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Focusing on the Experiences of Adolescents with Anxiety or Mood Disorders Accessing Mental Health Services in Primary Care

By: Lisa De Panfilis RN, BScN MScN student, McMaster University

In recent years, the increasing rate of children and youth accessing the emergency room for mental health and addiction problems have been alarming. To prevent acute distress, early identification and intervention ought to occur for young people in the primary care setting. Primary care is where children and youth have ongoing contact with their primary care health professionals. What's more, primary care should be their first point of contact for accessing comprehensive person-centred care. Shockingly, researchers have found that approximately 50% of children and youth utilizing the emergency room for mental health and addiction problems have not had prior contact with a physician for their concerns. There is growing apprehension that primary care may not be adequately recognizing or accommodating the mental health needs of young people.

My thesis aims to examine the gaps within primary care in the delivery of mental health services for adolescents with anxiety or mood disorders. The teenage years, particularly between 14 and 18, is a crucial time whereby adolescents begin to develop their independence, self-identity, and responsibility for their health. This is also a time when

many Canadians have reported the onset of symptoms of mental illness. Understanding adolescents' experiences of accessing mental health services in primary care is essential to recognize if their needs are being met and how access occurs, to support the delivery of improved recovery-oriented approaches in care. A secondary aim of my research is to examine the role of Registered Nurses in facilitating access to primary care mental health services for adolescents. Currently, the role of the RN in primary care is not well understood, and further knowledge about their functions could support optimization of their role in providing primary care mental health services.

I am incredibly grateful for this opportunity to explore the experiences of these young people. I look forward to the outcomes of this study, in hopes that navigation through the health care system will be easier for these brave, young people on their mental health journey.

Trauma-Informed Care - What Is It and What Does It Mean for Nurses?
By: Kimberly Jones, RN, BScN, MNursing, CPMHN, CBS GDip

Looking back on my medical nursing career, I at no time learned about trauma-informed care in college curriculum or on the job. Currently, I work as a psychiatric nurse with patients who have experienced horrendous traumas. Becoming a mental health nurse taught me about trauma-informed care. Here is a quick review on trauma and trauma-informed care. Remember that everyone we come in contact with has likely had a traumatic event and this ought to be a fundamental assumption in nursing.

What is trauma?
Trauma is a word used to describe emotional and physiological responses to experiences or events that are life-altering, shocking and agonizing. A traumatic event can be a single occurrence such as a car accident, loss of a job or an act of violence. It can also stem from prolonged, repeated exposure to illness, war, childhood neglect or sexual abuse. Traumatic events lead to feelings of terror, shame, powerlessness, and hopelessness (Bloom, 2009). Its consequences can be so ruthless that they hinder one's capacity to have a normal life, leaving people immobilized and making daily activities difficult. Some frequent forms of trauma are:

* Sexual assaults
* Domestic violence

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* Natural disasters
* Acute or chronic illness or injuries
* Grief over the loss of a loved one
* Witnessing violent behaviours
* Discrimination or racism

Who can be traumatized? How prevalent is it?
Studies have illustrated that at least three-quarters of all individuals of all ages, ethnicities, religions and sexual orientations have had some sort of traumatic event (www.cdc.gov/ace/prevalence.htm). Trauma can affect anyone, anywhere in the world. What's more; families, communities and whole cultures can be impacted. Trauma is under-reported because people fear the humiliation and stigma attached to it, fueling secrecy and fear.

Effects of Trauma
Those who have experienced trauma can be impacted physically, mentally, emotionally, behaviorally, spiritually and socially. Trauma can exhibit symptoms for days, months or years after the event, placing a heavy load on persons, relatives, and societies. Traumatic experiences can trigger:

* Mental health problems- anxiety, PTSD, self-harming or depression
* Dissociation- appearing withdrawn or not present
* Night terrors, flashbacks and physiological reactivity
* Difficulty relaxing and chronic stress
* Impaired concentration
* Mood swings- denial, rage, sorrow, irritability and emotional outbursts
* Chronic physical illness
* Substance use- smoking, drugs, caffeine or alcohol

Effects of Trauma on Health-care Providers:
Vicarious trauma (secondary traumatization or compassion fatigue) occurs when healthcare providers hear the lived experiences and observe the suffering of clients who have faced trauma. It can influence the nurse's relational, social, spiritual, physiological and emotional health.

Trauma Informed Care- Guidelines for the Health-care Provider:
Being "trauma-informed" means nurses acknowledge that individuals may have experienced a variety of traumas throughout their lives, suggesting that health providers must have a basic comprehension of trauma and be able to recognize its signs and symptoms. Assuming everyone has had a traumatic occurrence puts the nurse in a good place to provide advocacy and empathy.

Traumatic experiences can prevent people from seeking services but trauma-informed care does not force clients to disclose personal histories of trauma. Trauma survivors can be re-traumatized if forced to discuss details of their experiences. Things to consider:

* Be mindful of the words, phrases and tone of voice you use with your clients. Don't overuse medical jargon and monitor your judgments and assumptions.
* Be cautious about using words such as perpetrator or offender because the abuser may have been a family member or significant other.
* When asking a patient about trauma, commit to a "do no harm" approach, and assume all clients are trauma survivors. Review trauma-informed procedures that provide safe, empowering encounters for clients.

Ideologies of Trauma-Informed Care

Trauma-informed approaches can be hard at first but integrating some principles into your nursing care will help guide clinical practice. Trauma-informed care fosters:

* Safety for clients. Nurses provide physical, emotional, cultural and gender-sensitive safety for clients, as many still feel unsafe or live in unsafe situations.
* Trustworthiness and honesty among care providers and clients. Nurses ought to use non-blaming, non-shaming and non-aggressive forms of communication.
* Collaboration and leveling of power differences. Nurses should use nonjudgmental, inclusive, collaborative and benevolent ways to encourage clients to express feelings. Punitive, judgmental language triggers clients to re-experience intimidation and power used by the perpetrator
* Encouragement for clients to make treatment decisions. Clients are empowered to recognize their strengths and to continue developing resiliency and skills to cope.

Helping people who have experienced trauma is hard and rewarding. Nurses are in a good position to use trauma-informed care to observe the extraordinary improvement and transformation that clients go through. When will you start to use your trauma-informed approach?

References

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Biography

Kim is a master's prepared RN who initially graduated from a 3-year Diploma Program. She then completed a BScN and a Master of Nursing Degree and a post-graduate Diploma Program in Clinical Behavioural Sciences at McMaster University. She has her CPMHN certification. https://ca.linkedin.com/in/kimberly-jones-94461274 https://twitter.com/kimmmpossible3

"JUST LET ME KILL MYSELF, GRANDMA!"

By: Liz McGroarty, RN

I thought I had retired from active nursing at the end of June 2017, but my granddaughter Breana's mental health breakdown at a cottage in early July made it necessary to learn about Borderline Personality Disorder (BPD) and the treatment called Dialectical Behaviour Therapy (DBT). My granddaughter was in such obvious mental distress, from nothing that could specifically be determined, and through her tears said she wished we could all feel her pain. Her past behaviour included many incidents of property destruction when in an emotional state, along with attempts to drown her pain with alcohol, and we weren't sure what else. This had been going on since she was 17, and she was now 20.

I found out from my reading that BPD is a DSM-V diagnosis with suicidal ideation as a major factor, along with emotional dysregulation with its sudden 'highs' and frequent depression, plus anger and disgust with oneself, and sometimes, dissociative thinking. I found out that although both she and her mother, Martha, had started treatment and family therapy, she had not continued, and had not found any depression medication helpful. The advice to her mother from the counselling was to therefore toss her out on the street with no means of support, but what loving mother can do that? So, she was being supported in a separate accommodation, a bachelor apartment. She managed to find jobs, but never to stay in them long. She did work in occasional pop-up food ventures, and was attempting to go back to some modelling through an agency she had worked with in the past. She had an active social life with her friends from high school and our family.

The condition for continuing minimal financial support was that she continue to seek treatment, and get into the Ontario Works program and to eventually be able to support herself. The family even agreed to fund a $20-30K treatment program away from our community, but she had to start treatment in our community first. She continued to be resistant, saying she had friends who were helping her to cope with her problems.

I read the Registered Nurses Association of Ontario (RNAO) Best Practice Guideline for Suicide Prevention and that from the Centre for Addictions and Mental Health (CAMH). I've had training in Motivational Interviewing. Nowhere does it detail how to work with people who are resistant to treatment programs. But even if there was advice on actions to take, are there enough treatment programs available?

On July 27, 2017 Martha called, distraught. Would I meet her at Breana's apartment? She had just broken half of the windows in her apartment and threatened to throw herself off the 29th floor balcony. The police had been called. Her mother called the police and said it was a mental health issue, and could they please take her to CAMH emergency. The police did not send the team with the mental health nurse, but the officers were nonetheless understanding. My granddaughter was crying and upset and told me, while handcuffed and yelling in the back of the police cruiser, that as soon as she was released, she would take enough pills to kill herself and why wouldn't I let her just do that? We were told that on the way to CAMH, she kicked out the windows in the police cruiser with her feet; they did not charge her. We waited in the emergency waiting room while they assessed her, and eventually my daughter was called in. They said they were releasing her; they had given her a tranquilizer and she had stated that she would tell the doctor anything he wanted to hear in order to be released. That apparently was enough evidence of her sound mind to release her? On the way out to the car, she yelled abuse at her mother and I, but fell soundly asleep when we returned to her apartment to clean up the broken glass and put some protective cardboard over the open windows.

The next day we returned and took her back to CAMH emergency in a calmer state, looking for advice on entering the DBT residential treatment program. They described the process as having to phone a certain number on a certain day and time and hope to be the first caller through…… in essence, a lottery and may the first caller win. Her mother had heard about Stella's Place on Camden and I drove them to visit that place to hear about the programs there. Breana was very enthusiastic about the possibilities. Unfortunately – it was all too little, too late. She did go to her family doctor and agree to start and try Zoloft again. The week of the 14th, I took her shopping for groceries while the windows were replaced. In spite of many family meetings, phone calls and visits, and one more attempt to have her at a detox clinic, on August 22, 2017 the police came to my daughter's door to say that Breana had died by suicide. She did as she had threatened.

We later found out that she was being 'helped', but by new 'friends', to learn how to access Xanax from the street and Suboxone from the True North clinic at Queen/Church. Although we doubt she had the funds to be a cocaine addict, she had obviously been using marijuana

and alcohol.

Since that time, Martha (occasionally accompanied by her husband and myself) have had meetings at CAMH, with the Emergency doctor in charge and with the Quality Assurance team, to request an improvement in the emergency services and prevention of suicide. CAMH has added some more appropriate steps to be taken: a drug test, a search for previous psychiatric diagnoses and treatment in Ontario through a confidential data base, and a bridging program for those who can't immediately get into the DBT program. Martha continues to monitor if this is happening, through others' experiences.

I have found out by talking with colleague nurses and other families with members seeking psychiatric assistance at a hospital emergency, that the only way they get reasonable action is to be very vocal and demanding. I wish I had. The current Consent to Health Care Act allows the loose assessment of people with mental illness, to be dependent on whether they are seeking treatment or not. How does that serve those with dissociative thinking, in a crisis?
I have requested of many acquaintances and colleagues, to give support to NDP-Parkdale-High Park MPP Bhutila Karpoche's Bill 63- Right to Timely Mental Health and Addiction Care for Children and Youth Act, 2018, that will come before the house for second reading, proposed to be Feb. 22, 2019, by writing to their MPP with a personal story and asking for support for this Bill to pass and be studied in committee. As well, CAMH is posting some convincing personal stories about the differences between help offered for physical problems vs. mental illness issues

As I write this, today is Bell Let's Talk day……… I will be busy!