Network

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IN THIS ISSUE:

CANADIAN MENTAL
HEALTH ASSOCIATION
L'ASSOCIATION CANADIENNE
POUR LA SANTE MENTALE
Ontario Division/ Division de l'Ontario

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OUR MISSION:
To advocate with and provide programs and services for people with mental disorders, and to enhance, maintain and promote the mental health of all individuals and communities in Ontario.

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The Cost of Neglect

That the children of Ontario represent the strength and potential of the province is without question, And yet the sober fact remains that we are not adequately caring for them. This special issue of Network focuses on what it is costing us in financial, and emotional, terms to continue to neglect our most precious resource: our children.

CAMPAIGN 2000'S ONTARIO REPORT CARD 1997

Despite the resolution, unanimously agreed to by all federal political parties in 1989, to end child poverty by the year 2000, the situation today is even bleaker. Page 7 of this issue of Network shows the escalation in the numbers with the rate of child poverty climbing from 11% in 1989 to 19.1% in 1995. This increase in child poverty in Ontario is, to our shame, the highest in Canada. Too often percentage figures hide the faces of the real people who are represented: this percentage increase means that there are 252,000 more children in Ontario who are living on the poverty line. In the words of Dr. Paul D. Steinhauer, Chair of the Voices for Children Steering Committee "If we are serious as a society about valuing our children and about getting them all off to the best possible start, then we must commit ourselves to making changes at many levels - in our families, our workplaces, our communities, in our mainstream services, especially in our schools, in our specialized services for children and families and in, and between, our various levels of government".

|IT TAKES A WHOLE VILLAGE TO RAISE A CHILD

On page 5 of this issue we have a visual demonstration of this African proverb which shows, from a child's point of view, all of the important people who make up her "village". Several children were asked to submit drawings and the picture on page 5 by Heather Bebbington (age 9) was the unanimous choice of our Editorial Committee. Thank you Heather for demonstrating so clearly through your picture the important roles played by so many people in your life.

This issue of Network also takes a look at the fact that one in nine women in Canada between the ages of 14 and 25 have an eating disorder, and how the safety net for children of parents who are mentally ill can be broadened.

Our Social Policy column, which starts on page 18, outlines the CMHA, Ontario Division, response to the request by the Minister of Health for input regarding the Mental Health Reform process.

Finally, thank you to all of those who responded to our Readership Survey. The suggestions and comments made by all respondents are important to us as we strive to produce a magazine which in content and design meets your requirements and also helps to fulfill our mission to "...promote the mental health of all individuals and communities in Ontario".

THE COST OF NEGLECT

"If all of us were to be therefore the children and families in our communities whose needs are not being met, we would have many fewer children with mental health problems; many fewer children dropping out of school and/or remaining illiterate; less delinquency and violence. and lower court, policing and custody costs. We can either do what is needed to help families give their children the competence and coping skills they will need to get off to a successful start in life or we can avoid doing so, in which case we will pay later - and much more - for our short-sightedness and for the results of our, and their, failure."

PAUL D. STEINHAUER, M.D., F.R.C.P. (C), CHAIR, STEERING COMMITTEE
COALITION FOR CHILDREN, FAMILIES AND COMMUNITIES
CHAIR, SPARROW LAKE ALLIANCE, PROFESSOR OF PSYCHIATRY, UNIVERSITY OF TORONTO

The children of Ontario represent the strength and potential of the province. To raise our children we need high quality education, health and mental health systems. These three services, together with child welfare and young offenders services, provide the total safety net for children in our communities. If any one of these components falls short, it has an impact on the effectiveness of the other systems. Children's mental health is closely related to physical health, successful achievement in a school setting, responsible behaviour towards others, and decreased delinquency. Unfortunately, children's mental health has never been accorded a high priority by government and this has placed children and children's services in danger of receiving even less attention than before in the current restructuring climate. Without adequate recognition, and the resources that support children's health and mental health needs, there is a real threat that we may lose a generation of children, simply by not providing the preventative and longer-term supportive services that all children in Ontario require from birth to adulthood.

Decisions have been made by the government of Ontario (1996/97) which illustrate contradictory policy services. Services to street youth were reduced substantially by the Ministry of Community and Social Services (MCSS), even though infants of street youth are at high risk for poor pre and post natal care. Funding to maternity homes which helps teen mothers and their children was cut back by 25%. Junior kindergarten, in addition to being a vehicle through which the known benefits of early stimulation are applied, serves an early

It takes a whole village to raise a child: (AFRICAN PROVERB)

ILLUSTRATION By HEATHER BEBBINGTON, AGE 9.
Asked to convey, through a picture, the people who are important in her life, Heather has graphically shown the importance of being surrounded by a loving community

THE COST OF NEGLECT

intervention and prevention purpose for many young children, yet junior kindergarten became a discretionary program in an environment of severe financial cuts to schools. These are examples of the way in which government policies work at cross purposes to each other when there is no articulated commitment, or principle, on child well-being that is central to all government policy decisions. The Canadian Mental Health Association, Ontario Division, through the former Child Mental Health Committee has urged the Ontario government to observe the following basic principles, based on extensive analysis and research and well evaluated experience, as they restructure and reorganize the Ontario children's service system.

PRINCIPLE #1:

Children and youth should be an overriding Priority for the future of Ontario and given a central importance and priority equal to any other policy or economic area.

PRINCIPLE #2:

There must be an improved and coordinated service delivery system.

PRINCIPLE #3:

Preventive programs must start early.

PRINCIPLE #4:

Early intervention with troubled children and families is an investment.

The argument for prevention and early intervention in purely financial terms is an overwhelming one. The argument in terms of quality of life is, of course, irrefutable. A particularly critical stage in child development is the early childhood period when groundwork is laid for the full development of a person's potential. Physical, emotional, intellectual and social growth develops rapidly, and children require a variety of services and opportunities to assist in this development such as health, education, nutrition and play. A failure to invest in early childhood development can have long term social consequences; investing in early childhood programs is one of the best ways of having an impact on a wide range of social, behavioural and economic areas. What is the cost to taxpayers and society generally when we fail to adequately meet the mental health needs of today's children and youth?

1. EDUCATIONAL ATTAINMENT

Studies show that poor performance in school is strongly associated with a lifelong history of mental health problems. Drawing on Canadian data from the Standing Senate Committee on Social Affairs, Science and Technology (1991), Wright calculated the impact of different levels of educational attainment on lifetime earnings, use of income supports and contribution to the taxation base and found that there is a cost passed on to taxpayers, present and future, in terms of lost income or productivity, lost taxation and Employment Insurance premium revenues to federal and provincial governments, and increased costs to governments in the form of income support programs for each youth who does not graduate from high school as a result of unresolved mental health problems. The lifetime income/productivity loss, as compared to the high school graduate, is estimated at $350,000 per person and the associated lifetime government revenue loss and increased use of income supports is estimated at $167,000 in total.

"Too many Canadian children who are growing up in low-income families tire not getting the start they need to become healthy, happy, educated and productive adults who can contribute fully to the Canada of tomorrow. There is a growing consensus that the current child benefit system does not do all that it should for these children. ...If our plan for a strong economy is to succeed, then we must have a strong society as well. The ultimate test of a nation is its will and capacity to support those who are most vulnerable, to sustain programs on which every one of its citizens depends."
THE HONOURABLE PAUL MARTIN, P.C., MP FEBRUARY 18,1997

2. COSTS OF CRIME

Research shows a strong relationship between untreated childhood conduct disorder and antisocial personality disorder (APD) in adults. Persons with APD are disproportionately represented in the prison population. As high as 10% of the cost of crime in Ontario could be attributed to inadequate responses to the mental health needs of children and youth.

Statistics Canada shows the following breakdown of the cost of crime in Canada (federally):

- $5.3 billion in policing costs;
- 0.766 billion in court system costs
- 1.885 billion in adult corrections costs
- $0.4 billion in property loss and damage.

The total direct cost of crime to Canadians is $8.351 billion annually.

3. TIME LOST FROM WORK

Adults with mental health problems lose more days from work than do those who do not have a mental illness. The Ontario Health Survey (1990) found that 20% of the population that were identified as having a mental illness reported one or more days in the past month in which they were totally unable to work as compared to 13% of the "healthy" population. Multiplying the number of adults with mental illness in Ontario, and valuing the lost time at only the minimum wage gives a conservative estimate of $58 million annually for losses in productivity resulting from increased days lost from work due to adult mental illness in Ontario. From an economic viewpoint we can see that despite some recent new funding, the resources directed to children's services in Ontario are less now than they were in 1993. A redirection of even 10% ($25m) of the funding envelope of $248m currently assigned to children's mental health assessment and treatment services in Ontario may result in the passing on of an annualized liability to the next generation of taxpayers of, conservatively, $166 million in lost revenues and increased costs. Focusing only on the direct impact on government, the annualized savings arising from increased tax revenue and reduced social assistance resulting from all those who receive mental health treatment completing high school of $464.3 million yields a return on the taxpayers' investment of $248 million. (This is worked out on a "best case" assumption that all children treated for one year complete high school.) Even if only half the children receiving treatment complete high school, the annual direct return to the federal and Ontario governments in increased taxes and reduced social assistance of $232 million nearly offsets the annual expenditures. However, the benefits of treatment and education are not limited to the single year in which service is delivered but accrue throughout a person's lifetime. Given a forty year time frame, the one year expenditure of $248 million yields a potential benefit to the Ontario taxpayer of $9.3 billion. Children's mental health treatment helps children to manage their difficulties and reduce problem behaviour. It enables them to communicate more effectively, strengthen family and peer relationships, improve their prospects for success in school and work, and ultimately to participate productively in their communities. We know that treatment in children's mental health centres can make a significant difference to the severity of the disorders experienced by young people. Early intervention, before disorders have become severe, can help lessen the likelihood that childhood disorders will become significant and costly social problems.

In 1989 all federal political parties unanimously supported a resolution to end child poverty by the year 2000. Campaign 2000, a national movement dedicated to education and advocacy to eliminate child poverty in Canada, has tracked by means of an annual report card, how Canadian officials are keeping their promise to children. The 1997 Report Card shows a dramatic worsening of the situation since 1989.

NUMBER OF:	*INCREASE*
Poor children	*99%*
Poor two parent families	*114%*
Poor single parent families	*102%*
Children in families experiencing long-term unemployment	*136%*
Children in working poor families	*55%*
Children in families receiving social assistance	*114%*
Children in families earning less than $20,000 per year	*106%*
Poor children in unaffordable rental housing	*87%*

The only area which has decreased is the infant mortality rate by 13%

"If we are serious as a society about valuing our children and about getting them all off to the best possible start, then we must commit ourselves to making changes at many levels - in our families, our workplaces, our communities, in our mainstream services, especially in schools, in our specialized services for children and families with problems and in, and between, our various levels of government."

PAUL D. STEINHAUER, M.D.,
CHAIR, VOICES FOR CHILDREN
STEERING COMMITTEE

CHILD SEXUAL ABUSE

In 1992, the Hospital for Sick Children (HSC) began to seriously address the fact that child sexual abuse/assault victims and their families were not being adequately cared for in emergency departments. The Sexual Abuse Care (SAC) team of the Suspected Child Abuse and Neglect (SCAN) Program at the Hospital for Sick Children was developed to provide prompt, efficient, empathic and effective care for the sexually abused/assaulted child and their family in the emergency department. The SAC team is comprised of 15 pediatric nurses who provide care to children/adolescents and their families who have recently experienced sexual abuse/assault.

The goal of the SAC team is to provide 24-hour seven-day-a-week coverage to the emergency department. The SAC team was developed to decrease the length of stay in the emergency department, provide continuity of care, enhance accountability and quality control and improve educational opportunities for nurses, residents and medical students. The pediatric nurses on the SAC team work with emergency room staff, the police department and the Children's Aid Society to ensure continuity of care for the sexually abused/assaulted child and their family. The SAC team has functioned in an extended role for over four years and is presently working towards formalizing status at HSC and eventually within the community through the development of the Sexual Assault Nurse Examiner (SANE) role. In February 1992, the Ontario Ministry of Health recognized that registered nurses within the area of sexual assault were very interested in broadening their scope of practice to include those components of care which had traditionally been considered the responsibility of the physician. Forensic evidence collection, documentation of the assault, provision of prophylactic medication and testifying in court are all responsibilities that have been adopted by the newly developed Sexual Assault Nurse Examiner (SANE Training Manual, 1995). Since the team's inception in 1992, the SAC nurses have cared for over 400 children and their families in the emergency department. Many child sexual abuse victims and their families require extensive psychosocial support provided by the SAC nurse. The SAC nurse plays an instrumental role in coordinating services for the child and their family in the emergency department between police and the Children's Aid Society therefore enhancing continuity of care. As an autonomous practitioner in the emergency department the SAC nurse is supported by the Hospital for Sick Children emergency staff and the Suspected Child Abuse and Neglect physicians. Within the area of child sexual abuse, the role of the registered nurse is vital, especially in prevention, identification and intervention.

A disclosure of sexual abuse in a child can be one of the most distressing circumstances for parents and families Often the first reaction following a disclosure of sexual abuse is to bring the child to the emergency department to ensure the child's well-being and for the family to gain support from health care professionals. Many emergency departments, however, tire not staffed to adequately deal with child sexual abuse/assault victims and their families because of the extensive counselling and interventions that are required.

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Canadian Incidence Study of Child Abuse and Neglect

A $489,878 grant has been awarded to social work professor Nico Trocme of the University of Toronto to conduct research that will give the Child Maltreatment division of the federal health department the data they need to move toward a national strategy to combat child abuse and neglect. The data to be collected through a survey of 5,000 to 9,000 cases includes the type of maltreatment involved, the response of Children's Aid, and whether the allegations go to court. Researchers will also look at whether there is a history of abuse, the parents' history, whether the family has access to support systems and programs, and whether substance abuse is involved.

FACTS AND FIGURES

What are the effects of stress in families on children/youth growing up in Ontario? How are they doing when it comes to mental health? School achievement? The control of aggression?

12% of adults with elementary schooling and 16% of adults in Canada lack the competence and/or reading skills necessary to face the demands of everyday life.

I. Children's Mental Health

- Over 18% of Ontario's children and adolescents (i.e. almost 1 in 5) has one diagnosable psychiatric disorder. Of that 18%, 2/3 have 2 or more disorders, and only 1 in 6 have received any service in 6 months.
- 25% of our youth (between the ages of 15 - 25) have a mental disorder.
- The suicide rate for adolescent males is 4 times what it was 30 years ago, and has doubled in 10 - 14 year old boys. Canada is now third in the world for youth suicides.

2. School Achievement

- Statistics Canada estimates the corrected national drop-out rate (i.e. corrected by subtracting those who transfer or drop back in) to be 18%.
- A high-risk background, such as poverty, doubles the risk of premature drop-out.
- Of those who do drop out, 32% had not gone beyond Grade 9 and 40% were 16 or younger when they dropped out.
- 12% of adults with elementary schooling and 16% of adults in Canada lack the competence and/or reading skills necessary to face the demands of everyday life.

3. Delinquency and Violence

- School violence and other violent crime by youth continues to rise and the cost of correctional services for youth has increased by 37% in the past four years. (Globe & Mail. November 24,1994).
- The earlier a child begins to show violent or antisocial behaviour, the more severe and permanent that problem is likely to become. Most violent teenagers and adult males were aggressive as young boys.
- A 1991 Ontario study showed that 22% of a community sample of 3-year-olds were unable to control their aggression; a 3x increase in the rate found in 1970.
- Marked increases in reported rates of spousal and child abuse. Growing up in chronically conflicted and/or violent or abusive families, or a disadvantaged area, increases the risk of the child entering a developmental trajectory which leads from conduct disorder (child) to delinquency and violence (adolescent) to psychiatric and/or antisocial disorder (adult).
- Violence by 12-year-olds is UP 30% and by 13-year-olds up by 25% over the last year.

The Cost of Neglect

"The scale and complexity of our family problems requires nothing less that a massive commitment to children all levels of government. It will require a wrenching adjustment of personal priorities. Elaborate family supports will do little to advance children's well-being if parents elect to spend little or no time with kids. Only a massive infusion of political energy will prevent the tide of abuse and neglect rolling over another generation of children."

SYLVIA ANNE HEWLETT

WHEN THE BOUGH BREAKS: THE COST OF NEGLECTING OUR CHILDREN

DYING TO BE THIN

The shape and size of their bodies is an obsession for many women. According to Statistics Canada, more than one-third of Canadian women whose weights are within a healthy range believe themselves to be overweight. The obsession with body image can affect women of any age, but the number of young women it harms statistically outweighs other ages; eating disorders af f ect one in nine women in Canada, most of them between the ages of 14 and 25. Body image is a complex issue. “Part of growing up in this culture as a female is you learn to feel bad about your body,” says Carla Rice, a body image consultant at the Regional Women’s Health Centre at Women’s College Hospital in Toronto. “It doesn’t matter what the beauty ideal is, you learn your lack of value - or your value - lies in how you look.” Teens are especially vulnerable to the social messages that skinny is beautiful. Parents have an important role to play in preventing eating disorders in their daughters. Ann Kerr, coordinator of group therapy for Toronto Hospital’s Eating Disorder Programme and assistant professor in the University of Toronto’s psychiatry department, as well as Program Director for Sheena’s Place, encourages parents to raise anti-diet kids who are as adamant about not dieting as they are about not smoking. “I’d like to see the days kids say, ‘You gotta be kidding. Me, diet? I like myself just as I am,’” says Kerr.

How do parents cope with all of the many terrible aspects of having a child who is either anorexic or bulimic? Diane* is the mother of three children, the eldest of whom has an eating disorder, and she shares what it is like for a parent to have to struggle with this.

Diane, how and when did it first become apparent that your daughter had an eating disorder?

Jenna has always been a high-strung kid, a very high achiever, and I guess some of her characteristics made me concerned that she might develop an eating disorder. She was three when our second child, a son, was born and she started having problems with food at that point. She always wanted to be the person who was served first, and she had to have the biggest portion. It didn't matter where we went she had to be served first. From about seven years of age she tended to be on the higher side of average as far as her weight was concerned, and as she entered puberty she was more overweight, but we always tried to play down food issues in the home, but of course it came up. For instance at that time she was attending an arts school and there were several things that dealt with body image which was not the greatest thing for her. For instance wearing a leotard and dancing was not something she was really comfortable with. She transferred to another school where she really thrived in terms of intellectual stimulation, but she did have more freedom there, which resulted in her gaining weight because she could go out during the school day and buy food. When she was about 12 and a half she decided to become a vegetarian, which for her was a way to start limiting her food intake. She lost a bit of weight and was closer to a normal body weight for her height and age, but of course with today's standards of what average is, that just wasn't enough. We thought she looked fabulous but she still did not feel comfortable about herself so she started restricting her food intake even more.

How old was she at this stage?

About 13. We decided at this point that things were just not right and we took her to see a psychiatrist who works at Sick Kids in the eating disorder clinic. She was miserable and in denial and still didn't appear anorexic to look at. The doctor referred us to a pediatrician who deals with teenagers and we started going to her on a regular basis. Then Jenna started losing a lot of weight and we could see it was getting more and more out of hand. She went to summer camp because we wanted to keep her life as normal as possible, but she barely ate while she was away. She was booked to go to music camp but at that point the doctor told her that she could not lose any more weight and if she went to camp she would have to send a note saying that Jenna had to be weighed every day. Two days into the camp she called and said she couldn't handle it and could we come and get her. We picked her up and she was just so emotionally distraught we took her straight to the emergency at Sick Kids. it turned out that she was vomiting a couple of days a week, which then turned into a daily habit. She tried running away from home at one point. She's been caught for shoplifting, she's stolen money from us to buy food, it's a terrible thing. At one point she was going and buying tons and tons of food and squirelling it away in her room.

"She tried running away from home at one point. She's been caught for shoplifting, she's stolen money from us to buy food, it's a terrible thing. At one point she was going and buying tons and tons of food and squirelling it away in her room."

What kind of food was she buying?

All kinds of things, on sale items, pies, cakes, donuts, pastries, lots of ice cream, she'd have litres of ice cream melting in her room. She didn't really hide it, she'd leave the wrappers and cartons around in her room. So we worked on that first. I wanted to keep things open between us so I set up a space in the kitchen where she could have her food and we made an agreement that I would get some stuff in for her.

What are the dynamics of this on the rest of your family?

Well it's really difficult. I have a 13 year old boy and 10 year old girl, and Jenna takes a lot of attention. She's been really hard on them, they've had to take verbal abuse, they've had to put up with her stealing their Halloween Candy. It's not easy.

What does this do to the relationship between you and your husband?

I think our relationship is pretty strong. My husband is really good, I can yell at him and be really rough on him and he absorbs it! Jenna was really horrible to him and really tried to split us up. If she saw us hug-

DYING TO BE THIN

ging it would really bother her, so she would tell me things to try and alienate me from him, while telling me that I'm wonderful. She'd try to get me on her side, so we've really had to watch that. There is tension.

What about friendships? Does your daughter have close friends?

When she transferred to her second school she had some really close friends, the kind of friends you want your daughter to have. But she always wanted to be part of the popular crowd, so she started being friendly with the kids who are more socially active and that's when she started losing weight.

Does she have long term goals. university, a career?

Yes, she's never lost sight of those kinds of things. She's in her last year of high school, she'll probably end up staying at the University of Toronto. Her psychiatrist feels that it's important for her to move out of our house and live on campus, share an apartment with friends, that kind of thing.

Is that a frightening thought for you, that shell be dealing with this without your day to day help?

Well, we trust the psychiatrist and Jenna is definitely the kind of person who's got to do it herself.

Does Jenna took anorexic?

If you saw her on the street you wouldn't look at her and think she was a kid with an eating disorder. Maybe her face would be a bit puffy from the vomiting, but you couldn't really tell. The sad part is that since she's had the eating disorder some of our friends who know this have come up to her and said "Jenna, you look fantastic"and I'm ready to kill them!

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Can you do normal family things together? For instance, what happens if you want to go out as a family to a restaurant to celebrate an important event? What happens on birthdays, occasions like that?

If we go out to a restaurant, Jenna will eat lettuce with balsamic vinegar on it and that's it. I did once get her to eat some pasta, but we don't push it because we just end up with these battles at the table and it makes everyone uncomfortable and nothing is accomplished. Of course it still makes people uncomfortable when we're out, for

In November of 1994 Sheena Carpenter lost her battle with anorexia. Her dream was to be a model and at 14 she went to a modeling agency and was told that she would be more photogenic if she had a thinner face. Her mother Lynn said that's when it started. It ended in November when Sheena was 22 with a body that she had starved down to 50 pounds. Sheena Carpenter was one of the unfortunate 15% of those who do not survive their eating disorder. In response to her death from heart complications related to her eight year struggle with anorexia nervosa, friends and colleagues of Sheena's mother Lyn, were motivated to create a place that would offer help to people like Sheena. Sheena's Place has developed programs to encompass families, peers, educators and other care providers at no cost to users. They enlist professionals on a fee-for-service basis, who provide counselling or therapeutic support to those identified as having eating disorders, and their families.

instance the last time the waiter didn't bring the lettuce fast enough for her and they didn't have the right kind of vinegar so everyone had to sit there while she got hysterical about it. On her birthday I wanted to bake her a cake but I thought she'll either be angry with me, or she'll eat it and then feel guilty so she'll go and vomit and then I'll feel awful. There's a no-fat frozen seaweed dessert that she'll eat, so I got that and she was happy.

Are other family members supportive?

Some members of my family have been extremely supportive. My husband's family tries to avoid any kind of discussion. Jenna doesn't get on with them, if they come to the house she won't even come down and say hello. My husband's sister totally avoids the subject, and I get the feeling that her husband thinks that this is an illness that he doesn't want his family subjected to. My husband's parents also try to avoid talking about it. We've tried to confront them and tell them how bad it is, to try and get them to realize what's going on, but they don't really want to know. Jenna doesn't usually come to family things but if she does it's always stressful and there's always an outburst. Jenna feels that my mother is partly the cause of what has happened to her. My mother is very obsessed with body image and there were always food issues in my house when I was growing up. You were never supposed to eat normally, you were always supposed to diet. When we used to visit my mother when Jenna was younger she would always feel uncomfortable about her body. Mother would just sort of look at her and make comments, or pat her to feel how much fat there was on her body - she still does that. With my mother weight is a constant issue whenever you have a conversation with her. Everyone is described in terms of size, it's always a "little person" or a "big person". I think my older sister probably had an eating disorder which nobody acknowledged because it just wasn't talked about in the same way then. I always had to limit what I ate just to try and keep my weight down to what my mother approved of. I don't think that I was the same way as Jenna is, it wasn't an obsession with me, it was more the fact that if I gained weight my mother was not happy with me.

Do you think Jenna is happy with herself?

Off and on. I don't think she's totally happy. She's a really successful kid - the kind of kid that whatever she does, she does really well. She's incredibly talented at art, she's a terrific writer, she plays the cello and could be outstanding at that. We've always supported her, always told her how great she was, we never told her she had to do better or withheld praise. This summer she worked for a publishing company, she was just 16 and working for a woman who was very demanding, and this woman said she's going to be okay. She's got a job with them again for this summer. She picks things up really quickly and she's good with people when she wants to be. When she doesn't she can be really horrible!

My mother is very obsessed with body image and there were always food issues in my house when I was growing up. You were never supposed to eat normally, you were always supposed to diet. When we used to visit my mother when Jenna was younger she would always feel uncomfortable about her body.

It must be heartbreaking to see your daughter, who you know is an intelligent person with so much going for her, being so self destructive.

Yes, it is horrible. And if I try and explain to her how this affects the rest of the family, the fact that she may have eaten all the food that was there for everyone, she doesn't see it, she feels that she's entitled because she's got this disease and she should be able to do whatever she wants. It doesn't matter how other people suffer because they are not suffering as much as her. It's so hard to see this child that you have so much hope for, who has so many abilities, being so self-destructive. Sometimes I can't see any resolution, just small steps forward. It's heartbreaking for me to think that she might always have to battle with this.

***Diane is currently attending a counselling group at Sheena's Place and Jenna continues to meet regularly with her psychiatrist**. (*The names have been changed in this article to protect the privacy of there family.)*

PARENTING AND MENTAL ILLNESS

The spotlight that the media focused on the inquests that took place in 1997 has reinforced in the mind of the general public the concerns that children of parents with a mental illness may be falling through the cracks. Alice Broughton, a social worker at Queen Street Mental Health Centre has long been interested in this whole issue of parenting and mental illness, and has been actively involved in pulling together a group of people from all of the Metro Children's Aid Societies to address the problems. Jane Paterson, Chief Social Worker in the Schizophrenia Division at the Clarke, has been a member of this group since January 1997 and she explains some of the problems and the goals they are hoping to achieve.

There is a recognition in the literature, explains Jane Paterson, that people who have a mental illness and are parenting have needs that are missed. They fall between the cracks. People come into the hospital because their mental status has deteriorated, but the fact that they are parents doesn't always get addressed. Child Welfare has seen swelling numbers of cases of people with mental illnesses who are parenting, and of course we are all aware of the inquests this year that gained so much media attention. In 1996, the Social Work Department at the Clarke site of the Addictions & Mental Health Services Corporation was involved in formally training CAS workers. What became apparent was that child welfare workers were out there on their own, having to case manage people without any formal access to the whole mental health system to get them the services they needed. Because Alice Broughton of Queen Street Mental Health Centre was interested in this whole issue of parenting and mental illness, she brought together a group of people from all of the Metro Children's Aid Societies: the Catholic Children's Aid,

Metro Children's Aid, Jewish Family and Child Services, Native Child Welfare Agency, along with people from the Clarke Institute, Queen Street Mental Health Centre, Toronto General Hospital and a private psychiatrist. The goal of this group is to build some links and somehow help the child welfare agencies to have access to the formal mental health system and to partner up in a more formalized way. A proposal to develop a family case management team has now been put together.This team would be comprised of people from the mental health system and the child welfare system. They would work together managing these cases and helping people to link up to the formal services they need to help them manage their mental illness.

One of the examples of the type of services available is a women's program which is attached to the schizophrenia Division at the Clarke. Since the advent of that program they have, in many ways, begun to do some of the things that have been put together through this proposal. The literature tells us that the children of people with schizophrenia are at high risk. They can often demonstrate behavioural problems for instance. This doesn't mean that someone who has a diagnosis of schizophrenia is necessarily going to have parenting skills that will be compromised, it depends on the degree to which they are impaired. Other factors that must be taken into account are the presence of some other stable forces in the child's life, such as a well parent, or grandparents, or someone who can interpret for the child what is going on. There is no doubt though that if their parents are mentally ill, then the child will be at risk for all kinds of problems including social isolation. We know that people who are mentally ill do become more isolated over time, and this is what happens to their children too. They stop bringing friends home and start to develop behavioural problems. The support has to be widened, and services for these children put in place so they can try and ward off the problems that they are at high risk for. So often CAS workers are called upon to monitor mental status when that isn't necessarily their training. They are not psychiatric workers, case managers, in that sense. This concern has been addressed through our proposal that CAS workers team up with a psychiatric worker who will help them to recognize the signs and symptoms of mental illness and how that affects parenting skills. There is a great deal of sympathy on the part of the mental health workers for the CAS workers who are called upon to do such enormous tasks. As CAS and psychiatric workers team up both will be able to learn from one another.

Jane Paterson believes that one of the exciting things about the group is the amount of goodwill around the table. "I believe that the links that we want to see made are already happening. For instance here in our in-patient unit one of the children's aid workers who is part of the group has come to talk to our nursing staff about supervised visits and access, so I think it's been a really good collaboration. There's a real desire to augment the services that the CAS workers have." Jane goes on to say that she thinks that psychiatric rehabilitation principles have a lot to offer some of these parents because people often have profound deficits as a result of their illness. "We need to determine what supports can be put in place, and how we can help them to augment their parenting abilities." The child welfare system is also concerned that they speed up their processes so that children don't remain in foster care for lengthy periods. There is also the issue of how someone with a psychiatric illness can stimulate their child. Meeting these kinds of challenges, working together as a team to broaden the safety net and look at someone as a whole person, is the essence of what this group is trying to develop.

If they have children what is going to happen to them? Are there care arrangements in place? Is there someone who is a stabilizing force for their children and will the children get appropriate information about their parent's illness? These questions often get overlooked when someone is admitted into a psychiatric ward.

Jane Paterson
CHIEF SOCIAL WORKER
CENTRE 1; FOR ADDICTION
AND MENTAL HEAL TH,
SCHIZOPHRENIA DIVISION
CLARKE SITE

Mental Health Reform

The Canadian Mental Health Association (CMHA), Ontario Division, has long been involved in the provision of community-based services for persons with mental illness and has been an active participant in the present Mental Health Reform process since its inception. In late January, 1998, the Minister of Health announced a five week review of the Mental Health Reform process to date, and requested input from stakeholders. Overall we are concerned that adequate community services and supports for persons with mental illness be in place as the mental health system in Ontario is restructured and institutions are downsized. To this end, we strongly urge the Ministry of Health to immediately provide transitional funding so that existing community services can be expanded and new ones developed prior to further bed closures. The need for a common information system for all health care providers in all settings as a precondition to successful reform of the health care system cannot be stressed enough. Such a system will enable service providers to more readily exchange information, increasing continuity of care, and will permit assessment of needs and outcomes. The CMHA, Ontario Division continues to advocate for the development of Integrated Delivery Systems across Ontario. Such systems would ensure that an accessible, client-centred continuum of care was available, which will provide services based on the assessed needs of the population. Time limited mental health agencies should also be created, so as to integrate the mental health system and ensure that there is no further erosion of the mental health funding envelope. Once Integrated Delivery Systems arc in place, the mental health agencies could themselves become part of the larger system. We believe that the Ministry of Health should adjust its role to that of creating overall policy and fiscal management, leaving general management of health care to Integrated Delivery Systems (and mental health agencies as long as they exist).

Regional Ministry of Health offices, if they are developed, should not duplicate the functions of Integrated Delivery Systems. Provision of a full continuum of health services through Integrated Delivery Systems will necessitate a consideration of all of the determinants of health, including housing, employment, income maintenance and education. The CMHA, Ontario Division urges the Ministry of Health to continue to work with other provincial Ministries to ensure that a full continuum of services is provided. Mental health promotion and prevention activities must increase, and must encompass all of the determinants of health. Public education about mental illness and the stigma and fear surrounding it are of paramount importance. The primary recommendations made by the CMHA, Ontario Division concerning the Mental Health Reform process are as follows.

RECOMMENDATIONS.

1. Integrated Delivery Systems, providing a continuum of care encompassing all of the determinants of health, should be developed across Ontario. In these systems, services should be provided to a rostered population based on assessed need, and service providers compensated on a capitation funding basis.
2. Immediate transitional funding to both increase existing and develop new community mental health services is necessary while institutions remain open. This will allow the creation and development of community services for persons discharged from institutions which are to be closed.
3. Time-limited mental health agencies should be developed across the province, so as to permit the integration of mental health services and preservation of the mental health funding envelope. After a set period of time, the agencies would become a part of the larger Integrated Delivery System.
4. The Ministry of Health should continue in its efforts to become more of a “policy” Ministry, and

emphasis should be placed on the development of standards for health services evaluation and outcome measurement. Regional Ministry of Health offices should not duplicate the intended functions of Integrated Delivery Systems.

5. The Health Services Restructuring Commission (HSRC) should expedite its work in reviewing community services, defining what is meant by "community services", so that the Ministry of Health "implementation teams" which are to implement the HSRC's recommendations have a basis from which to work, and resources which are to be reallocated are not lost to the system.

6. A human resources/labour strategy for those workers displaced by institutional closures must be developed immediately. This strategy should include (re)training of staff for positions in the community.

7. Information systems which will permit the exchange of healthcare information between all health care providers in all settings must be developed immediately, so that needs can be assessed and outcomes measured as restructuring of the health care system occurs.

8. Integrated Delivery Systems could contribute greatly to an increased emphasis on determinants of health and a "wellness" approach to health care. All provincial Ministries must work together to ensure a full continuum of care.

9. Mental health promotion and prevention activities could both decrease the need for institutional care and stigma, and increase public awareness about mental health.

10. The Ministry of Health should continue studies regarding the need for forensic beds in Ontario, as well as the development of interministerial protocols and service agreements for forensic clients. The Mental Health Act should not be amended, as, with appropriate application of existing legislation and improved community services and supports, such amendments would not be necessary.

11. An integrated and co-ordinated service system for children's mental health is necessary; early intervention is of paramount importance.

12. The mental health, long-term and chronic care sectors should continue to work together to plan and develop services for older persons with mental health needs.

13. Specialized, multi-disciplinary community treatment services should be developed for persons with mental illness and substance abuse concerns.

14. Individualized and flexible supports should be provided in the community for persons who are homeless: staff serving this population should be trained in the provision of outreach skills.

The CMHA believes that the key factors in any changes to the mental health system in Ontario should take into account the following:

• that at least $0.350 billion in transitional funding is required immediately so that community supports and services can be put in place prior to any further institutional downsizing;

• that, whatever the governance system used f or the health system in general and the mental health system in particular, there must be an underlying vision and principles used to develop province-wide policies for both systems;

• that the Mental Health Act should not be amended to include provisions providing for compulsory community treatment of persons with mental illness.

May 4 - 10

National Mental Health Week Make Mental Health Matter. Contact your local Branch for activities and events in your area.

June 4 - 6

Canadian Mental Health Association, Ontario Division Conference and Annual General Meeting. Holiday Inn Yorkdale, Toronto, Ontario. For more information call Susan Macartney at (416) 977-5580, Ext. 35.

June 11 - 13

Watch, Wait and Wonder: Advanced Training Workshop for Parent-Infant Intervention. (Previous attendance in the Introductory Workshop and/or experience using the infant child-led approach is required.) For more information contact: Edythe Nerlich, C.M. Hincks Institute (416) 972-1935 ext. 3341.

June 25 - 26

Together for Healthy Kids. Prevention Congress VIII of The Ontario Prevention Clearinghouse. Presented jointly with The Canadian Pediatric Society at The Convention Centre in Hamilton, Ontario Division. For more information call: (416) 408-2121.

July 12 - 16

39th Annual Institute on Addiction Studies, Kempenfelt Conference Centre, Barrie. For more information contact Concerns Canada (416) 293-3400 or fax 293-1142.

NETWORK READERSHIP SURVEY RESULTS

The Canadian Mental Health Association, Ontario Division, would like to express their thanks to everyone who responded to our Readership Survey. All of the responses are now being studied to determine how we can make Network even more valuable to you our readers. It was certainly encouraging to find that 73% of those who responded already consider Network to be a valuable/informative mental health document which they are able to use as a reference tool. The suggestions and comments made by all respondents are important to us as we strive to produce a magazine which in content and design meets the requirements of our readership and also helps to fulfill through our editorial, our mission of "...promoting the mental health of all individuals and communities in Ontario".

The growth, development, safety and well-being

CANADIAN MENTAL HEALTH ASSOCIATION, ONTARIO DIVISION

ANNUAL GENERAL MEETING AND CONFERENCE

Approaching the Next Millenium: New Frontiers in Mental Health

The Conference will take place at the Holiday Inn Yorkdale, Toronto, on June 4 and 5 with the Annual General Meeting following on June 6

KEYNOTE ADDRESS:

The Future of Community Care

PANEL DISCUSSION ON COMMUNITY CARE:

Perspectives and Trends

CONCURRENT WORKSHOPS:

Skill Development and Training for Emerging Needs, Issues and Challenges

PLENARY SPEAKER:

Judith Wright, Ministry of Health, will be reviewing the current status of mental health reform, specifically with respect to the results of the five week review and recent budget announcements.

PRESENTATION AND DISCUSSION WITH AUDIENCE:

Achieving our Vision for the Next Millenium.

INFORMAL GROUP DISCUSSIONS.

For more information call

SUSAN MACARTNEY: (416) 977-5580 EXT. 35.

CHILDREN - OUR FIRST PRIORITY

The following principles are taken from the October 1996 Statement of Concern. This document was developed by the Child Mental Health Committee of the Canadian Mental Health Association, Ontario Division.

of all children and youth is important for the well being of society as a whole. Fortunately, most children are cared for in a manner which helps them prepare for productive lives and good citizenship. There are however, an unfortunate number who get off to a poor start in life and then suffer various obstacles which makes it difficult for them to realize happy and productive lives. We believe it is important for all of us to be mindful of our individual opportunity and responsibility to contribute to children's health development. We also recognize that some children and families will require the services and supports and professional service providers that only governments can provide. Governments have an essential role to play, both in policy and in funding of those children who arc "at risk". The following are the principles which the Child Mental Health Committee of the Canadian Mental Health Association (CMHA), Ontario Division, feels are essential for the preservation and development of healthy children.

Prevention/ Intervention:

We believe in a proactive and population-wide approach that emphasizes early prevention and early long term intervention for those children and families who need it. By strengthening protective factors and improving the health, socialization, competence and resilience of growing children, we would be making a powerful investment in all of our futures.

A Healthy Environment:

We believe that the children of Ontario have the right to safe and nurturing environments, self determination and a health/mental care system that strives for excellence.

Interdependence /independence:

We believe that children, families and communities are mutually interdependent as well as independent of each other and that this will guide our research, advocacy, policy development, public education and communication.

Capacity, Resilience and Strength:

We believe that through organizational and governmental collaboration, co-ordination and integration, children and their families should, and can, be provided with effective and timely assistance and support when needed.

Children are our first priority. The primary, overriding principle to be applied in all policy development, planning and decision making, legislative and judicial processes is the well-being and best interest Of the child.

Provision of Resources:

We believe that high-quality, child-centred, flexible, accessible services and social programs will promote and maintain healthy development and good physical and emotional well-being for all children and their families.

Research Links to Policy and Accountability:

We believe that research into what works and is most cost effective is necessary to provide the foundation for rational, accountable planning and decision-making. Ways must be found to support making accessible such information through the sponsorship of relevant research projects and making known what work has already been done.