

BC Partners for
Mental Health and
Addictions Information

Visions

BC's Mental Health and Addictions Journal

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bc partners

Seven provincial mental health and addictions non-profit agencies are working together as the BC Partners for Mental Health and Addictions Information. We represent Anxiety BC, British Columbia Schizophrenia Society, Canadian Mental Health Association's BC Division, Centre for Addictions Research of BC, FORCE Society for Kids' Mental Health, Jessie's Hope Society and the Mood Disorders Association of BC. Our reason for coming together is that we recognize that working together we have a greater ability to provide useful, accurate and good quality information on mental health, mental illness, substance abuse, and addictions including how to prevent, recognize, treat and manage these issues and improve quality of life.

visions

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

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



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Mental health problems among elementary and high school students are much more common than many British Columbians believe, and use of alcohol and other drugs by teenagers has its own misconceptions. No classroom is immune to these issues or their interweaving; at any given time, at least a handful of students in each classroom in this province are going to struggle with them. And behind each of these kids will be a family—often confused, frustrated, misjudged and yearning for help.

Teachers and other school professionals are 'first responders' whether they want to be, or are prepared to be. Because they see kids regularly most days of the year, school professionals are in a unique position to be able to notice the first sign of changes in kids' academic, social and emotional development. They may also be able to help kids develop skills in resilience to cope with or even prevent early signs of trouble. These trusted adults may help encourage the school belonging that's known to be protective against a whole range of problems in young people. Or, as some articles in this issue point out, they may not always offer the trust and help that's needed. Teachers and counselors are only part of the picture, though, because this issue is focused on what schools, as a whole, can do.

There is no profile of the mentally ill or drug using young person. Some children or teens with mental health and/or substance use problems will be disruptive; others may hide their symptoms and behaviours. Some of these children will excel in the mainstream curriculum; others will need additional support or alternative pathways to help them learn at their best. Some kids will have more disabling problems requiring treatment; others will not have anything diagnosable but will need to learn to navigate mental health and substance use risks like all of us have to. And some kids with these issues are represented by the absent seats in class. Add to this the lenses of culture, gender, age, and geography and our guest editor hits it on the mark when she notes that 'diversity is the new norm' in the classroom. She reminds me of another saying—if you can get it right for the most vulnerable, you will usually get it right for all the others. ■

Sarah Hamid-Balma

Sarah is Visions Editor and Director of Public Education and Communications at the Canadian Mental Health Association's BC Division. She also has personal experience with mental illness

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The opinions expressed in this journal are those of the writers and do not necessarily reflect the views of the member agencies of the BC Partners for Mental Health and Addictions Information or any of their branch offices

The Rise in “Non-typical” Students

A Challenge for Our Times



Cheryl Ashlie

Cheryl worked in the nutrition field prior to staying home to raise her three children. Involvement in her children's education prompted her to run for the Maple Ridge school board in 1999, where she served for nine years, the last six as board chair. Now a municipal councillor, Cheryl is also enrolled in Political Science at the University of Athabasca

I am delighted to be the guest editor for *Visions*' issue focusing on schools and student mental health and substance use issues. This is a perfect way to end my nine-year commitment to public education as a school trustee.

When I was a picture-perfect “greenhorn” trustee, one of my key goals was to increase awareness and funding to our schools to address youth mental health and substance use issues. Now, as a slightly wiser retired trustee, my views have changed somewhat. “Awareness” has created its own boondoggles—and funding may be going into a growing, bottomless pit.

Labels, specialization and an endangered ideal

I have observed that awareness of special needs in the classroom, which mental health and substance use are a part of, has led to labelling the students who have such issues. The increasing specialization of our medical system has been applied to the school system.

Students are labelled by district staff so that school districts can get ministry funding to assist with additional support for these students. In today's medical model of education, administrators have become very adept at “coding” children to get the required funding that comes to a “coded” student. Boards of education allocate millions of dollars in funding for these children.

Students are also labelled so that specialized education can be designed and delivered by specialized educators. The supports for the identified special needs child—such as the child with autism spectrum disorder or the child with anxiety issues—are becoming more and more specialized. And the more specialized the support, the harder it is for the average classroom teacher to keep up with the professional development required to be current in special education. This is only one of the demands being placed on a teacher's professional development allowance; time and dollars for professional development is limited.

Newly trained teachers enter classrooms armed only with the tools to teach reading, writing and arithmetic. These teachers quickly realize that the reality of the classroom demands far more from them than methodology learned in academia. So these teachers look to experts to help them as they struggle to meet the needs of the different learners in their classrooms.

I believe this labelling is being done with the best of intentions. But I worry that it may be moving us away from the goal of letting these children have a

classroom experience and relationship with the teacher that is equal to that of their non-labelled peers.

Many children with ‘special needs,’ as recently as the early 1970s, were placed in institutions or segregated classrooms. Today, these children learn side-by-side with budding physicists and future prime ministers, who themselves may have identified—or unidentified—needs for support.

We need to be doing more so that, from the moment teachers step into the classroom, they are better equipped to meet the needs of today's diverse learners. Otherwise, the expectation that all learners will be together in the classroom will soon be a thing of the past.

An eye-opening set of statistics

In a presentation last fall to our school board, Laurie Meston, Director of Student Support Services for our district (SD#42, Maple Ridge and Pitt Meadows), walked us through the history of special education.

She explained that 97% of the students in the '60s and '70s were considered to be typical learners. In the late '70s and into the '80s, when integration started to appear, those considered typical learners dropped to 90%–92%, as more and more students had specialized needs defined. She went on to explain that, from the late '90s to the present day, the typical learner has dropped to 65%–70% of students in the classroom. That means almost one-third of students in today's classrooms are considered non-typical learners. She also noted that there is added pressure from the teachers and parents to code students' differences on an even wider range.

Ms. Meston, who has worked in both the segregated and integrated systems, contends that if we continue this trend, in ten years only 30%–35% of the student population will be considered typical. Two-thirds of the student population will be considered non-typical learners!

With the current trend to demand specialized services, it may not be realistic to believe we could ever keep up with such a demand, as the support system is already stretched. Instead, Ms. Meston challenges the system to focus back on the classroom teacher. “It may be more effective practice to prepare classroom teachers to teach all learners using universal practices (academic, social, emotional, behavioural) that allow more learners to be successful in the classroom. This would reduce the demands for specialized services,” she says. (See text box, next page.)

Revising teacher training for a changed world

Funding is often a factor that is cited as a barrier to the needs of these children. While I will never argue against more funding in the area of special education, I don't agree that the money should go toward the structure we're using today.

I'd request that more money go to post-secondary institutions for improved teacher training. Teacher training programs need to be redeveloped to address what the teachers of today are facing in the classroom. The education system must work hand-in-hand with experts in other fields, such as the social sciences. Together they can design teacher training that would prepare our teachers to handle the diverse needs of the students.

At the district level, we need to foster a culture that encourages participation in in-service programs and professional development to improve teaching strategies. Teachers in the classroom need to stay current on effective teaching methods for diverse learners.

Ms. Meston pointed out that teachers themselves want more specialized knowledge. If they have the knowledge, they can help students themselves, instead of having their classrooms disrupted by outside specialists. And they can help move away from a new kind of 'segregation,' which can happen right in the integrated classroom when a coded child ends up relating primarily to a special education assistant.

"Diversity is the new norm..."

We are very lucky to have dedicated people willing to take on the challenges that the public education system puts before them. When we ask them to teach our children, we must acknowledge the enormity of that job and the fact that most do it the best way they can. And, to support their teachers, the education system needs to reach out to service providers who specialize in supporting children with special needs.

Ms. Meston said it best when she concluded with the following words: "Diversity is the new norm—we must acknowledge it, accept it, understand it, plan for it, teach to it and celebrate it."

I believe the system is capable of this. Leaders such as Ms. Meston and other members of the BC Council of Administrators of Special Education (BC CASE) are working toward it throughout our province. And the provincial government needs to provide a structure that arms teachers with the knowledge they need, both at the beginning and during their careers, to handle the diversity in their classrooms and maintain their own well-being.

This issue

Enjoy this edition of *Visions*; it has been a pleasure to participate in its creation. I hope you will gain some insight, tools and, most importantly, the inspiration to make sure every child continues to have a place in the classroom. ■

The threads referring to trauma and stresses that are not traditional DSM-IV categories deserve pulling together. Why is this important? I have been in many meetings with First Nations folks and service providers over the last few years and this is often a bottleneck for communication.

First Nation people speak about a cluster of 'issues' or underlying causes: family or community violence and sexual victimization, experiences of poverty, marginalization or colonization, children raised by parents who attended residential schools, racism and discrimination, repeated traumatic loss etc. These are universal but not usually as prevalent in most mainstream populations. The complication arises when discussing the results or effects of these causes and options for improving care. The socially-derived risks get bundled together with substance misuse and conditions that I consider more bio-chemical (thought and affective disorders). I think mainstream providers feel threatened by the anger of the First Nation people and their own lack of knowledge about how to tackle these deep-rooted issues. First Nation people feel that they just get diagnostic labels thrown at them. Net result: lack of communication etc.

Keep up the great work on *Visions*—one of the few journals that I actually peruse carefully!

—Alex Berland, Slocan Park BC

we want your feedback!

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

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Footnotes Reminder: If you see a superscripted number in an article, that means there is a footnote attached to that point. Sometimes the footnote is more explanation. In most cases, this is a bibliographic reference. To see the complete footnotes for all the articles, see the online version of each article at www.heretohelp.bc.ca/publications/visions. If you don't have access to the internet, please contact us for the footnotes by phone, fax or mail using the contact information on page 3.



resources for teaching in the classroom of diverse-learners

- Hume, K. (2007). *Start Where They Are: Differentiating for Success With the Young Adolescent* (with CD-ROM). Toronto: Pearson Education Canada.
- Tomlinson, C.A. (2001). *How to Differentiate Instruction in Mixed-Ability Classrooms* (2nd ed.). Alexandria, VA: Association for Supervision and Curriculum Development.
- Wormeli, R. (2007). *Differentiation: From Planning to Practice, Grades 6-12*. Portland, ME: Stenhouse Publishers.

Youth and Mental Health Substance Use Problems

How Schools Are Involved



Lynn D. Miller,
PhD, RPsych

Lynn is an Assistant Professor in the Department of Education and Counselling Psychology, and Special Education at UBC, and Director of the Counselling Psychology doctoral program. She is also the lead trainer for the FRIENDS program

* pseudonym

Angela was a shy grade seven girl with few friends. She did very well in school until the spring term when she had to give a speech in her language arts class. She knew that a big percentage of her term mark would be based on her speech. She was well prepared, but even thinking about standing in front of her classmates made her feel faint and nauseous. She had remembered that her older brother, before going to a job interview, drank a beer to feel “more courageous.” Angela also overheard several of the popular kids laughing about having sneaked wine coolers into one girl’s basement on the weekend. Angela decided to try drinking a wine cooler before giving her speech at school. She did very well giving her speech—so well that one of the popular kids asked her for help drafting their speech. Angela thought that she might even be invited to go to a party the next weekend at this girl’s house.*

“In an average classroom of 25 students, five could meet the criteria for a diagnosable disorder. Only one of these students might actually receive psychological help.”

Approximately one in five school-aged youth (ages 4 to 19) experience mental health problems.¹ More than 80% of those in need of mental health treatment don’t get the treatment they need.² Schools are often the first place where mental health problems can be identified.

School staff and teachers historically have little or no training or background in issues of mental health. Children and youth are left to struggle in classrooms with teachers who are concerned, but don’t have the resources to help. For example, in an average classroom

of 25 students, five could meet the criteria for a diagnosable disorder. Only one of these students might actually receive psychological help, either in or outside of school.^{1,2}

What happens to the other students who are struggling with mental health problems? These youth and their families may suffer in silence. Some youth, seeking relief, develop poor coping strategies such as skipping school, social withdrawal and high-risk behaviours, including substance use.

Mental health issues showing up in classrooms

A BC study was done on the prevalence of various mental health problems among children and youth. The most common concern is anxiety disorders, estimated to affect 6.4% of kids in BC. Attention deficit/hyperactivity disorder (4.8%) was the second most common concern, followed by conduct disorders (4.2%) and depression (3.5%).³

The study also found that the most likely age of onset for most disorders was 11 years old. And, of youth with some form of mental disorder, most suffer from more than one type of disorder.

The link to substance use

Early adolescence is when some youth try substances for the first time. For youth with mental health problems, this time can mark the beginning of a vicious spiral into self-medication. When a student has a mental health problem as well as a substance use problem, it is called a concurrent disorder.

Even experimental use can make existing symptoms worse for a youth with mental illness. Substance use can also cause mental health problems such as anxiety and psychosis.

BC's McCreary Centre Society,⁴ which has been conducting research on adolescent health since 1992, is a reliable source for information about drug and alcohol use. In the latest province-wide survey,⁵ 60% of youth had used alcohol at some point in their lives. Of youth who had tried alcohol, 45% had engaged in binge drinking (i.e., consuming five or more drinks in one sitting or relatively short period of time). Ten percent of all youth had used alcohol on 100 or more days in their lifetime and would be considered 'regular' drinkers. Twenty percent used cannabis (marijuana) and 11% used tobacco.

Given the high rates of mental health problems and the high rates of substance use, it is likely that many youth will present with a concurrent disorder. Approximately half of adolescents who seek treatment for alcohol also report psychological distress.⁶

Youth with concurrent disorders are at highest risk for negative outcomes, including suicide, homelessness, sexual exploitation and incarceration. Untreated mental health issues clearly contribute to addiction problems in a big way.

Early, quality treatment is crucial

Without proper treatment, mental health disorders can last for a lifetime. The presence of one mental health problem creates risk for developing more. For example, recent

research has shown that untreated anxiety disorders are the leading predictor for developing depression, for future drug and alcohol use/abuse, and for suicidality.⁷

Children respond better to psychological intervention treatment when it is offered early on.⁸ This highlights the important role of schools in the early identification of such problems.

MCFD: a resource for schools

The BC Ministry of Children and Family Development (MCFD) is the primary treatment provider of psychological services for children and youth. MCFD has developed a multi-faceted plan (BC Mental Health Plan) that targets each common disorder, both in school and community settings.

Over the past few years, MCFD Child and Youth clinicians have been getting certified in cognitive-behavioural therapy (CBT) for anxiety disorders. This has increased the treatment capacity for children and youth in BC.

Children who have mental health problems should be assessed and treated according to the best known practices. CBT is the psychological treatment of choice for anxiety and depression, the two largest diagnostic categories for mental health problems in children and adolescents.⁹⁻¹¹ CBT focuses on identifying and changing poor ways of thinking and behaving, thus helping a child or adult think and act in ways that are more successful.

Since 2002, MCFD has provided training to teachers on how to identify anxiety and depression in school kids. If teachers recognize mental health concerns early and refer students to MCFD community health teams, more children will be getting psychological help earlier.

MCFD also pays for materials for a curricular program that is based on CBT principles called the FRIENDS program.^{12,13} Students enjoy 10 weekly lessons about identifying unhelpful thoughts, understanding the link between thoughts

how do we know when a child has mental health problems?

When a child's behaviour or emotional responses:

- impact their academic progress in a serious way
- make it difficult to form and maintain friendships
- cause problems at home

It's important to remember that not all mental health issues are the same. They each appear differently and require different treatment.

and feelings, identifying body symptoms associated with worries, and developing coping plans for when they feel distressed.

Angela remembered her FRIENDS program from school and decided to use the lessons she learned from it when she thought about her next speech assignment. Instead of using alcohol (wine coolers) to calm herself down, she made a coping plan. In her plan she identified unhelpful thoughts ("I can try drinking a wine cooler") and came up with more helpful thoughts ("I'll give it my best effort; the popular kids even see that I can be clever because they asked for my help; I didn't like feeling I had to drink to give my speech"). She also offered to help practise with one of her new friends. ■

footnotes

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

related resources

- AnxietyBC:
www.anxietybc.com
- McCreary Centre Society:
www.mcs.bc.ca
- Ministry of Child and Family Development:
www.gov.bc.ca/mcf
- Canadian Association of School Health:
www.cash-aces.ca



Alcohol and Other Drug Use Among BC Students

Myths and Realities

Elizabeth M. Saewyc,
PhD, RN

Elizabeth holds a Canadian Institutes of Health Research/Public Health Agency of Canada Applied Public Health Chair in Youth Health. She is an Associate Professor in the School of Nursing at the University of British Columbia, and the Research Director for the McCreary Centre Society

Alcohol and other drug use by young people is a frequent concern among adults. Most people know someone who has suffered problems from misuse of alcohol or other drugs. They worry that any use during the teen years will lead to addiction.

There is a widespread perception that drugs are easier to get now than ever before, even in school, and that more teens are trying drugs at younger and younger ages. Every so often, media stories raise the alarm about an epidemic of illegal drug use among teenagers, whether of cannabis (marijuana), ecstasy or crystal meth.

Are these perceptions accurate, or are they myths? How common is substance use among adolescents, and is it increasing? Should we be worried about drug use among teens? Why do they use drugs anyway?

The BC Adolescent Health Survey (BC AHS),¹ conducted in high schools by the McCreary Centre Society every five years, can help provide answers.

Is there an 'epidemic' of substance use among teens?

Contrary to popular perception, alcohol and other drug use is not universal among youth in high school; nor is it increasing.

The drug most commonly used by teens is still alcohol. Just over half of adolescents in school have ever tried alcohol (57%), and around 38% had used alcohol in the past month—usually just a few times, and most likely on weekends. Boys and girls are just as likely to use alcohol.

Marijuana is the next most commonly used drug, with just over one in three teens having ever tried marijuana (37%), and only about 20% having used marijuana in the past month. Among those who use marijuana, however, boys are twice as likely to be recent or regular users compared to girls.

Other illegal drugs, like cocaine or crystal meth, are far less common among youth in school. Indeed, teens are more likely to report ever having tried psilocybin mushrooms (13%), or someone else's prescription drugs (9%) than they are to report trying cocaine

(5%) or amphetamines like crystal meth (4%). And only about 1% have ever tried heroin or injected a drug. Fewer than one in five have ever tried any illegal drug other than alcohol or marijuana.

Is substance use by teens increasing? According to the BC AHS, most substance use has been declining over the past several years. For example, in 1992, 65% of teens had ever tried alcohol; this dropped to

57% in 2003. Teens tend to wait until they are older to try alcohol or other drugs. Only a third of 13-year-olds have ever tried alcohol and about 15% have tried marijuana. Among 17-year-olds, it is more common: more than three out of four have tried alcohol (78%) and 55% have tried marijuana.

No epidemic, but there are harms and concerns

Most young people who use alcohol or other drugs during their teen years do not have substance use problems and do not end up with abuse problems as adults either. If, however, a young teen is already using alcohol or other drugs, it can be worrisome. Youth who begin alcohol or drug use at young ages are more likely to develop substance abuse problems as they get older.² Also, if an adolescent you know has used illegal drugs such as crack or cocaine, which is uncommon among teens in general, you might have cause for concern. Teens who use the rarer illegal drugs, or use multiple different drugs, are at higher risk for substance abuse problems.

Long before any dependence or abuse might develop, excessive alcohol or drug use can cause harms such as:

- injuries and car accidents while drunk
- unintended sex
- conflicts with family or friends
- problems with school

About one in four youth report at least one negative consequence in the past year from drinking or drug use. Students who report frequent use of alcohol, marijuana or other drugs (three or more times in the past

“Most substance use has been declining over the past several years.”

month) are far more likely to report negative consequences than those who have used but not frequently. For example, 16% of frequent users got injured in the past year because of their drinking or drug use, while only 5% of those who don't use frequently got injured.

Binge drinking (five or more drinks within a few hours) appears to be fairly common among youth who drink alcohol, with nearly half of them reporting bingeing at least once in the past month. Binge drinking is linked to car accidents, alcohol poisoning and unprotected sex.

Why do teens use alcohol and drugs?

Young people use alcohol and drugs for many of the same reasons adults do:

- because their friends do
- to feel more comfortable in social settings
- sometimes to manage their moods
- to cope with stress and pain in their lives

This isn't surprising, since teens see many adults regularly drinking alcohol at family celebrations, while watching sports events and with friends in social settings. These adults may see drinking and drunkenness among young people as a part of growing up. Also,

movies aimed at teens often depict alcohol or other drug use at parties as normal behaviour.

Some youth with mental health issues also use substances to help manage their symptoms. Youth with anxiety disorders, for example, may use marijuana or alcohol to become calmer. Teens with attention deficit disorder who are not on medications may use stimulants to improve their concentration.

The reality

There is no epidemic of illegal drug use among adolescents, and substance abuse disorders are not common. And even if drugs are easier to get, this doesn't seem to have caused an increase in use by teens.

Although many teens will try alcohol or marijuana during their teen years, parents and other adults may prevent serious problems if they set a good example. Adults can be effective role models by making their own responsible decisions around alcohol and other drug use. **i**

footnotes

visit heretohelp.bc.ca/publications/visions for Elizabeth's complete footnotes or contact us by phone, fax or e-mail (see page 3)

related resource

Tonkin, R., Murphy, A., Lee, Z. et al. (2005). *British Columbia youth health trends: A retrospective, 1992-2003*. Vancouver: McCreary Centre Society. www.mcs.bc.ca.



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My School Years

The Wild Ride From Basements to Bikes

Chris

Chris, now 25, lives in Vancouver and studies psychology at the University of British Columbia. He is a team rider and the Charity Director for a competitive cycling team

Nuch of my life has been a wild ride into mental illness—and a climb out of it. It's a ride I'm still on and will continue on until it's done. No matter where you are on this life journey, however, it is vital to know that working your way out of mental illness is worth the effort.

As a child, I was always very quiet at school. That changed in grade five. I began speaking up for the first time, cracking a lot of jokes and eventually befriending the cooler kids at my school. My increased energy from hypomania (i.e., mild mania) was not disabling at that point—it actually made me attractive to other people. And my academics weren't adversely affected either. In my grade six year, I won my school science fair with a project on animal intelligence and my teacher told my parents he thought I might be gifted at Math.

I was in the prodromal (beginning) stage of my illness.

From basketball to the basement to a special school

When I was 12 and in grade eight my real difficulties began. Early in that school year, I hit my head while playing basketball for the school team. I developed a head-

ache that was constant for the next five years.

But what was much worse than the headache was that the head injury triggered psychosis. A month after I hit my head I had to leave school because of my illness.

I don't remember much from my high school years. But—consistent with a diagnosis of schizophrenia—I do remember paranoia and thinking that people could read my thoughts and thinking that the television was speaking to me. I had a fear of ghosts and saw them in hallucinations, and thought I had magical powers. I was clinically depressed and had little energy to do everyday activities. I pulled out my hair and rubbed my skin. And I had an extreme amount of social anxiety. All this made functioning at school extremely difficult.

During my grade eight year, my parents and the homebound education service attempted to home school me, but I was too sick to handle the demands. My teachers, however, decided to pass me on my grade eight courses so I could return to my same classmates. When I went back to high school at the beginning of the grade nine year, I only lasted two weeks. My symptoms were very strong when I was at

school; I simply couldn't handle the stress of the social environment.

When I was 14, I spent the whole time in my basement. I had a sleep disorder that caused me to sleep for only short periods at odd times and in a state of psychosis. I only left the house to see doctors and therapists. I was put on antipsychotics by a psychiatrist and began to improve, but gained a lot of weight from the medication and the lack of activity.

When I was 15, in what would have been the start of my grade 10 year, I tried to take grade nine again at another high school. I only attended for one week because the school environment brought back my symptoms.

In January of that same school year, I was placed at Glen Eden Multimodal Centre, a treatment centre and school for children with disabilities.¹ At first, I only attended for about 10 minutes each day. But, after half a school year, I began to attend more regularly. I had problems with academics because the focus of the school was more clinical than academic, and problems with social functioning because of my interrupted social development. But it was probably the best environment for me—being around



other young people struggling with mental illness was reassuring. I spent a year and a half at Glen Eden, though I continued to have occasional relapses and wasn't able to attend for a four-month period.

Saving graces— including cycling

When I was 18, I was put on another antipsychotic medication and my functioning improved markedly. I lost a lot of weight because of the change in medication and started doing adult education at the Vancouver School Board. First, I took a Biology 11 course and scored 96%. Next, I decided to take Biology 12 and received 94%. Courses at adult education are done in terms of two months. I realized that, if I could do this three more times, I'd qualify for admission to a science program at university. An English placement

test allowed me to jump right to grade 12 English. In Math, I had to start again in grade eight. However, I completed Math 8 through 12, plus differential calculus, in one year. I scored 100% on about 80% percent of the Math exams that I took, including 100% on my Math 12 provincial exam. I graduated with a grade 12 Provincial Scholarship Award, a Passport to Education Scholarship for grades 10, 11 and 12, and tied for first place on the provincial Math 12 exam.

I understand that both psychosocial and medication treatments are very important to recovery. But, for me, the vast improvement has been due to a medication that suited me well. It's unfortunate that, for many people, finding the right medication can take a long time. I have great empathy for people still in this process.

Later, I regained much more functioning because of good psychological treatment and my social interactions through cycling.

Today, I attend UBC where I'm studying psychology. I also spend a lot of time pursuing competitive cycling. The team I'm on rides in support of the Canadian Mental Health Association. Our aim is to raise awareness for the association and reduce stigmas around mental illness.

I still struggle with problems related to my illness, but I'm confident that I will continue to improve. I think the future is very bright for people with mental illness. Discrimination and stigma will continue to be fought and newer treatments will be discovered, making us all better off. ■

footnotes

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To Tell or Not to Tell? The question of disclosure

I've always believed that to combat stigma we need to discuss mental health issues openly. This has been the credo by which I've lived my life.

When my son Liam* was about to enter a new school for grade one, I disclosed to the school principal—after discussion with my family doctor and much thought—that I live with bipolar disorder.

I had debated this credo beforehand: Might my disclosure affect Liam's life? Would there be a stigmatic trickle-down effect? On the other hand, maybe talking about my illness would be helpful in case Liam were to develop his own mental health issues.

Much to my astonishment and horror, the principal's response was: "How will you interact with teachers and staff? Will you be aggressive or violent?"

The school year hadn't even started and stigma had already raised its ugly head.

Liam and me

My son is an extremely bright child with unique abilities and challenges. Until he was about four, Liam had some problems with motor skills, including an inability to speak properly. He did well in the calm atmosphere of a Montessori¹ preschool and kindergarten. But in the late fall of his grade one year, at his new school, much of Liam's uniqueness came to the fore.

Currently, Liam has an 'official' diagnosis of attention-deficit hyperactivity disorder (ADHD). However, he exhibits symptoms of obsessive-compulsive disorder (OCD), high anxiety and seasonal affective disorder (SAD). Liam also copes with sensory processing disorder; that is, he has sound and touch hypersensitivities. In addition, he has challenges with social skills.

We've had a rough time, Liam and me. I probably had early bipolar disorder, beginning at age six—and had a mother in denial. (I wasn't officially diagnosed until the age of 32.) I was a high-achieving student—and as a teen I struggled with alcohol. I've been a single parent since Liam was a year old. And I spent the majority of Liam's preschool years almost catatonic, sleeping 20 hours a day, while Liam's grandmother looked after him.

Caris Smythe*

Caris is a dedicated mother and volunteer currently living on the island. She and her son enjoy camping and exploring this beautiful province



*pseudonyms

☞ In his grade one year, much of Liam's uniqueness came to the fore. ☞

Because I continue to struggle with bipolar disorder, I've have been unable to go back to work. I had also disclosed to school staff that we lived on a provincial disability income (which is about 50% beneath the poverty line). At times we needed funding assistance for supplies and so Liam could participate in camps and other special activities. The school—largely attended by kids from well-off families—was aware that I had a mental health issue and was poor. Double stigma effect!

On a roller coaster that never stops

Having a child with “special needs” in the school system is like being on a roller coaster that continually gains speed and doesn't stop. I realized quickly that I was going to have to work with the school to figure out and set up accommodations for Liam. So began an ongoing struggle to find our way through the bureaucratic maze of assessments, labels and individual education plans, or IEPs (an IEP is a plan written specifically for Liam that describes the program modifications and/or adaptations he needs and the services to be provided).

 **Having a child with *special needs* in the school system is like being on a roller coaster that continually gains speed and doesn't stop.** 

As my son's advocate, I'm in constant communication with his school-based team (SBT). The SBT includes the teacher, learning assistant, speech language pathologist, counsellor, principal, pediatrician and child psychiatrist.

As an advocate, I'd like to think these professionals would be capable of assuming a position of neutrality. I cling to a personal fantasy that the world is inhabited by kind, compassionate, non-judgmental and stigma-free individuals. Liam and I received wonderful consideration and assistance from most of the educators and support workers. But unfortunately, stigma continues to rear its head when I least expect it.

A distressing encounter

Liam holds all of his frustration and anger inside while at school. He waits until he's at home, in a “safe” environment, to unleash all his pent-up emotions from the day. I had told school staff about his explosive behaviour at home.

Because Liam's behaviour was so changeable, school staff questioned my parenting and highly recommended that I take a parenting course. So I took the regular Triple P—Positive Parenting Program from April to June 2006. There was a Triple ‘P’ Parenting program available for parents of children with special needs, but this one was a prerequisite.

I did try to implement the methods and suggestions given in the regular program. Unfortunately, many of these methods simply didn't work for Liam and me because of Liam's specific issues, many not yet diagnosed. It was extremely frustrating.

As part of the program, a practitioner, to whom I had disclosed about having bipolar disorder, came to our home to watch me interact with Liam and to help with the implementation of the program. I voiced my concerns and frustrations to her and was told I was a “bad parent.” Because I wasn't completely ascribing to the program. The practitioner repeatedly told me I was a “bad parent.” This did wonders for my self-esteem!

Incidentally, the Triple Program brochure states: “There is no ‘right’ way to raise healthy, well-adjusted

a mother's advice

Tips for teachers

- o Know your boundaries.
- o Be considerate in your language and the questions that you ask.
- o You don't know what the parent(s) are dealing with, so don't make judgments.
- o Recognize your own biases; your bias can hurt the relationship you have with your students and their families.
- o Work with parents; it should be a partnership, not a power struggle.
- o Listen to and heed parents' observations and recommendations—honour their concern for their child.

Tips for parents

- o Communicate with and observe your child.
- o Constant, effective communication with your child's pediatrician, child psychiatrist and education professionals/school-based team is essential.
- o Stay in control of the situation; don't let yourself and/or your child be controlled by other people.
- o Develop a thick skin and a compassionate outlook.
- o Show appreciation to service providers who are supportive and go that extra mile for you.
- o If you're not happy with a situation, seek change.

children.” And when it comes right down to it, you—and only you—as a parent know what is best for your child.

Boundaries, anyone?

In September 2006 Liam entered grade two. September is start-up time, right? A new teacher, being surrounded by new students, being in a split-grade class, going through fire and earthquake drills—this and all the other back-to-school regimens overwhelmed Liam. He has a great deal of anxiety regarding new social groups and routines. Furthermore, he doesn’t transition well from one activity or situation to another. So Liam’s anxiety level was extraordinarily high. In addition, he began seeing a worker from the Boys and Girls Club, and both soccer season and Friday Night Basketball were starting.

As for me, on top of advocating for Liam in all this and managing my own mental health, I was trying to secure funding for the basketball program, buy school supplies and put together an earthquake comfort kit. For my own self care, I had begun a Learn to Run 10 KM program. And I was running my father’s one-man business because he was out of town. The pressure was huge.

Early in September the school’s child and youth worker came to my home for our second meeting of the school year. We were discussing how the start of the school year was going and the plans that were in place for Liam.

Suddenly, out of the blue, the worker asked, “Are you manic?” I was stunned by her question. I was certainly exhausted and running on pure nerve, but I was definitely not manic.

This was an inappropriate comment. Even in an appropriate situation, such a question must be posed with an enormous amount of gentleness and tact. Did this woman even understand what mania looks like? Or was “mania” simply a word to her? Did she have any idea how offensive the question was? Did she understand the implications of asking me such a question? I started to doubt myself. Had I misread myself? Was I, indeed, manic? My insecurity mushroomed. I was so thrown off that I had to seek the opinions of people I trusted—close friends and medical professionals. Obviously, this worker hadn’t stopped to think before asking that question.

The invisible disease

The issues for Liam continued. One day after school in the spring of 2007, the counsellor asked if she could speak with me. Rather than taking me to her office, our conversation began in the hallway and proceeded to the photocopy room, where we were continually interrupted. I felt awkward about discussing Liam’s issues so publicly, and there seemed to be an odd undercurrent to the tone of the conversation. Suddenly, the counsellor moved us across the hall into the principal’s office and point-blank asked, “When are you going to get a job?”



Shocked. Flabbergasted. I just sat there. Finally, I exploded, bursting into tears and storming out of the office.

The invisible illness! What? I looked fine, therefore I must be fine and work-ready? Just because I could manage to pick Liam up after school didn’t mean I was capable of employment. And how was it her business anyway?

If I’d been a parent of privilege, would I have been asked this question? There were many mothers at Liam’s school who chose to stay at home with their school-age children. Isn’t being a mother a job, and a more than full-time one at that? Particularly when you’re a single mom and your child has unique needs that have to be advocated for? Quite frankly, being Liam’s advocate *is* a full-time job!

Déjà vu

Last June (2008), I was speaking with the principal about Liam’s class placement for the following September. It was a cordial conversation. But as the conversation drew to a close, the principal said, “So, what’s next for you? Are you going to get a job?” I stammered something feeble like “now is not the time.”

Was I angry? You bet. This was twice now I’d been asked that question. I feel sad that now I’ve developed a repertoire of ‘prepared’ responses to help me deal with questions like this in case they arise again.

I was—and am—an excellent mother and advocate for Liam. Isn’t that enough?

A new start—undisclosed!

Liam has now changed schools. The new school doesn’t know about my financial situation or my mental health diagnosis. Though I may never know what the stigmatic trickle-down effect on Liam was, I won’t put him in that ‘disclosed’ situation again. As much as I’ve fought to combat stigma over the years, it’s a battle I can’t put Liam in the middle of. Our society is not as progressive as I would like to think it is. ■

footnote

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Let's Not Talk About It?

Teaching teens about substance abuse

Andy Sibbald

Andy has a master's degree in community development. He lives in Nanaimo, BC, where he's writing a book about the arctic and his experiences as both a provider and then a recipient of mental health/addictions services.

Andy hopes to help reduce the stigma of being mentally ill. Contact Andy at sibbald@shaw.ca

Sin the 1990s, I worked as an alcohol and drug specialist in Inuit communities two to three air hours north-east of Yellowknife, NWT. My job required that I visit schools and, in spite of having no teacher training, I was expected to teach the alcohol and drug portion of the school curriculum. The Northwest Territories alcohol and drug prevention curriculum was highly regarded, as evidenced by the many requests for copies of it, but I had difficulty getting teens to engage.

Substance use education in the classroom—a hard slog with the teens

Teaching kindergarten students was easy. I showed them pictures of items such as apples and a bottle of bleach; they told me whether the item in the picture was edible or dangerous to eat. The young children were interested, energetic and ready to learn. I'd walk out of a kindergarten classroom feeling that I'd played a useful role in their learning.

The teens, however, had 'heard it all before' and appeared disinterested. They certainly didn't respond well to a lecture-style format—the last thing they thought they needed was a "don't use drugs or alcohol" lecture. The curriculum for teens covered the responsible use of alcohol, but advocated abstinence when it came to illicit drugs and those who couldn't drink responsibly due to addiction.

I tried supplementing the curriculum with related information on mental health issues: how many people use alcohol and other drugs to self-medicate untreated mental health issues, the importance of early diagnosis and treatment of mental health issues, the stigma-

tization of mental health and substance use problems, and the impacts of having both an addiction and a mental health problem. The kids all but fell asleep as I delivered the information.

I tried more interactive approaches with grade seven and eight students. The students were asked to prepare a presentation on an aspect of alcohol and drug abuse and deliver it to students in the primary grades. I think there's no better way to learn something than having to teach it. I also led open discussions about healthy alternatives to alcohol and other drug use, while staying away from moral judgements. These approaches engaged the youth to a greater degree, but many students were still not participating.

I wondered if sharing my own experiences in the areas of addiction and mental health issues would help engage the teens. (I'm an alcoholic who, at that time, had been sober for 10 years. I had used alcohol to medicate feelings of inadequacy, not being whole and feeling alone and isolated.) But I decided against disclosing. I was worried about potential stigmatization by the professionals I had to work within the school, health and social services systems. This would have decreased my ability to do my job effectively.

Less 'teaching,' more learning

Also in the early 1990s, I began organizing youth camps with some of my Inuit NNADAP (National Native Alcohol and Drug Abuse Program) colleagues from Kugluktuk and Cambridge Bay. Over the course of week-long camps on the land, the teens were provided with a great deal of information by myself and other professionals, on issues ranging from alcohol and drug use and

abuse to nutrition and HIV/AIDS. But again, this didn't seem to engage the youth. I continued to wonder what would.

In 2000, I moved to the Yukon and began developing relationships with First Nation alcohol and drug workers in various communities. I was no longer visiting schools, but over the next couple of years I helped First Nations and Inuit coordinate a total of three different youth camps.

While working with the NNA DAP staff in Ross River, it finally occurred to me—after 10 years of struggling to educate youth—that I needed to stop talking about healthy alternatives to alcohol and drug use, and get on with practising healthy alternatives with the teens. Rather than having presentations on nutrition, leisure activities and exercise, we would eat a healthy diet, make materials available for recreational use during leisure times, and go walking and fishing.

The NNADAP workers in Ross River and I organized the first teen camp about 100 kilometres south of town on Kaska tribal land. We invited 17 teenage girls from four First Nations to come to the 10-day-long camp. Two of the girls were pregnant. The girls got into discussions, while doing beadwork, on topics ranging from boys to being drunk or high, to pregnancy, FASD (fetal alcohol syndrome disorder), communicable diseases and condoms. This occurred spontaneously, without any lectures or some adult determining what they needed to know.

In many northern communities, the teens do know a huge amount about alcohol and drug use. All have been impacted by substance use in some way and they don't need to know theories or >>



Bullying at School Can Take the Sunshine Out of Life

A student and parent share their experiences

A daughter's story

Hi, my name is Lenette Doskoch and I have generalized anxiety disorder. I don't know exactly what to write. Remembering what happened to me and sharing it with you is very painful.

I've always been judged by the way I behaved, how I dressed and who I hung out with. Growing up in Castlegar, I was tortured day after day about my weight, my looks, and whether I was good enough for anyone. As early as kindergarten, I can remember being picked on by my peers because of my weight—and I've never even been a heavy kid, nor was I too skinny. I was normal. But the kids said very nasty words to me. I was called fat, slut and whore, every day that I was in elementary school. I didn't understand why I was called all those things. I tried to be everyone's friend...

I started high school thinking that these years would be the best of my life. But nothing changed. The kids that had bullied me in elementary followed me to high school. In grade eight I was bullied, just for being me. I was still treated like a piece of trash that no one cared about and called horrible names—including by my teachers and principals. My principal even called me a lesbian for dancing with my 'girl' friends. I was devastated. In high school

the words came with physical attacks and, even though I was older, I still didn't understand why I was hated.

I started experimenting with alcohol, pot and smoking cigarettes. I also began skipping class and cutting myself—all this by the age of 13. I was still so young, but my whole life had turned upside down. I wasn't the same person anymore. I looked the same on the outside, but the hurtful words from peers and teaching staff had changed me. My self-esteem had been shattered and I hated myself. I had opportunities in front of me, but I chose to lose them because I had no faith in myself. I had thoughts of suicide.

One day I ran away from home. That day, it felt like the bullying would never stop, and the pain became too much. Two 'friends,' who made me a regular target for their bullying, decided to run away. Because I was

Lenette Doskoch

Lenette is a grade 12 student at Williams Lake Senior Secondary School. She is active in dance and loves spending time with her friends. After graduation she plans to move to Kamloops and is thinking about becoming a writer

“I looked the same on the outside, but the hurtful words from peers and teaching staff had changed me. My self-esteem had been shattered and I hated myself”

desperate for their friendship, I allowed them to talk me into running away too. This was to be the last day of my life as I knew it. >>

Let's Not Talk About It? | continued from previous page

the generic-versus-brand names of prescription drugs. They know firsthand that alcohol and other drug abuse is not a good thing. They are equipped with enough information to actively learn from each other, with some adult guidance.

I also tried self-disclosure at one of the later camps. The youth were highly attentive! This non-threatening, non-moralistic approach allowed for learning with no threat of embarrassment—no one needed to know an answer to an alcohol and drug-related question. The youth were much more interested in real-

life situations than in theoretical and statistical information. Also, for these First Nation youth, this storytelling approach was similar to oral history spoken by their Elders.

Real-life stories and real-life activities—a way in

Though I never got to apply my insight to school classrooms, after many years of trial and error I had discovered two approaches that reached youth relatively well.

The first approach creates opportunities for unstructured activities with an adult of the same gen-

der who is well versed in health issues. This approach also acknowledges that the students already have a fair bit of knowledge.

The second approach involves having people with addictions and mental health issues tell their stories to the young people in a way that doesn't glorify the behaviour we wish to change.

Both approaches are non-threatening. In both, learning is a by-product of another process—and stories and shared personal experience are the hooks. ■

challenge day coming to williams lake

Lenette Doskoch made her mom Darlene promise to bring the day-long Challenge Day program to Williams Lake before she graduated from high school, so she and her brother Dillian could take part in it. Challenge Day is a six-hour facilitated experiential workshop for high school teens on racism, violence and bullying. It breaks down communication, social, racial and other barriers that separate teens and teaches them acceptance and how to communicate with one another. Jubilee Care/Canadian Mental Health Association, Williams Lake Branch has raised more than \$30,000 to bring the Challenge Day to Williams Lake in February 2009. In addition, the Challenge Day curriculum is now being taught in the Planning 10 courses at both the town's high schools.

For more information about Challenge Day, go to www.challengeday.org and watch the video excerpt from Teen Files: Surviving High School. It will touch your heart. Darlene Doskoch guarantees it!

It was winter and we hitchhiked from Castlegar to Osoyoos, three hours away. We were picked up by the RCMP after the first person we got a ride from reported us as possible runaways. We were only gone for about 18 hours, when my mom and the other parents arrived to pick us up.

When that day ended I thought I could never be the same. But what I didn't know is that running away wouldn't make things any better. Because I was trying to run away from myself. I tried to change myself to make other people happy and ignored my heart and my soul.

* * * * *

We moved to Williams Lake for my grade nine year. I was so scared I'd be bullied again. What if the kids didn't like me? Or, what if I wasn't pretty enough to be in their cliques?

I had a bit of a break down in the first month at school because I was waiting for the kids to bully me—but they never did. I'm not sure if it was the town that was different or me. Maybe a bit of both. I do know that I make better choices in friends now.

Before I moved to Williams Lake I was a seed, unwatered, uncared for and lonely. In Williams Lake, I found an amazing best friend named Sarah and a lot of other good friends who support me. They've all helped me bloom into a beautiful flower—a yellow tulip, bright and colourful.

Darlene Doskoch

Darlene moved from Oklahoma to Williams Lake in 1983 to be reunited with her mother after 14 years of separation, and she married in 1991. Darlene is a graduate of the Social Services Program at Selkirk College

A mother's story

I was sitting in my office in Nelson, BC, getting ready to close up my office for the day and go home. Home is a 45 minute drive to Castlegar, which gives me plenty of time to unwind from a busy day and think about what I'm going to make for dinner. And I start to get excited about seeing my children, Lenette (13) and Dillian (11).

In 2002, I decided to go back to school and change my career. I took the Social Services certificate program at Selkirk College and got a job right out of school. I haven't looked back since. As part of my job, I work with people who have mental illness and other disabilities, so I'm fairly familiar with the signs of depression and anxiety.

This particular winter's day at the office had been no different from any other. As I was finishing up, the

phone rang. The person on the other end identified herself as a constable from the Osoyoos RCMP detachment; she wanted to speak to me.

Imagine my shock when she told me that my daughter was sitting in her office; that she'd been picked up as a runaway. I laughed and told her she must be mistaken. Lenette couldn't be there; she must have the wrong number. After a few more denials on my part, it became clear that my daughter had, indeed, run away from home.

My big question was: why? What had I done? What had I missed?

When Lenette started grade eight, I wasn't happy with the new school system. Kids from grade eight through 12 were now together in the same school, and I was concerned about her being around students so much older than her. But Lenette kept reassuring me that she was fine. She had many friends and was often invited over to their homes, or they came to ours. The fact that she was spending more and more time alone in her room was surely just a symptom of being a teenager, right? I was a professional; I would know whether my child was depressed, wouldn't I?

That ride from Nelson to Osoyoos was the longest ride of my life. It was winter and the roads were icy. Even though I went along with another set of parents (there were three girls who had run away together), I felt very alone. I couldn't understand why Lenette would run away. I knew nothing.

Over the next few hours the facts became very clear. Lenette was being bullied at school. So were the other two girls she ran away with.

The next morning, while we were talking to the 'adults in charge' in the vice-principal's office at the high school, the girls were attacked. I could hear one of them screaming in the hallway. The vice-principal went to see what was going on, found Lenette and the two girls, and brought them into his office. One of the girls had a large chunk of her hair ripped out. The attackers had knocked her to the ground, stomped on her legs and then dragged her down the hallway by her feet, while Lenette and the other friend tried to help her.

The girls told us later that a teacher had merely told them to "knock it off" and walked on by. The vice-principal's action was to take no action. Instead, he

told the girls that if they'd stayed seated outside the office where he'd told them to wait during our meeting, it would never have happened.

One of the other parents phoned the RCMP to report the attack, because the school had refused to do so. We also went to the RCMP to file complaints, but they did everything they could to dissuade us from pursuing the complaint. We were told it would take a lot of paperwork and time, and the results wouldn't be worth the effort. I'd have climbed Mount Everest to help my child, but it felt like no one wanted to help me—or her.

The sad part is, the girl who received the major brunt of the attack was also suspended for fighting in school. I find it even sadder, as Lenette's parent, to discover that she had chosen to report this particular grade 11 bully to the vice-principal long before this incident and wasn't believed. The VP's words to her were something to the effect of: "I don't believe you; she's one of my favourite students and wouldn't do anything like that." He admitted to this conversation during our meeting. And it was later confirmed that this girl had been accused of bullying before and there were reports in her file prior to this attack.

Ultimately, our concerns fell on deaf ears, leaving the girls to suffer in silence and feeling they were to blame.

Changing schools was, unfortunately, not an option at that time because there were no other high schools in Castlegar. We did look into the Trail school district, but the district representative's first words to Lenette were: "Well, if I put you in a new school, are you going to be a problem there too?" This was the final blow for Lenette, and it sent her into a deep depression.

Over the next few months, our lives changed dramatically. Lenette was changed. My smiling Sunshine girl was gone and replaced by a sad, withdrawn and depressed child. I had nicknamed Lenette "Sunshine" when she was only a couple of months old. She was an extremely happy baby, always smiling.

On looking back, I realized that my Sunshine had been depressed for a long time, but I had missed it. I began to notice that Lenette was drinking and smoking. Eventually I noticed that she was cutting—I'd see the marks on her legs. At first she denied it, but eventually she told me that it helped relieve her pain.

My worst day as a parent came approximately two months after she had run away, when we had to take her to emergency at the regional hospital in Trail because she was threatening suicide.

* * * * *

We moved to Williams Lake at the end of the school year. I could not—would not—make my child go back to that school.

Through my workplace in Williams Lake, I was able to have Lenette assessed so that we could obtain some assistance for Lenette in school. She was struggling with her academic studies. After a difficult assessment, Lenette was diagnosed with generalized anxiety dis-



Lenette (left) in sunshine yellow prom dress with best friend Sarah

order, specifically around school-based activities and authorities and brought on by the bullying. They also found a mild learning disability. The assessor however, felt that the learning disability was due primarily to her anxieties around school.

Lenette was put on antidepressants and attended counselling for a time. I wish she had stayed in counselling longer than she did. But, while Lenette knows that counselling is good for her, she's a strong-willed young lady and felt she'd had enough.

You see, Lenette wasn't bullied because she was fat, or of a different race, or some other 'difference.' She was bullied because she liked to be friends with everyone. If she hung out with group A on Monday and then group B on Tuesday, group A would call her terrible names and body slam her into lockers, simply for wanting to hang out with a different group of friends. In her first year at Williams Lake Senior Secondary, however, she was voted best friend of the school!

Lenette continues to struggle with what happened to her; it affects every day of her life. But the good news is that I'm starting to see glimpses of my Sunshine girl again—changed, but still there. ▮

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School Connectedness: It Matters to Student Health

Laura MacKay

Laura is a Post-doctoral Fellow at the University of British Columbia in the School of Nursing. Her research examines the relationships between youth assets such as family and school connectedness, and adolescent health

Children and youth need to feel connected to others in their social environment in order to flourish. For most young people, schools are not just about academics. Schools are where they find their friends, have lunch, socialize, discuss problems and interact with adult role models. Schools are also where young people can talk to the school counsellor, get health and nutrition information and vaccinations, exercise in gym class and participate in after-school sports.

Not surprisingly, these connections influence school success. These connections are also important in supporting better personal health, including decreased substance use and better mental well-being.

What is school connectedness?

School connectedness is a general term to describe a sense of belonging to the school environment. The school environment includes people, places and policies—other students, teachers, staff, administrators, classroom settings, activities and school rules, for example.

Students feel connected when:

- they feel they are a part of the school
- they are happy and like school
- they are engaged at school
- they feel safe at school
- they feel accepted and valued
- they participate in school activities
- they feel that teachers are fair and care about them
- they have good relationships with other students

footnotes

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The connection between school connectedness and health outcomes

Connections to school and relationships with teachers are important protective factors in the lives of children and youth. Having good

relationships, feeling safe and feeling like they belong at school helps youth to make healthy choices.

Research has consistently shown that youth who feel connected to their school engage in fewer risky behaviours.¹⁻³ For example, in British Columbia, youth in grades seven through 12 who felt connected to their schools were less likely to:²

- use cigarettes
- use marijuana or other illegal drugs
- drink and drive
- binge drink (have more than five alcoholic drinks at one time)
- be involved in aggressive acts such as physical fights or carrying a weapon
- attempt suicide

Youth who are at greater risk for problems because of abuse or unstable circumstances at home are also protected by school connectedness. A high level of school connectedness felt by at-risk youth in BC reduces the odds that they will attempt suicide, have substance use problems or behave violently.³ Positive outcomes are also increased: vulnerable youth who feel connected are more likely to report good or excellent health, do well in school and want to continue with school past grade 12.³

Although some at-risk youth find it hard to feel connected to school, not all do. For example, many at-risk and high-risk youth in alternate education programs in BC, feel highly connected to their school environment.⁴ Higher connectedness is related to lower drug use for youth in these supportive school programs.⁴

A sense of connection to school also influences mental health. Studies have shown that youth who do not have a sense of school belonging are more likely to experience

emotional distress, thoughts of suicide and substance use problems.⁵ Among younger teens, a high level of school connectedness is related to fewer depressive symptoms over time.⁶ In contrast, students who feel less connected to their school develop more depressive symptoms over time.⁶

What can schools do to foster school connectedness?

There is no single strategy that will create a greater sense of connectedness. Instead, schools need to implement a variety of approaches so that students feel valued, included, respected, cared about and have someone to turn to in times of need.

Current evidence suggests that to improve school connectedness schools should:⁷

- set high expectations for school performance and provide academic support to all students
- encourage families to also have high expectations for achievement and graduation
- have fair rules, which students have agreed to, for discipline
- establish trusting relationships among students, teachers and families
- help students feel close to at least one adult at school
- ensure skilled and capable teachers are hired to meet the different learning needs of students

The Healthy Schools Network in BC (www.bced.gov.bc.ca/health/hsnetwork) has an assessment tool that helps schools plan for improved school health and connectedness.

A number of schools in BC have established creative plans to help kids feel more connected to their school environment. For example, the Mount Prevost Middle School in the Cowichan Valley

began by creating greater awareness and understanding of school connectedness among students.⁸ In order to be better connected, students need to understand what that is. The school formed student advisory teams so students can give input and promote school events. A creative board game format is used to introduce students to various resources, issues and possible solutions to problems.

Some students will find it easy to be connected to the school environment; others will find it more

difficult. Programs to create greater school connectedness will help those students who find it harder to be connected because of negative school experiences or problems getting along with others. By increasing school connectedness, we can help young people attain better academic success and, perhaps more importantly, better physical and mental health. ■



Rethinking Drug Education

It's a familiar pattern. A story breaks in the media about some new drug being used by young people. Soon the buzz is about how this new drug is the most harmful and most addictive drug yet discovered. And then someone suggests that schools should solve the problem. But can schools really provide the solution? And, if so, why aren't current drug education programs addressing these new challenges? Perhaps we need to rethink our whole approach to drug education.

A brief background on drug education: Well-meaning roots, iffy results

Formal school-based drug education started in the United States during the late 19th century as part of the Temperance movement. This movement was based on a belief that the ills of society were the result of drinking alcohol. All students were taught that any use of alcohol (and to a lesser extent, tobacco and opium) was physically harmful and immoral.¹

In the 1920s, alcohol was banned in the United States; this period of time was called Prohibition. Banning alcohol, however, led to violence, corruption and organized crime, and there was little respect for the law. So, Prohibition came to an end in 1933. Ending prohibition was an admission that alcohol could be used socially. This undermined the foundation of alcohol education at the time and it was largely abandoned.²

Following Prohibition, the attention shifted from alcohol to illegal drugs. US government agencies began suggesting that the real problem was drugs such as cannabis, which, they said, led to killings, sex crimes and insanity. These new crusaders felt that real knowledge might encourage people to try drugs. They promoted drug 'education' based on sensational claims and scare tactics.³ This approach remained popular for

many years and continues to be used today, despite evidence that it is not effective.⁴

The next generation of drug education—the affective approach—was not much better. This affective approach assumed drug use resulted from a personal weakness or deficit, and it aimed to enhance individual self-esteem or improve decision-making skills. But most people use alcohol, not just those with low self-esteem or poor decision-making skills. It should be no surprise that this approach has not been able to demonstrate effectiveness, since it is based on a false assumption.

The current wave of drug education seeks to help young people resist social pressures and decide against using drugs. Governments around the world have given more funding for drug education over the last decade to help young people learn the skills to remain drug free.⁵ The best of these programs might stop or delay the onset of drug use in a small percentage of students under perfect conditions. Programs delivered in normal classrooms have not shown effectiveness.⁶

Drug literacy—a clear goal for effective drug education

Drug education is provided because the use of alcohol and other drugs is associated with considerable risk and harm. On that everyone agrees. But the history of drug education suggests that providing such education is driven by political and moral concerns. Whether or not drug education works has not been a core issue.⁷

Getting the most out of drug education requires careful attention to two critical factors: identifying an achievable goal and using an effective approach.

Drug education has suffered from a lack of clear goals. Public opinion and legal status don't reflect actual levels of harm and the messages they deliver about

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drugs are inconsistent. For instance, some drugs, like heroin, are demonized, while other forms of the same drug are found in many painkillers. Likewise, young people are told not to drink alcohol, yet everywhere it is promoted as part of the “good life.”

In this context of mixed messages, the only consistent goal for drug education would be drug literacy. This means that drug education should provide students with the knowledge and skills they need to avoid harm from alcohol and drugs in the real world. We can still teach them to avoid certain substances or to only use substances at certain times. The goal, however, must be to help students successfully navigate through competing claims of good and bad, so they can survive and thrive.

Evidence for connectedness—a clue to more effective approaches

After more than 100 years of drug education, you would think we’d be clear about what approaches are effective. But the nature of education; the political, social and economic factors related to drugs; and problems in evaluating approaches have contributed to our current confusion.

Still, there is one growing consensus: evidence is showing that greater levels of harm are experienced by people who are less connected to their community or peers.⁸

This evidence regarding connectedness indicates that current drug education programs are likely to be ineffective. These programs over-emphasize peer pressure as being an external force. They encourage individuals to be strong and resist the influences of their peer group, thus promoting isolation rather than connectedness.⁹

To encourage connectedness, drug education programs could help students to explore the complex social factors that influence their behaviours and to reflect on their connections to their peers and communities. Likewise, an education approach that encourages students to think critically and to interact with each other will help them gain drug literacy while making connections with fellow students.

iMinds—education for the real world

Students need to explore the many questions that surround substance use. Why do we use psychoac-

tive substances? What are the risks and harms, both physical and legal of using substances? How valuable are ethnic, cultural or faith-based reasons for not using substances? What is the relationship between personal happiness and community well-being? Exploring these and other questions prepares students to be real participants in their world.

At the Centre for Addictions Research of BC (CAR-BC), we are developing a new set of lesson plans and support materials called iMinds.

iMinds is designed to help students in grades 6 through 10 understand behaviour, substance use and mental wellness. We designed the program using the best available evidence. We want the program to engage students in real issues and be easy for teachers to deliver. We’ve tried to develop a resource that fits well within the curriculum students already have. And teachers are not expected to be content experts (in fact no one is), but, rather, facilitators of the learning process.

iMinds engages students at each step of the 5-i model: identify, investigate, interpret, imagine, integrate. Students explore how they handle themselves, their social situations and environments. The learning exercises provide structures rather than content. The students themselves fill in the content. For example, to explore influences on behaviour, students are not given a list of influences, but are prompted to come up with influences on their own for categories such as family, environmental or personal factors.

What the future may hold for drug education

The ultimate goal is now clear: students need to gain the knowledge and skills for making smart decisions about substance use.

Maybe one day, when a new drug appears, we will ask what it is that makes this drug so appealing. Instead of simply expecting schools to solve this new problem, we will draw upon the drug literacy education our schools have provided. Being more literate, we—including the media—will be able to develop broader community responses that address the full range of issues involved. |



footnotes

visit heretohelp.bc.ca/publications/visions for Dan’s complete footnotes or contact us by phone, fax or e-mail (see page 3)

for more information

on iMinds or current pilot testing, contact info@carbc.ca

Student Mental Health: Teachers Can Help



When educators look at ways to improve achievement and create safer schools, they need to consider factors that affect students' mental well-being. The link between mental health, behaviour and student learning is well accepted. Mental illness can seriously affect a child's ability to reach his or her potential.

In British Columbia, one in seven children and youth experience serious mental health problems. These problems cause much distress and impact the way these students act at home, at school, with their peers and in the community.¹

Because teachers see students regularly for 10 months of each year, they are in a key position to help protect the mental health of these children. Teachers can be the first to notice signs and symptoms of mental illness in their students. They can also help prevent mental illnesses from developing in the first place, through preventive measures in the classroom.

Intervening early in a child's development may prevent a down-

ward spiral that can have devastating effects if a child doesn't receive the help they need. Preventive measures taken at the elementary school level are likely to be most effective in changing early patterns. This can reduce problems before they become more serious at the secondary school level.

Classroom teachers need to have a basic understanding of the development of mental illness, with strategies to address some of the underlying issues in the classroom. Teachers are in a position to help children become more resilient, so they can better deal with stresses they may experience on a daily basis.

What are some preventive and intervention measures teachers can employ?

When we talk about child and youth mental health, we consider a student's ability to handle day-to-day demands, unexpected problems, relationships and social networks. We also look at their ability to effectively communicate and understand their own thoughts and feelings. In

the classroom setting, developing a culture of acceptance and belonging is an important preventive measure.

What opportunities do teachers have to prepare themselves for this facet of their work?

Resources focusing on mental health and social-emotional learning are available on the Ministry of Education website (www.bced.gov.bc.ca). *The Social Responsibility Performance Standards*² provides a ready reference for guiding students in developing positive social skills. *Safe, Caring, and Orderly Schools: A Guide*³ provides a framework for creating a school environment where students feel safe and experience a sense of belonging. *The Health and Career Education Integrated Resource Packages (IRPs)*⁴ include learning outcomes in the area of mental well-being. And the two-volume series, *Teaching Students with Mental Health Disorders: Resources for Teachers*, focuses on eating disorders and depression.⁵⁻⁶

Cheryl Hofweber

Cheryl is a former Director of Student Services in School District #54 (Bulkley Valley), and former president of the BC Council for Administrators of Special Education. She currently works in her district as an elementary school counsellor and teaches in the Special Education Assistant Program at Northwest Community College

additional mental health resources for teachers

Ministry of Children & Family Development (MCFD)

- o A student self-help book entitled DWD: Dealing with Depression was produced by the Centre for Applied Research in Mental Health and Addiction at SFU. The book has been distributed to all public libraries and school districts in the province.
- o A collection of books on anxiety, psychosis, depression and behaviour have been provided to each public library in the province by MCFD Child and Youth Mental Health. The goal of the books is to give parents and professionals working with children up-to-date information. The books also provide strategies to help children cope with challenges to their mental well-being.
- o A video series produced by the Knowledge Network on behalf of MCFD offers practical tools for understanding and finding solutions to mental health problems among children and youth. Each documentary explores causes, symptoms, impact on family and treatment. The four titles are:

- Beyond the Blues: Child and Youth Depression
- Fighting Their Fears: Child and Youth Anxiety
- A Map of the Mind Fields: Managing Adolescent Psychosis
- Struggle for Control: Child and Youth Behaviour Disorders

For more information visit www.knowledgenetwork.ca/takingcare. The videos have also distributed to all public libraries and school districts in BC. To order copies, contact the National Film Board of Canada

Schizophrenia Society of Canada

- o A video called Reaching Out, developed in BC, helps students and teachers understand schizophrenia and teaches them how to respond with sensitivity. See www.schizophrenia.ca/Reaching.htm.

The Child and Youth Mental Health division of the provincial Ministry of Children and Family Development has two initiatives that support mental health issues. These initiatives are available to all school districts in BC. The FRIENDS For Life program is focused on giving students the tools to deal with anxiety. The FRIENDS For Youth curriculum was introduced to grade seven students in the fall of 2008.*

Roots of Empathy (www.rootsofempathy.org) is a program that

fosters emotional literacy and empathy in students, kindergarten through grade eight. In 2007/2008, the program reached 16,700 students in 668 classrooms in BC.

There are many resources for teachers that focus on child and youth mental health (see sidebar for more). Using these resources will increase teachers' confidence when facing the challenges mental health issues present in the classroom. ■

helpful websites

- Children's Mental Health Ontario: kidsmentalhealth.ca
- Here To Help: heretohelp.bc.ca
- Mood Disorders Society of Canada: mooddisorderscanada.ca/page/quick-facts

footnotes

visit heretohelp.bc.ca/publications/visions for Cheryl's complete footnotes or contact us by phone, fax or e-mail (see page 3)

related resources

- Atkinson, M. & Hornby, G. (2002). *Mental health handbook for schools*. New York/London: Routledge.
- Hymel, S., Schonert-Reichl, K.A. & Miller, L.D. (2006). Reading, 'riting, 'rithmetic and relationships: Considering the social side of education. *Exceptionality Education Canada*, 16(3), 149-192.

Making the Most Out of Making Your School Smoke-Free



Gerald Thomas, PhD

Gerald is a Senior Policy Analyst in the Communication and Resource Unit, a satellite office of the Centre for Addictions Research of BC, which is based at the University of Victoria

In September 2007, the BC government took an important step in reducing youth smoking rates by banning the use of tobacco on school grounds. Previous tobacco control legislation had only banned tobacco use inside the schools. The smoking ban on its own, however, may serve only as an annoyance that forces students (and staff) who smoke to go off school grounds to light up.

A comprehensive approach is needed

To achieve meaningful, long-term results, say researchers, schools need to take a comprehensive, or broad, approach to tackling smoking in the schoolyard and beyond.

Evidence shows that smoking bans are most effective when combined with other types of prevention, rules and stop-smoking initiatives.¹ And all these initiatives need to be used consistently and sustainably across the whole community. To help a smoking ban do more than clear the air in one place and push the

problem over to another, a larger strategy needs to be in place.

An integrated approach—known formally as a comprehensive tobacco control strategy—stands the greatest chance of impacting student choices and behaviours. It links people, policy and programs. It makes sure that a message of health is delivered in different ways, from different angles and from different people.

A good example of integration is the way the smoke-free school grounds policy works to support the aims of the BC Healthy Schools program. Healthy Schools is a well-established health promotion program that invites students to learn and use decision-making skills around their own health and well-being.² Linking policies such as the school grounds smoking ban to the Healthy Schools initiative gives consistent messages. It also helps reinforce broader lessons about positive health choices among students.

Seven steps toward a smoke-free school

Developing and carrying out a comprehensive tobacco control strategy takes time, effort and a long-term commitment. Below are seven steps for creating a smoke-free school. These steps help make the process easier, because they are manageable and based on common sense.

1 Set up a tobacco control steering committee

School leaders can form a committee to create and monitor progress of the comprehensive tobacco control strategy. The first six months after start-up are the most crucial to the strategy's long-term success.

However, the committee will likely need to continue its leadership role well after the strategy takes effect to ensure the effort is ongoing.

2 Create capacity: encourage support and involvement of relevant school and community members

Enlisting full support of stakeholders (i.e., those who care about the issue) is best done by including them in both the development and execution of the strategy. The steering committee should actively reach out to relevant stakeholders, both in the school and the community.

At the school level, stakeholders may include:

- administrators
- teachers
- other school staff (counsellors, nurses, clerical support, janitors, bus drivers, etc.)
- students (including those who smoke)
- parents

At the community level, key stakeholders may include:

- tobacco reduction coordinators (within each health authority)
- municipal bodies
- local police services
- neighbourhood associations
- local businesses
- youth services organizations

3 Gather information in order to design a tailored strategy

Each school is unique. Therefore, it is important to collect information on the local situation so that the tobacco-free strategy can be tailored to local needs and circumstances.

Some of the key pieces of information to collect are:

- the percentage of students and staff who smoke
- community perceptions and concerns regarding a tobacco-free school (pro and con)
- anticipated concerns or problems in enforcing a smoking ban; for example, students gathering in locations near the school to smoke during school hours
- profiles of what life is like on the school grounds and in surrounding areas (e.g., neighbourhoods, malls, parks, etc.)
- examples of educational and promotional activities already in place that could support the implementation of a tobacco-free school strategy
- a list of successes and problems of previous tobacco-reduction activities, both locally and further afield (if available)

4 Develop the strategy

Successful tobacco control strategies for schools involve a well-thought out mix of policies and pro-

grams. This provides students, staff, parents and other stakeholders with the information, skills and supports needed to address tobacco use. All relevant groups should be involved in coming up with specific interventions and procedures. The local situation, as identified in step 3, will determine the best overall strategy. The steering committee should provide leadership and support for the development process.

5 Develop clear and consistent messages

Once the tobacco control strategy has been developed, staff, students and parents must be made aware of its basic elements (rules and expectations). This can be done through school newsletters, posters, signs and other tools that clearly communicate these rules and expectations. Ideally, both general and stakeholder-specific information will be used in messaging campaigns (see Table 1, next page for examples).

6 Ensure measured, consistent and fair enforcement

Smoke-free school policies work best when the rules are well understood, consistently applied and the consequences of breaking them are seen by students as fair and reasonable. Consistent enforcement of the rules shows that school officials are serious about compliance and fair in their response to violations.

When designing consequences for breaking the rules, a school should:

- use a positive approach (i.e., recognize successes and encourage connectedness and social and emotional development)
- focus on the purpose of the rule (i.e., to promote healthy choices and reduce tobacco use)
- change the consequences based on how many times the person has broken the rules (i.e., progressive consequences) and whether the person is a student, staff member or visitor

Heavy-handed consequences, such as suspension, should be used in special cases and only as a last resort. >>



take time to understand tobacco legislation

Knowing as much as possible about the Tobacco Control Act may help schools and communities better understand what it takes to create a smoke-free school. For details about BC's new tobacco control legislation, see the following:⁶

Government of British Columbia. (2007). Bill 10—The Tobacco Sales (Banning Tobacco and Smoking in Public Places and Schools) Amendment Act. www.leg.bc.ca/38th3rd/3rd_read/gov10-3.htm.⁶

7 Provide support for students and staff who want to quit smoking

Schools are encouraged to take advantage of existing cessation support resources in the community. One of these resources is BC's QuitNow program.³ There are other local tobacco cessation programs offered by regional health authorities, such as the Nicotine Intervention Counselling (NIC) program in the Northern Health Authority. For more information, contact your local Tobacco Reduction Coordinator.⁴

Schools should also be creative in organizing supports at the school level. For example, research shows that tobacco users who are supported by friends and family are more likely to be successful in their efforts to quit.⁵ So, a school could encourage the development of a "buddy system," where smokers pair up to support each other in their attempt to quit. Buddy arrangements could be student to student, staff to staff, or even staff to student.

8 Prepare for and respond to students who leave school grounds to smoke

One of the most difficult issues with having a tobacco-free school grounds policy is students leaving school property to smoke during the school day. This can create problems with student safety and public disorder in areas close to the school. Since every environment is different, schools need to:

- talk through the issue with students, staff and people in the areas surrounding school property

- talk about potential safety and public order problems before they happen
- be creative and flexible when dealing with students choosing to leave school grounds to smoke (e.g., bring students together with neighbours or local business owners to discuss the situation and possible solutions that serve everyone) |

footnotes

visit heretohelp.bc.ca/publications/visions for Gerald's complete footnotes or contact us by phone, fax or e-mail (see page 3)

related resources

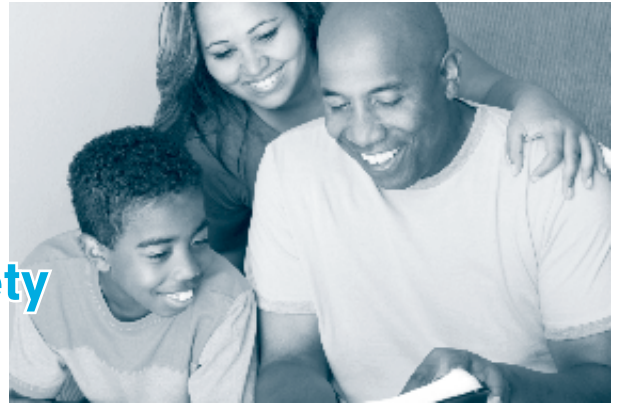
- Tobacco-Free Schools, BC Ministry of Health. www.health.gov.bc.ca/tobacco/schools.html
- Guide to Implementing a Tobacco-Free School Strategy, Government of Quebec. publications.msss.gouv.qc.ca/acrobat/f/documentation/2006/06-006-20A.pdf
- Smokefree Schools, Government of New Zealand. www.smokefreeschools.co.nz
- Cigarette Smoking Project: Suspension Learning Assignment, BC School District #22 (Vernon). www.sd22.bc.ca/fulton/smoking

Table 1- Examples of tailored messages in a comprehensive tobacco control strategy

| General messages about the Act and strategy | Messages to students should... | Messages to school staff should... | Messages to parents should help them... |
|---|--|---|---|
| <ul style="list-style-type: none"> • date when Tobacco Control Act measures took effect • restrictions set out in the Act • principles of the tobacco control strategy • rationale for the strategy • consequences for violating the provisions of the Act • people responsible for enforcing the Act • complaint mechanisms for reporting violations of the Act | <ul style="list-style-type: none"> • help all students understand that the strategy stems from a concern for their health and well-being • make sure that students are aware of the consequences of violating the Act • encourage student participation in implementing the strategy, including students who smoke • convince students that school officials are serious about enforcement • encourage students who smoke to take advantage of in-school and/or community support available to help them quit • foster a spirit of understanding among non-smokers for their peers who smoke | <ul style="list-style-type: none"> • help staff assume their roles as positive models for students and fully comply with the rules of the Act • endorse the strategy's importance as part of the educational mission of the school • encourage staff to take advantage of the support available to quit smoking, thereby setting a good example for students | <ul style="list-style-type: none"> • support school management in implementing the strategy • support their child's participation in anti-tobacco activities • support their child's efforts to quit smoking • take advantage of supports available in the community to help them stop smoking, thereby setting a good example for their child • emphasize the importance of a tobacco-free lifestyle • make sure their children are aware of the consequences of violating the Act and the school's rules by smoking on school grounds |

FRIENDS Parent Training

Helping parents help their children deal with worries and anxiety



If only...

My son, Kelly, was one of the one-in-10 children in Canada who are born hard-wired for anxiety.¹ From the moment he was born, there was something about Kelly that was different. His dad and I couldn't really put our finger on the difference, but it was there. He had explosive moments, even as a very young child, that were of an intensity I never saw in other children. As one of my very dear friends once said: the volume was just way too loud.

What we know is that 60,000 children in BC have a diagnosable anxiety disorder.² We also know that anxiety, left untreated in young children, is an indicator for depression and suicide in teens.³ Suicide remains the second leading cause of death of our young people in Canada;⁴ this is something we cannot ignore.

Unfortunately for my family, Kelly was one of those children who went on to develop depression as a teen. After a valiant struggle with obsessive-compulsive disorder and depression, when he was in grade 12, at just 18, Kelly died by suicide.

A common helping 'language' for home and school

From September 2005 until June 2008, I had the privilege of bringing the tools from the FRIENDS program (see sidebar, next page) to parents in communities throughout BC. The FRIENDS Parent Training program educates parents on the basics of cognitive-behavioural therapy, and gives them the same skills and tools that their children are learning in school through the FRIENDS For Life and FRIENDS For Youth programs.

These school-based programs help young people cope with and manage anxiety and depression.

With funding from the Ministry of Children & Family Development, The FORCE Society for Kids' Mental Health⁶ formed partnerships with individual school districts, mental health teams and school parent advisory councils (PACs) to host FRIENDS parent trainings. Many school districts went out of their way to be welcoming and enthusiastic about informing parents. In just three years, FRIENDS parent training was delivered to parents in 45 school districts in BC. To ensure fair geographical representation, three school districts were chosen in each of the five MCFD regions⁵ in the province. In remote areas, where school districts are spread over a large area, this often involved more than one community.

During the 2007/2008 school year, The FORCE partnered with the First Nations School Association⁷ to bring the FRIENDS parent training to four First Nation communities in BC. My life as a parent trainer was particularly enriched by those experiences. They gave me new insights into, and understanding of, Aboriginal people, their history and their culture. I had the privilege of listening to the stories of a First Nation elder who told me about her childhood growing up in Bella Bella. I shared in a spaghetti dinner cooked by the senior students in a First Nation school in the Stein Valley. These are experiences I'll always remember.

Many times parents said that the program helped them recog-

nize their own anxiety. Parents also said that they were able to start to use these skills the next day and that they saw a change in how they communicated with their children. Imagine—adults using the same language to help children, both at school and at home!

Over and over again parents were grateful to learn that this program is offered in our schools, so they could learn how to help their children deal with anxiety. Attendance at workshops grew as parents told each other about this valuable learning opportunity.

Donna Murphy

Donna is a co-founder of The FORCE Society for Kids' Mental Health and past coordinator of its FRIENDS Parent Training program. After Donna lost her son Kelly to suicide, she chose to work for improved information and services for children and their families. Donna is no longer with the FORCE and teaches at Fraser Health's Adolescent Day Treatment Program in Surrey

*together,
anything is possible...*

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BC Mental Health
and Addictions
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Contributing to the excellence
of mental health and addictions
research in BC

for more information

about the FRIENDS Parent Training program, visit www.mcf.gov.bc.ca/mental_health/friends.htm or e-mail FRIENDS.Parent.Education@gmail.com.

A potential gift for a staggering number of children and families

I have taught children in the school system for many years. In reflecting back, I feel strongly that as educators and parents the greatest gift we can give children is a love of learning. It's hard to enjoy learning, however, if you spend your school days worrying.

The FRIENDS For Life and FRIENDS For Youth programs help children learn to manage their worries, so their minds can be more open to learning. And the FRIENDS Parent Training pro-

gram helps parents help their kids to worry less. With 60,000 children in BC experiencing anxiety, the number of children and families who could benefit from these programs is staggering.

I'll never know what the outcome may have been for my fam-

ily if we'd had some of this training when Kelly was growing up. What I do know is that I desperately looked for help and the skills to be able to help him, and found nothing. I also know that if I'd had the skills offered

to conquer his fears. But, remember, we didn't talk about children's mental health in 1987—the teen years were considered 'early' intervention at that time.

How lucky children and parents are today that the Ministry of Children and Family Development sees the value in early intervention at age nine and supports the FRIENDS Parent Training program. Today's parents will not have to struggle to find information to help their children, as I did. I firmly believe that, through the parent training, we can prevent families

from losing their children. Families with the FRIENDS knowledge have a strength base. This will help the parents to access further help and to support their children through a difficult time. ■

Parents have said:

“I am grateful to have these strategies to be used at school and home.”

“Thank you for coming to share this program with us.”

“My son has anxiety issues from birth and school is a huge problem. This program has some excellent ideas, which I know will help.”

in the FRIENDS Parent Training program, our family life would have been different. I would have been able to recognize anxiety in Kelly at an early age and would have had tools to help him recognize these feelings in himself. I'd have learned how to help him relax and plan how

footnotes

visit heretohelp.bc.ca/publications/visions for Donna's complete footnotes or contact us by phone, fax or e-mail (see page 3)

the **FRIENDS** program

FRIENDS is a school-based early intervention and prevention program, proven to be effective in building resilience and reducing the risk of anxiety disorders in children. It teaches children how to cope with fears and worries and equips them with tools to help manage difficult situations, now and later in life. To learn more about FRIENDS in BC, visit www.mcf.gov.bc.ca/mental_health/pdf/friends_for_life.pdf. For an overview of the specific concepts, skills and techniques taught during the program, visit www.mcf.gov.bc.ca/mental_health/pdf/friends_for_life_overview.pdf.

The FRIENDS program is sponsored by Child and Youth Mental Health Services within the Ministry of Children and Family Development (MCFD), in cooperation with the Ministry of Education, school districts and independent schools.

The FRIENDS For Life program is provided to children in grades four and five. New this year is the FRIENDS For Youth program for grade seven students. Implementation of the youth program began in September 2008. These programs are delivered by school professionals and they address many of the prescribed learning outcomes in the Health and Career Education K-7 curriculum.

FRIENDS Parent Training evening workshops are available to provide parents with the tools and life skills that their children are learning in the FRIENDS programs. Parents also learn how best to support their children in using these skills. The FORCE Society for Kids' Mental Health coordinates and delivers these trainings, in partnership with MCFD. Check the FORCE website at www.bckidsmentalhealth.org for a listing of where parent training is being offered.



A New Path in School District #22 (Vernon)

Our substance abuse prevention policies and procedures

In School District #22, we have a simple philosophy with respect to drug and alcohol issues. We ask, what would I do if my child had a drug problem? This uncomplicated philosophy shapes our programs and actions.

The days of permanently removing students from school for drug use are over—at least in our school district. We have a commitment to educating kids right through grade 12 completion, and that education includes learning how to live a healthy life.

Young adults do need clear rules and expectations, however, and they need stiff consequences for poor behaviour.

In 2003, we spent 12 months reviewing drug and alcohol policies and procedures from over 80 school districts from around the globe. Our goal was to reduce substance use by students and help kids who are suffering with addiction issues. We created a straightforward policy based, in part, on the four pillars paradigm of harm reduction, prevention, treatment and enforcement.¹

Our four pillars:

- **Prevention** – In partnership with the Centre for Addictions Research of BC (CARBC), we have been piloting a series of classroom lesson plans on drug and alcohol abuse prevention (grades six and seven in 2007/08; grades eight, nine and 10 in 2008/09). We've also done significant professional development with our teachers and administrators, specifically in the area of substance abuse prevention and treatment.
- **Intervention** – All secondary school counsellors have been trained in the counselling technique called motivational interviewing.² This technique was created for dealing with youth who have substance use issues. Counsellors can also send students directly to any of our local agency partners that provide treatment programs for kids with substance use issues. Additionally, all students who have been suspended must meet with SD#22's District Substance Abuse Prevention Counsellor before they can return to their regular classes. The district counsellor will screen each child for potential drug or alcohol problems using a number of screening tools, including CRAFFT,³ DUST⁴ and GAIN.⁵
- **Enforcement** – Teachers and administrators have been trained to detect drug use in their students. When students are caught using (in the act of using or post-use), they are suspended from school for up to five days.

- **Treatment** – Students who request help, or who are caught for the second time in the same school year using an illicit substance, are required to go to one of three treatment programs: Axis Intervention Centre, Vernon Treatment Centre (VTC) or to a residential facility arranged by the Interior Health Authority. The school district partially or fully funds VTC and Axis services, and funding partnerships with the United Way and VTC ensure that kids all have access to treatment. Residential treatment is covered by the Ministry of Health.

- Axis Intervention Centre is for kids who are new to substance use (i.e., grade seven or eight students) or who have a history of problematic use but still function in school. Axis offers a five-session, weekly intervention/treatment program.
- The Vernon Treatment Centre offers a two-week day program for our kids who are struggling with a significant drug problem.
- The third option is Interior Health's Alcohol and Drug Services for a referral to residential treatment—usually Peak House in Vancouver. Interior Health is also a fantastic resource for our students who are suffering from a concurrent disorder.

And, since substance abuse is a family disease, we strongly encourage the parents of these children to enroll in, and complete, a parenting course at the North Okanagan Youth and Family Services Society (NOYFSS).

Our 'fifth pillar'

The final aspect of our program is public education. Through our Partners in Prevention program, we regularly host public forums. Topics always deal with substance abuse, and featured guests include doctors, researchers, police, lawyers, public health officials, impacted parents and drug and alcohol specialists.

Our public information sessions are promoted on one of our local radio stations, as well as in school newsletters. Also, the District Substance Abuse Prevention Counsellor regularly writes a column in the local newspaper.

Doug Rogers

Doug is the District Substance Abuse Prevention Counsellor for School District #22 (Vernon)



What does our practice look like?

The following is a step-by-step description of what happens when a student requests help or is caught using or under the influence of alcohol or other drugs.

- **Self-reporting** – When a student comes forward and asks for help, they are not given a disciplinary consequence. They are simply screened and assigned a treatment plan.
- **Enforcement** – Students caught using or under the influence of drugs or alcohol are suspended from school for up to five days and referred to the District Substance Abuse Prevention Counsellor, and, a letter is sent to their parent(s). If a student is caught a second time in the same school year, they may be sent to see the school district’s Assistant Superintendent. At that meeting, the Assistant Superintendent may assign the student to a treatment centre, or may change the student’s educational placement if treatment hasn’t been effective in creating change in a student. Relocating the student serves to sever relationships with other kids they’ve been buying from and/or using with.
- **Dealing or supplying** – Students caught dealing or supplying drugs, alcohol or ‘look alike’ substances (e.g., over-the-counter pharmaceuticals passed off as ecstasy; oregano standing in for marijuana) are suspended for two weeks and referred to the Assistant Superintendent. They may be moved to an alternate educational setting—usually adult education. The RCMP are also consulted.
- **Education** – Each student must complete an online assignment before they return to school. The assignment is designed to raise the awareness and knowledge base of the student and their parent(s). The parent(s) must sign the completed assignment before the student can return to school. If a student doesn’t have access to a computer, a hard copy of the assignment can be obtained from the school. The assignment is available online at www.sd22.bc.ca. (Click on Students; click on Student Support Serv-

- ices; then on Suspension Learning Assignment.)
- **Intervention** – Each student meets with the District Substance Abuse Prevention Counsellor. At that meeting, the student is screened for problematic substance use behaviours and, when applicable, assigned to a treatment program. For students who prefer help from outside the school system, an appointment is arranged with Interior Health Alcohol and Drug Services.
- **Treatment** – When it is appropriate, students are assigned to a treatment program, and their parents are encouraged to seek help from local agencies.
- **Post-care** – After the completion of a treatment program, students are seen by the District Substance Abuse Prevention Counsellor and/or school counsellor, and they attend a post-care program (e.g., Alcoholics Anonymous, Narcotics Anonymous).

It’s working

Our policy and process is working. Referrals to administrators have significantly declined and students are self-referring at higher numbers each year. We are allied with places where our young adults and their families can get the help they need. And, students who would have dropped out or been ‘kicked out’ of school in the past are remaining in school, graduating, living healthier lives and contributing to society. ■

vernon school district #22 treatment stats

Out of five secondary schools, with approximately 4,500 students, the following numbers represent students required to attend treatment programs and students who self-report and ask for help (about 25% of the District Substance Abuse Prevention Counsellor’s clients self-report):

- 20–30 kids per year attend Axis Intervention Centre
- 30–50 kids per year attend Vernon Treatment Centre
- 1–3 kids per year go for residential treatment

for more information
contact
Doug Rogers
at 250-549-6179 or
drogers@sd22.bc.ca.

footnotes

visit heretohelp.bc.ca/publications/visions for Doug’s complete footnotes or contact us by phone, fax or e-mail (see page 3)



Reaching Out Two BC Programs Bring Mental Health Awareness to Youth

Two programs here in BC are doing their part to combat mental illness in schools and among young people.

ReachOut Psychosis is a program of the BC Schizophrenia Society, funded by the BC Partners for Mental Health and Addictions Information. It won the Schizo-

phrenia Society of Canada Initiatives/Programs of Excellence Award for 2008. And a video about the program was featured at the 6th International Conference on Early Psychosis, October 2008, in Melbourne, Australia.

Youth Net Delta has been offered by the Canadian Mental

Health Association, Delta Branch for six years. This youth-to-youth approach was originally developed 15 years ago by two Ontario doctors and has been helping young people to recognize and get help for mental health issues ever since.

Get the scoop on these programs below.

ReachOut—Spotting and Stopping Psychosis Early

What

The ReachOut Psychosis Concert Tour teaches youth spot to psychosis symptoms in themselves and their friends, and empowers them to seek medical help or help others when they do spot symptoms.

A high-energy rock band, slam poet and professional teacher present information on early psychosis intervention. This is done in an interactive and fun way, mixed with music and spoken word performance. Some of the performers have either experienced psychosis directly or have a friend with psychosis, and they talk about their experiences during the show.

Young adults in the audience learn what it might feel like to have psychosis and what psychosis looks like from a friend's perspective. They also learn that treatment is available and successful, and that early medical intervention is important to increase the chance of full recovery. They learn where to go for help, both online and within their community.

Audience members complete a brief questionnaire, in person or on the website, about symptoms and how to get help. If they fill in the questionnaire correctly, they are eligible to win donated prizes. The completed questionnaires also help track the success of the program in increasing young people's knowledge.

Where

The performance tours to colleges, high schools and correctional centres throughout BC at no cost to hosting locations.

Who

Over 24,000 youth aged 16 to 25 attended the presentation last year. The performers and teacher are all youthful, and the performance is of a calibre that young adults would normally pay to see.

Why

Psychosis affects 3% of the population.¹ First symptoms usually show

up between the ages 16 and 30.² Early medical treatment has been shown to have a big effect on the speed and completeness of recovery from this brain condition.³⁻⁵

Psychosis is hard to spot in yourself. In this young adult age group, peers may be the first to notice something is wrong and are often the first people youth turn to for help.

Equally important, this program helps to reduce the stigma of the condition by bringing in attractive role models who set a tone that undermines discrimination and fear of persons with mental illness.

Contact

Tracy Dudley, Tour Coordinator
604-682-7020 or
reachout@bcss.org. Visitors to reachoutpsychosis.com can view a video of the performance, listen to clips of the performers, read or watch videos about psychosis and enter a knowledge-testing contest. Teachers can download teaching resources and sign up to receive information on teacher resources by e-mail.

Youth Net Delta—For Youth by Youth

What

Youth Net Delta is an interactive mental health promotion program for youth. It aims to reduce the stigma of mental illness and create a supportive climate for youth to access help for mental health concerns.

Older youth facilitate focus groups for young people on the topic of mental health and stress. The facilitators are usually college or university students who have direct or indirect knowledge and experience of mental health issues. The discussion groups are loosely structured around five questions: What is mental health? What is mental illness? What issues/stresses are you dealing with? How do you deal with them? Do you know who you could trust to help you in your school, community and personal life?

The presentation goals are 1) to provide self-awareness tools and in-

formation about mental health and mental illness, 2) to introduce coping skills that can be used during difficult times, and 3) to provide "youth friendly" resources on how to help themselves, family and friends.

The hour-and-a-half presentation is designed to encourage critical thinking, start conversations and foster open communication on issues of mental health and personal well-being. Teachers are encouraged to leave the classroom (and usually do) so the discussion can be among just youth. Participants are able to talk about their stressors and concerns.

Additionally, participants complete a questionnaire that prompts facilitators to check in with any youth who may be in crisis. Further support is available through a clinical backup person, who may be a suicide prevention worker or a high school counsellor. If needed, the youth facilitators can also connect the youth with other professional help.

Where

The school system is the target to reach the youth, and groups take place primarily in Delta high schools. However, we have been invited to present at schools in Surrey and White Rock, as well as to private groups that work with youth.

When

Youth Net Delta is active from September to June. Presentations are usually delivered during school hours.

Who

Youth Net Delta's primary target is grade 10 students enrolled in Planning 10, since the learning outcomes fit with the BC Ministry of Education health curriculum. In the 2007/2008 school year, Youth Net Delta presented to 910 students.

Why

A Ministry of Children and Family Development study done in 2002, *Prevalence of Mental Disorders in Children and Youth*,¹ states that 15% of children and youth may

Sophia Kelly, DVATI

Sophia is Manager of the ReachOut Psychosis program for the BC Schizophrenia Society, and a consultant in private practice. She has designed and run programs addressing peer support, health education and outreach. Her background includes project management, technology and business analysis, with master's-level training as an art therapist

Judy Gray

Judy recently added coordinating Youth Net Delta to her financial management duties at the Canadian Mental Health Association, Delta Branch. Over the past 10 years at CMHA, Delta, she has also been volunteer coordinator, program coordinator and information services coordinator

be affected by a mental disorder. Anxiety and conduct, attention and depressive disorders are the most common mental health issues young people have. This study suggests a multi-faceted approach that includes programs to promote health for all children.

Youth Net was developed by Dr. Ian Manion and Dr. Simon Davidson from Children's Hospital of Eastern Ontario.² This was in response to a 1993 survey on youth and men-

tal health and illness done for the Canadian Psychiatric Association.³ The survey showed that youth are at high risk for mental health problems. But out of all youth reporting mental health or addiction symptoms, the majority never sought professional help. Embarrassment, fear, peer pressure and/or stigma were the major barriers to seeking help. Young people felt most comfortable talking about these concerns among themselves.

Youth Net Delta aims to educate youth on mental illness and encourage them to seek professional help at the earliest signs. Early recognition and treatment helps promote recovery and well-being.

footnotes

visit heretohelp.bc.ca/publications/visions for Judy and Sophia's complete footnotes or contact us by phone, fax or e-mail (see page 3)

Contact

Judy Gray, Coordinator
youthnetdelta@dccnet.com
For more information, visit www.delta.cmha.bc.ca/youthnet

related resource

Manion, I.G., Davidson, S, Clark, S. et al. (1997). Working with youth in the 1990s: Attitudes, behaviours, impressions, and opportunities. Ottawa: Canadian Psychiatric Association. ww1.cpa-apc.org/Publications/Archives/Bulletin/1997/Aug/c-review.htm.



Jessie's Hope Society Celebrates 'EveryBody' by Fostering Healthy Resilience

Brian W. Chittock

Brian is the Executive Director of Jessie's Hope Society. He has participated in the development of the society's provincial prevention program for children, Celebrating EveryBODY! Brian oversees all Jessie's Hope program development in the province of BC

What if we had a society where everybody was celebrated? Where individuals found a way to appreciate themselves regardless of shortcomings they may see in themselves?

Jessie's Hope Society is a BC non-profit, volunteer, organization that focuses on the innate resiliency and capacity for well-being that everyone has, regardless of circumstances and problems.

Jessie's Hope Society believes that we don't need to 'fix' people, we just need to help them tap into to this resilience they already have inside. A 15-year-old high school student once described resilience as "bouncing back from problems and stuff with more power and more smarts." This understanding speaks to the human self-righting ability we all have.

When children are living in well-being, they work well, play well, love well and expect well.

Three life principles that guide our work

At the heart of our program is the Three Principles of Innate Health—Mind, Consciousness and Thought.

This leading-edge approach to wellness has been researched and developed for over 25 years. It has been shown to decrease anxiety and depressive symptoms, and to increase self-esteem and positive changes in personal relationships and communities.¹ The academic home of this approach is the West Virginia Initiative for Innate Health at the University of West Virginia (www.hsc.wvu.edu/wviih) in the United States.

Our mental life operates from these Three Principles of Innate Health at all times; they govern how we experience life, moment to moment. Mind is described as the energy behind life. Like electricity, it is a formless energy, and is a constant source of power and wisdom. Consciousness is awareness; like a cord being plugged into an outlet, we can access different levels of wisdom through our understanding of this principle. Thought is like a light bulb: it's how we see life. It's through Thought that we create our personal reality.

When we have an understanding of these principles, we are less reactive to life and more responsive. By responding rather than reacting to life's challenges, we can handle our challenges with greater ease of mind. This helps us maintain our wellness.

Our school prevention program: Celebrating EveryBody!

To engage the wellness of children, we developed the two parts to our Celebrating EveryBody! program—one for teachers and one for students. We also have a program for parents, as an extension to the in-class program for students.

Training teachers to share the Three Principles of Innate Health

Teachers must take a 12-hour training workshop in order to use the Celebrating EveryBody! lesson plans

with their students. School counsellors and special education assistants are also encouraged to take this training so they can support the teachers by also speaking resilience-based language with the students.

The health of the teacher and support staff—which is facilitated by this training—is critical for sharing the Three Principles of Innate Health with students. By living in their own well-being, teachers will naturally role model resiliency and wellness.

Our training is relaxed and informal and taught through presentations, discussions and group work. It doesn't rely on memorizing techniques, tools or skills. Rather, trainees explore how their experiences in life are created and how they can use the function of thought to help them day to day, moment to moment. By learning to quiet their mind, participants discover how to live in a state of well-being more of the time. When teachers live in this state of mind more of the time, they create a learning environment where children are better able to reach their potential.

Here's what teaching staff have said:

"Thank you so much for helping us shift our thinking and learn about our 'higher state of mind.' This is important personal and professional work. We are all on this journey. Your workshop helped us move along the path to greater peace of mind." – *SD#36 counsellors and teachers*

"It has been very powerful for me on a personal level. I have been able to use this training in various situations. Now, I am becoming more aware of my thoughts." – *a SD#42 support teacher*

Training students to use the power of Thought in their lives

Celebrating Everybody! is focused on bringing the best out in children. Through a variety of activities and reflection time, the students begin to see how they do or do not live in their well-being. Part of the learning touches on positive body image and developing healthy eating behaviours.

Celebrating Everybody! is designed for students in grades four, five, six and seven. The lesson plans are adaptable to each teacher's personal teaching style and can be used to enrich lessons in core academic subjects. The 10 lessons range from 30 to 45 minutes in length and can be presented over a 5 to 10-week period.

Each lesson is matched to Ministry of Education learning outcomes. The program also supports BC Schools Performance Standards by providing social responsibility programming for students.²

To help students engage with their resilience and common sense, the program uses metaphors to explain the workings of the inner life. We use the sun as a metaphor to convey the power of the human potential that exists in all of us. This includes ideas of goodness, wisdom and peace. The students are asked: What does it feel like to live in this place? And to understand the

power of Thought and Consciousness, the metaphor of clouds is used. Habitual thinking can get in the way of, or cloud, our sun. The goal is to guide children back to the sun, back to this innate ability to make healthy choices in their lives. Thought is the "vehicle" in which they learn how to do this.

To determine the impact our program is having on the students, we include questionnaires for students to fill out before and after the program. There are also reflection sheets for the students to complete. We want to hear from the students about how Celebrate Everybody! guides them in their everyday life.

Here's what students have said:

"I never knew feelings were so powerful, and thoughts too. I didn't know how to see a situation in another person's view. But, thanks to Jessie's Hope, I now know." – *a grade five female student*

"I learned that nobody can hurt your feelings." – *a grade five male student*

Connecting with Your Kids

Our Connecting with Your Kids program provides training to parents who want to raise their children in an atmosphere of well-being and resiliency. We offer a four-week parenting workshop to help parents discover how their state of mind impacts the way they connect with their children. Parents have said the program has also helped in other aspects of their lives such as work and other relationships.

Here's what parents are saying:

"It's more about how I need to change than about what I want my kids to do."

"[I learned how] to stay present—to connect in the moment."

Making inroads to change

Since April 2007, Jessie's Hope Society has trained over 500 counsellors, teachers, parents, community nurses, and mental health workers working in human services programs and schools. Last year, trained teachers and school counsellors reached over 570 students with our program. School districts, teachers, school counsellors and parents are embracing our approach, which explores the root cause of harmful behaviour and focuses on drawing out children's natural resiliency.

We have continued to expand our programs throughout the Lower Mainland and plan on expanding to key communities throughout the province in the coming years. ■

Quinn Cashion-Vosburgh

Quinn is Program Director for Jessie's Hope Society. She has over 15 years experience as a trainer in personal and professional development. Quinn designed and has delivered Celebrating Everybody! to parents, teachers, children and professionals in communities around BC.

Heather Quick Rajala


Heather is the Program Coordinator and Executive Assistant for Jessie's Hope Society, and has assisted in the design and development of Celebrating Everybody! She currently coordinates the logistics for taking the program to schools, community professionals and parent groups.

footnotes

visit heretohelp.bc.ca/publications/visions for Brian, Quinn and Heather's complete footnotes or contact us by phone, fax or e-mail (see page 3)

for more information

about Jessie's Hope Society, its other programs and opportunities to become a trainer, visit www.jessieshope.org or call 604-466-4877.




New School Resource Guide

a catalogue of educational programs and materials for use in BC schools (K-12) covering topics of:

- mental health promotion
- mental illness
- substance use

→ find it at www.HeretoHelp.bc.ca/schools

 BC Partners for Mental Health and Addictions Information

We've made a few changes to *Visions* as a response to reader feedback ...

So, how are we doing?

We want to hear from you about *Visions* magazine, as well as your experience on HeretoHelp.bc.ca

Let us know what you think by May 31, 2009 and be entered into a draw for \$100 to a store or restaurant of your choice!*

to fill out the survey, visit www.HeretoHelp.bc.ca




* store or restaurant in BC which carries gift cards

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Weathering the Storms—Family's Journey Through Earthquakes, Loss and Bullying | Shabana • Educating Youth About Mental Illness | Shelby Rankel

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