Suicide can appear to be an impulsive act. But it’s a complicated process, and a person may think about it for some time before taking action. It’s estimated that 8 out of 10 people who attempt suicide or die by suicide hinted about or made some mention of their plans. Often, those warning signs are directed at a friend.

Recognizing the warning signs is one thing; knowing what to do with that information is another. Suicide was a taboo subject for a very long time. Even talking about it is still difficult for most people. But being able to talk about suicide can help save a life. Learning about suicide is the first step in the communication process. Suicide is about escape. Someone who thinks seriously about suicide is experiencing pain that is so crushing, they feel that only death will stop it.

To learn more about this condition:
- www.kidshealth.org/teen/your_mind/mental_health/trichotillomania.html
- www.trich.org/about_ttm/intro.asp

Web resources regarding suicide
- www.suicideinfo.ca
- www.sprc.org
- www.youthsuicide.ca

Canadian Statistics

- Suicide is the second leading cause of death among Canadian youth aged 10–24 after motor vehicle accidents
- Between 70% and 80% of Canadian youth consider suicide before graduation (Source: www.youthsuicide.ca)
- Over the period, 2000-2006, there were 137 suicides among BC youth aged 15–19 (BC Vital Statistics)
- There are typically three to four male youth suicides for every female youth suicide

Statistics

Canadian

As of November 1, 2008 there will be a province-wide number for the Crisis Line, and you will be transferred to the nearest available line. The new number is 310-6789

Thompson (Kamloops)

Kamloops Urgent Response Team (KURT) (250) 377-0088

Parkview (crisis intervention and mental health assessment) (250) 376-7855

Cariboo (Williams Lake)

Canadian Mental Health Association Crisis Line (250) 398-8224

Story from a Youth with an Obsessive Compulsive Disorder

I have a form of obsessive compulsive disorder that is known as trichotillomania. In simpler terms, I pull out my own hair. It all started when I was about 8 years old. I started pulling the hair on my knees. Then as I got older my mental illness got worse and I started pulling the hair from my head, eyebrows and even my eyelashes. It got to the point where I wasn’t able to hide it any more. I was being teased at school, and I was struggling a lot with trying to keep the pulling a secret. I didn’t think I was ever going to stop. My dad and I researched hair pulling on the internet and found a lot of information about trichotillomania. I went to my family doctor and told him that this is what I thought I had. From there I was referred to a psychiatrist at the hospital. I started on medication to help deal with my anxiety. I also saw a youth outreach worker and a counsellor. I did cognitive behaviour therapy and learned skills to help deal with the pulling. With their support, and the support of my family and friends, I started to get better. My hair started to grow back. For a long time I didn’t have enough eyelashes to wear mascara. I can happily say that I can wear mascara again. My hair is long, and still growing. I will never be completely “cured” of my mental illness. It will be a roller coaster, but at this point I am doing really well. I probably have a form of obsessive compulsive disorder that is known as trichotillomania. In simpler terms, I pull out my own hair. It all started when I was about 8 years old. I started pulling the hair on my knees. Then as I got older my mental illness got worse and I started pulling the hair from my head, eyebrows and even my eyelashes. It got to the point where I wasn’t able to hide it any more. I was being teased at school, and I was struggling a lot with trying to keep the pulling a secret. I didn’t think I was ever going to stop. My dad and I researched hair pulling on the internet and found a lot of information about trichotillomania. I went to my family doctor and told him that this is what I thought I had. From there I was referred to a psychiatrist at the hospital. I started on medication to help deal with my anxiety. I also saw a youth outreach worker and a counsellor. I did cognitive behaviour therapy and learned skills to help deal with the pulling. With their support, and the support of my family and friends, I started to get better. My hair started to grow back. For a long time I didn’t have enough eyelashes to wear mascara. I can happily say that I can wear mascara again. My hair is long, and still growing. I will never be completely “cured” of my mental illness. It will be a roller coaster, but at this point I am doing really well. I probably have
Most people who consider suicide are not determined to die. They are undecided about whether to live or die, so they may take risks and leave it to someone else to save them. Warning signs may be their way of asking for help or revealing the seriousness of their situation. Warning signs can be very subtle. They can also be as obvious as someone saying, “You won’t be seeing me any more.”

Here are some common warning signs

- sudden change in behaviour (for better or worse)
- withdrawal from friends and activities
- lack of interest
- increased use of alcohol and other drugs
- recent loss of a friend, family member or parent, especially if they died by suicide
- conflicting feelings or a sense of shame about sexual orientation
- mood swings, emotional outbursts, high level of irritability or aggression
- feelings of hopelessness
- preoccupation with death, giving away valued possessions
- talk of suicide: eg. “no one cares if I live or die”
- making a plan or increased risk taking (in a diary, for example)
- “hero worship” of people who have died by suicide
- writing or drawing about suicide
- sudden change in character. Sudden shifts in a person’s attitude or actions can alert friends to potential problems.

You can help by:
- really listening, without judging
- not challenging, or becoming angry and shocked
- finding ways to break through the silence and secrecy
- asking if they have plans or have made prior attempts
- helping them find ways to lessen their pain
- helping them see positive possibilities in their future
- guiding them to other sources of help as soon as possible, such as a counsellor or other trusted adult, or community crisis lines listed in your telephone book

No one can solve another person’s problems. But empathy and support can help; knowing that someone else has faced similar tough times and survived can help a suicidal person see a light at the end of a very dark tunnel.

(Taken from CMHA National website www.cmha.ca)

There is a strong link between suicide and mental disorders. Most research in this area confirms that suicide and suicidal behaviours among youth are strongly associated with certain mental health conditions, particularly depression, substance abuse and disruptive disorders. Anxiety, eating disorders, and co-occurring disorders have also been linked to suicidal behaviour among youth.
Self Harm (or Self Injury)

Young people learn to cope with emotions in different ways. Tears, anger, depression and withdrawal are some of the ways of responding to—and finding relief from—overwhelming feelings. Some teens are troubled by frequent intense and painful emotions. While some are able to deal with these feelings, others react differently to their problems because they have not been taught ways to handle their emotions effectively. They are unable to find the words and the buildup of feelings makes it difficult for them to think clearly. Some teens release this bottleneck by cutting or burning or otherwise hurting themselves. Self injury provides immediate relief, but this is a short-term solution with serious consequences.

Self injury is not a new phenomenon, and it is becoming more common. In one survey, approximately 13% of adolescents who responded indicated that they engaged in self-injurious behaviours. Because this is a very secretive activity, it is difficult to determine exactly how many young people are affected.

The rate of self injury is growing. Gaining a deeper understanding of self harm is an essential first step to helping yourself or another. There is treatment, but as with all mental and physical conditions, early diagnosis is key to a successful outcome.

What is Self Injury?
Self injury, also called self harm and self abuse, refers to deliberate acts that cause harm to one’s body, mind and spirit. Examples include cutting the skin with razor blades or pieces of glass; burning and hitting oneself; scratching or picking scabs or preventing wounds from healing; hair pulling; and inserting objects into one’s body. Cutting is the most common form of self injury among today’s youth.

In a broader sense, behaviours such as smoking, alcohol and drug addiction, binging on food and staying in an abusive relationship can also be considered forms of self harming.

People who self injure may not be trying to kill themselves. Usually, they are not trying to end all feeling; they are trying to feel better.

Why do People Self Injure

Experts describe deliberate self injury as ineffective problem-solving. People who self injure are often seeking relief from psychological pain, unbearable tension, loneliness, depression, anger or an absence of feeling or numbness. Some people self harm to feel emotions more intensely; others do it to punish themselves for being “bad.” They either cannot or have not learned how to express those feelings more effectively.

Self injury usually starts during puberty or adolescence. It can last for up to ten years, but if left untreated, it may persist. Episodes are usually responses to a “trigger,” such as a perceived rejection or other emotional pain. Cutting behaviour can spread, and there is a rising trend for teens to discuss cutting on the Internet and form cutting clubs at school.

There is no single pattern or profile for self injurers. According to research, most are from a middle to upper-class background, with average to high intelligence, and low self esteem. Some 40% have a history of eating disorders. Almost half report physical or sexual abuse during childhood. Almost all say that they were discouraged from expressing emotions, especially anger and sadness.

By physically harming themselves, self injurers often report feeling relief from the emotions that overwhelm them. They feel pain on the outside, not the inside.

Warning Signs

People who self injure go to great lengths to hide the behaviour. But there are warning signs, such as:

- unexplained frequent injuries, such as cuts and burns
- wearing long pants and long sleeved shirts in warm weather
- low self esteem
- problems handling emotions with relationships

What Can I Do?
If you are hurting yourself, it is important to begin talking to someone you trust—for instance, a friend, family member, a teacher, school nurse, guidance counsellor. Your doctor may be able to recommend a therapist or psychologist who can help you. There may be a support group in your area.

If you are concerned about a friend or family member, it’s okay to ask. Just talking about self injury won’t cause someone to begin hurting themselves. Before you ask, learn more about self injury. It can be shocking to find that someone you care about is deliberately harming themselves, and it can be difficult to hear what they have to say.

Offer support without judging or criticizing. Try not to blame, or react as though their behaviour is impossible to understand.

The path to good mental health may be a long one. Having realistic expectations can help both you and your loved one manage what may be a slow pace of change.

Treatment for Self Injury

Treatment by a mental health professional is recommended. A specialist can help teens find alternatives and guide them toward substituting less harmful acts to express their feelings. Behavioural therapy can help to break the habit and maintain change.

Experts advise that early treatment is important. Some teens stop injuring themselves when their behaviour is found out. For others, being surrounded by a caring network of family, friends, teachers, counsellors and doctors reduces their need to cut or otherwise harm themselves. Assessment for depression or anxiety may reveal underlying issues that can be treated.

Where To Go For More Information

For further information, contact a community organization like the Canadian Mental Health Association (CMHA) to find out about support and resources in your community.
I was Born in a Storm
the experience of one young man who lived with a parent with a mental illness

My father was an elementary school teacher and so all the teachers in my high school knew about my mother and her mental illness (schizoaffective disorder) yet not one teacher approached me on the matter. When I approached friends on this, they did not know what to say. I spent most of my healing time in the wilderness where I would go on extended weekend trips when I was 16 and found that life was really worth living. After I saw my mother attempt suicide, I often thought of death and what that would be like. I never attempted suicide but I did wonder a lot about what the benefits to living are. That is where I found my love for nature and to this day I relish being in the woods whether I am camping, skiing, backpacking, canoeing, and if I want to really challenge myself there is always rock climbing.

I also spent many countless nights as a teenager attempting to have my mother be happy, to get herself out of her intense and deep cries. I managed to find a way where I could come home from school and see her crying and within an hour or so, she would be stable. I also learned how to talk her out of a delusion and/or hallucination. I learned that when she was really anxious that she became most psychotic and I really got a deep sense of fulfillment when I was able to make my mother’s life more enjoyable. Making her feel better became the most important thing I could do in my day. At least it gave me the most enjoyment during those times she was profoundly depressed. My father often told me that if he got too close to my mother he would crack up. So this left me the role of taking care of my mother even when she was never really able to take care of me growing up. My father was there in a crisis but he was often busy correcting papers that his students wrote. My father was real committed to teaching but somehow did not know how to really commit to my mother or me. I lived an isolated life in my growing up years.

When I went to college, I received therapy for the first time and this changed my life. I would suggest that early intervention is key. That mental health workers really need to intervene in the early ages. I know that my parents and I would have dearly appreciated real good mental health workers to participate in the healing of the family. Unfortunately there were none to be found. I even looked myself.

From all of this, I believe that offering hope to anyone works wonders. A sense of hope was the longest lasting strength that my family had and mental health workers can offer more of this and help to socialize the family. My parent’s upbringing was worse than what I had. Each generation becomes more aware, but in my opinion early intervention speeds the process up a bit.

How Can You Help a Friend

If you are worried about a friend, it’s important to be supportive and to say things like “I am very concerned about you. You are saying things that I am really worried about, and we need to tell someone”. You need to let an adult, like a parent, teacher, or counsellor, know what’s going on. Don’t promise to keep secrets, especially if your friend is talking about suicide. As a friend, you must tell an adult so that they can get help right away.

• Offer to accompany your friend to talk with an adult they can trust.
• Let your friend know that you care, and that you haven’t forgotten about them, even if they repeatedly try to put you off. Stay in touch and reach out to them.
• Stand by your friend during their recovery. Reinforce your positive feelings about them, and your confidence in their continued recovery.
• Find ways of having fun together that don’t involve using drugs or alcohol.
• Offer to go to support groups or important meetings (such as with teachers, counsellors or doctors) with your friend, and to be another set of eyes and ears in meetings.