YOUTH MENTAL HEALTH

Supporting The Supporter:
Knowledge For Front Line Youth Workers & Community Stakeholders

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Objectives & Goals

The objective of this knowledge transfer is to increase the capacity of front line youth workers and community stakeholders in providing necessary mental health interventions with young people and brokering essential services for ongoing support. Emphasis of this training is placed on areas of knowledge and skill regarding youth mental health, community service knowledge and referral expertise. While short term goals are the emphasis within this learning opportunity, medium and longer terms are documented below. This information can be shared with participants to better inform the deliverables and hopeful outcomes of the day.

Short Term goals:

- Enhance knowledge of youth mental health challenges inclusive of signs & symptoms and problem-solving techniques;
- Increase understanding of the impacts of youth mental health within the youth's ecology;
- Enhance knowledge of therapeutic interventions inclusive of their necessity for expertise in both skill and delivery;
- Increase abilities in critical analysis and self-reflection related to bias, knowledge of self and service barriers of front line youth workers and community stakeholders;
- Front line youth workers will experience an increase in confidence to administer interventions and service brokerage surrounding youth mental health.

Mid Term goals:

- Increased capacity of frontline youth workers and community stakeholders to engage in self-reflection related to roles and responsibilities of interventionists;
- Broaden understanding of case management and its importance in effective service brokerage.

Long term goals:

Youth and families experience increased mental health wellness through the provision of effective mental health services;

Front line youth workers and community stakeholders collaborate and coordinate effective service delivery for youth and families.

Welcome & Introductions

As much as possible, start this knowledge transfer within 10 minutes of the posted start time. It is critical to show consideration for the participants who arrived on time and starting late interferes with the integrity of the material and learning opportunities for participants.

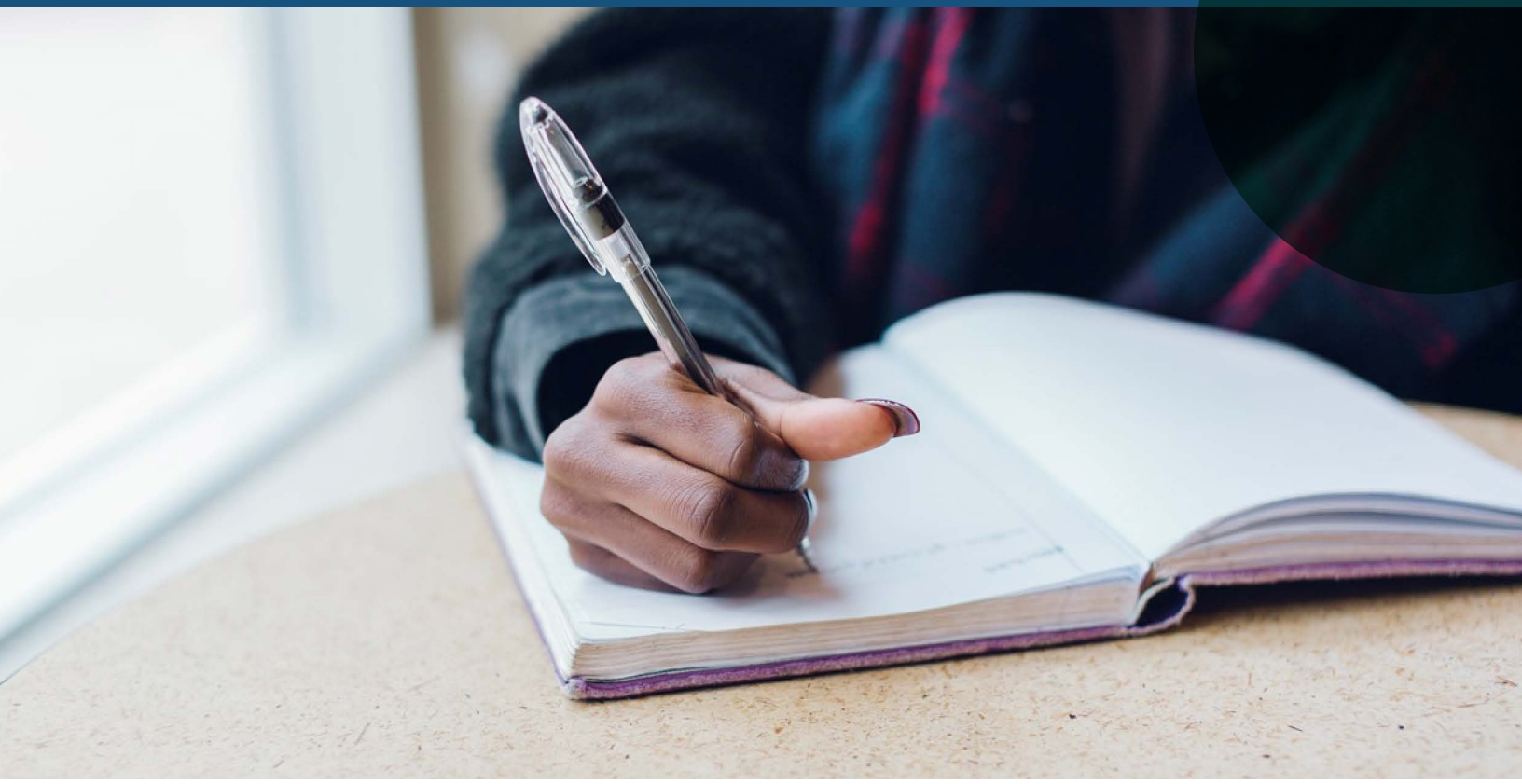
Each facilitator should provide an introduction to themselves including name, pronouns and experience in the area of front line youth mental health work and employment/volunteer experience relevant to the materials provided in this curriculum. It is helpful if facilitators share their interest in the work inclusive of knowledge transfer facilitation.

Project History and Background

It is very important to provide information relevant to how this knowledge transfer opportunity came to be. This includes interest in the work, funder information, knowledge gathering activities and participating consultants and their roles. Find relevant information documented below as well as noted in the corresponding power point presentation.

In 2017, Agincourt Community Services Association 'ACSA' responded to a call for proposals from the City of Toronto to investigate the needs of front line youth workers and create corresponding curriculum to create increased learning opportunities in areas of youth mental health.

ACSA collaborated with the Students Commission in the summer of 2018 and completed 8 focus groups with a total of 56 young people in Scarborough who identified with experiencing mental health challenges and/or receiving support for those challenges, 8 interviews with parent/caregivers of young people who have been identified with mental health challenges and required support, 1 focus group with frontline youth workers and completed an online survey with 37 front line youth workers and 7 managers/supervisors of front line youth workers. It was very important for ACSA to include various voices throughout the data collection process in order to engage in robust learnings of the successes, gaps and



barriers to knowledge of youth mental health and create productive, engaging options to in-crease confidence, knowledge and support positive outcomes.

Share with participants the format for the day- this is a full-day training making up approximately 7 hours with two 15 minute breaks and one lunch break with negotiated timing based on the needs of the group. Share that this negotiation will be discussed after the first 15-minute break in order to prepare for the rest of the day.

Throughout this curriculum you will see centred points noted as Variables of Success. These points are mentions to facilitators as points to consider. They are not designed to be articulated to participants but things to remember and possibly incorporate into the learn-ing. Some points are activities and are meant to enhance the learning of participants and support growth facilitators.

Variable to Success: As adult learners, facilitators do not necessarily have to engage in a ‘group agreement’ exercise in order to set the 'rules' of the day. Another option is for facilitators to share their expectations/needs for the day i.e.: confidentiality, silenced cellphones, waiting until outside to answer calls, participant 'thumbs up' when they exit room, etc. Ask participants if they need anything else and incorporate this into the 'agreement.' Also, don't forget to mention location of fire exits and bathrooms!

Warm Up Exercises

Often associated with icebreakers, warm-up exercises can be utilized to achieve varying goals. Mainly, exercises bring a sense of familiarity to the facilitators and the participants as both parties/groups should participate. Given the emotionally and mentally challenging nature of some content of this knowledge transfer, exercises can also be used as grounding activities to familiarize ourselves with our own histories and experiences in the topics.

Variable of Success: Please consider not every person enjoys and/or engages well in warm up exercises. Such activities can create or increase feelings of vulnerability or frustration. Some adult learners attend knowledge transfer events with the intention of having limited to no participation at all.

Below, are options for warm up exercises, it is up to the facilitation teams to identify which exercise will fit the spatial and group needs best. Warm up exercises are best utilized after the background to the project, inclusive of facilitator bios, format of the day and any questions have been answered.

1.Skills & Thrills:

This exercise does not require any materials. It is an opportunity to hear from participants individually on two specific areas, 1) Their best skill in working frontline with young people and families and 2) What keeps them engaged in front line youth work/what brings them the most thrill? Have participants begin by providing their names and pronouns.

This is an opportunity for participants to identify their abilities and reflect on what they find enjoyable in the area of frontline youth work. This is a strengths perspective exercise.

Facilitators should be able to make a connection between the similarities of skills and thrills amongst participants and call this to attention. Facilitators are also responsible for the positive reinforcements that should occur throughout and after this exercise which unites the group in their dedication to the sector - this is known as compassion satisfaction and will be briefly discussed at the end of the day.

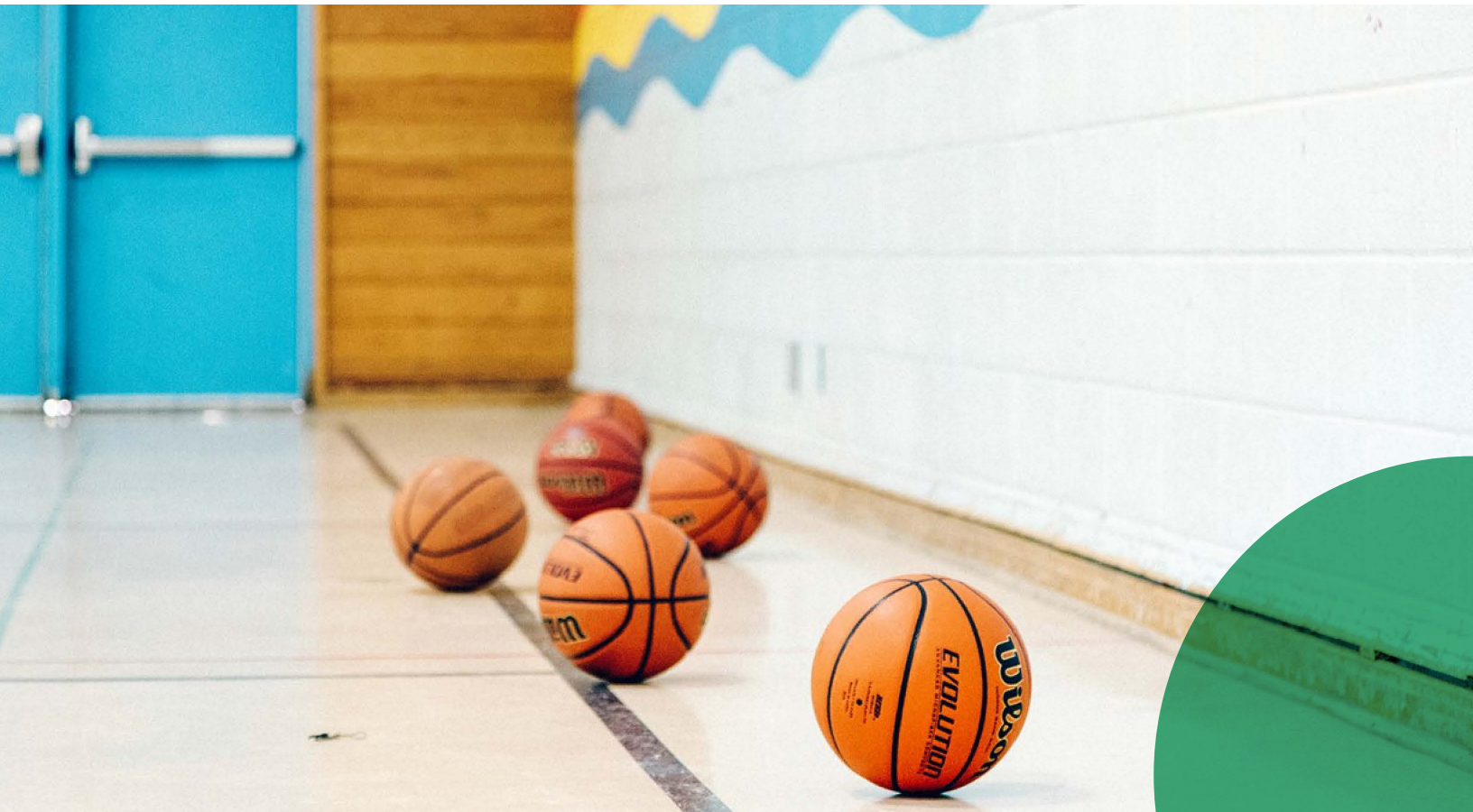
2.One Word Says it All:

Materials: Large flip chart paper, markers

Identify a group participant as the 'writer', have them stand at the flip chart with a marker OR allow time as participants enter in the morning and/or allow for 5 minutes at the beginning of this activity for participants to choose a marker and write their own words.

Instruct participants to choose one word that best describes Youth Mental Health. Do not prompt, instead instruct them to identify their word based on their lived and professional experiences. Words can be positive and negative in nature. There are no rules, besides only writing one word.

Once all words are on the paper, you can ask each participant to read a word that is not their own, aloud OR a facilitator can read the words aloud.



Examples of key messages are:

- How we understand and perceive youth mental health is linked to our successes and challenges in the sector;
- The area of mental health work in our sector can be exhausting and feel defeating at times;
- Our relationships with clients, communities and sector partners are linked to how we feel about our work in youth mental health.

Variable of Success #1:

This exercise does not prompt for participants to provide their names and pronouns. If choosing this exercise, please ensure facilitators build in the opportunity to share this information; this can be done when asking for participant feedback or within the first half of the knowledge transfer as participants have comments or questions.

Variable of Success #2:

When identifying participant's names, it can be helpful for the facilitators to draw out the seating set up and document participant names/pronouns based on where they are seated- this can help when recalling participant identifiers as needed.

Variable of Success #3:

Exercise #2 can be combined with both exercise #1 and #3 for a combined engagement tool and both can be facilitated comfortably within approximately 20-30 minutes.

ABC's of Me

Materials: Card stock or laminated, coloured paper; Markers; 1 paper for each letter of the alphabet.

As participants enter into the room OR as instructions are being provided, ensure each participant is given one piece of paper with a corresponding letter on it. Ensure papers are NOT in order when given them out. Participants should not be informed prior to the exercise what the letters are for.

Have participants work together and line up in the order of the alphabet as per their cards. This exercise requires some communication amongst participants and it becomes increasingly engaging when there are less than 26 participants, therefore not all letters are accounted for.

Once participants are lined up accordingly, have each participant identify themselves with their name, pronouns and mention a personal characteristic and/or an activity they enjoy that corresponds to the letter they have been given.

This activity can increase participants engagement in the content and amongst themselves as individuals may struggle with a characteristic or activity that corresponds correctly, which is increasingly difficult with some letters such as Z or Q (for example).

Youth Mental Health Challenges:

Let participants know this section will provide an oversight of dominant youth mental health challenges inclusive of signs and symptoms and risk and protective factors. In order to increase connections to learning materials, we will provide qualitative feedback from the Youth and Mental Health Report with comments from young people, parents/caregivers and service providers as necessary. It is important to inform participants this section will provide as much practical information as possible, creating insights into what mental health challenges can look like and how they may show up in people's lives. This is particularly important when looking at youth mental health challenges from an ecological perspective- signs and symptoms may be more prevalent in some areas of our lives compared to others.

Mental Health Disorders at a Glance:

According to **Youth Mental Health Canada** (**2018**), mental illness is the number one illness affecting people in the industrialized world. In Canada, only 6% of the healthcare budget is spent on mental health, much lower than the estimated 30% of funding needed to represent the actual number of individuals living with mental health challenges and disorders. This can be relational to the fact that in Canada 1 in 5 children who require mental health interventions will actually receive them. In Canada, suicide accounts for 24% of all deaths amongst young people aged 15-24. Stigma and discrimination continue to exist across the spectrum of mental health disorders, from signs and symptoms to diagnosis and treatment, despite efforts and slow wins at changing narratives surrounding mental health challenges and disorders. It is critical to remember that gender expression and identity, cultural identity, race and religion (for example) can greatly impact an individual's ability to disclose challenges they may experience and affect their openness to receive interventions. Fear of judgement, of not being understood or taken seriously, previous negative experiences in service provision and at times fear of persecution, abandonment and isolation are very realistic concerns for young people.

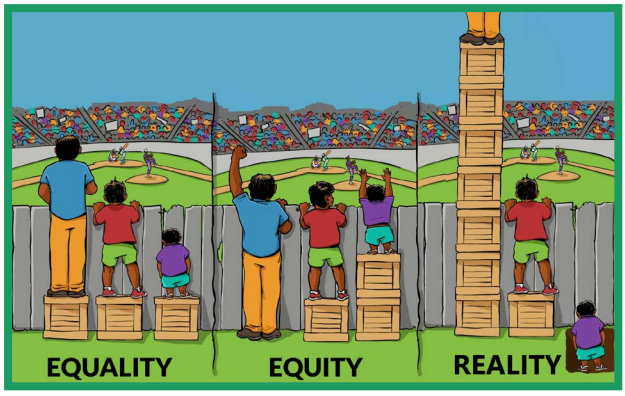
Variance of Success:

This is a good opportunity for a brief discussion with participants on their (possible) lived and professional experiences with stigma/discrimination and/or how identities shape our experiences disclosing and receiving interventions for mental health challenges. Prompts can include: have you or a young person you supported experienced discrimination when trying to access services? How have you seen differing identities treated when trying to access services?

Facilitators are also free to provide a very brief example from their own lived/professional experiences or you can provide this example, “When interviewed, a young person who identifies as LGBTQ2S mentioned going to a specific agency for services because they understand how they identify - that was important, ensuring youth know they will be well received and supported by likeminded individuals.”

Youth Mental Health and Social Justice:

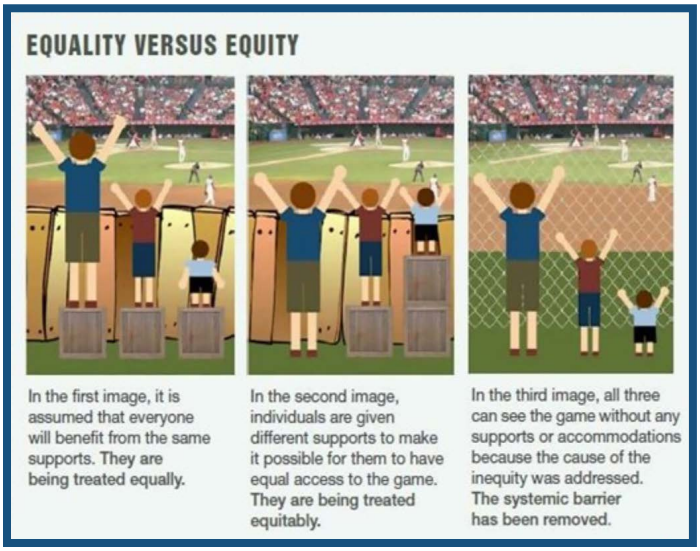
Conversations of stigma and discrimination should be opened up to include mental health as a social justice issue. Simply, all individuals, regardless of their abilities, race, sexual orientation and gender identity have the right to receive services and supports they require to promote the best quality of life possible. This is included in the Canadian Human Rights Act and within the United Nations Declaration of Human Rights. We know not all individuals have proper access to supportive services, receive equitable service provision once connected nor do they have their signs and symptoms taken seriously. The picture below is often used to demonstrate the difference between equality, equity and depicts an image of reality.



There are multiple images similar to this depicting equality and equity with an alternative version of reality, or current lived experiences. In this image, we can see equality essentially means giving people the same thing, this is done regardless if it meets their needs and in some cases can create more barriers than what existed before. Equity is more relatable to what people need. This is evident in the middle image with individuals being given different sized boxes to stand on with one person given no box at all.

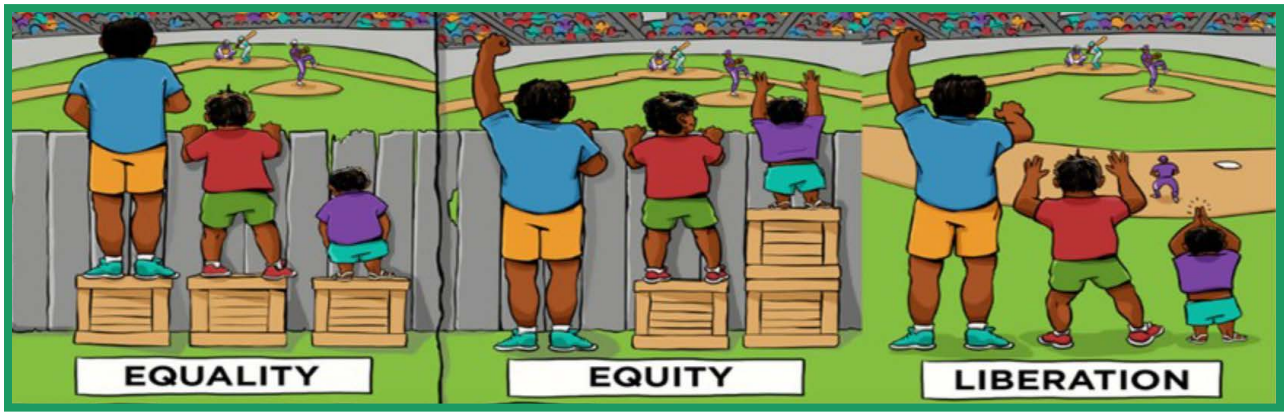
The final image depicts what is often identified as our current reality, one individual is given more than what they truly need (when essentially they didn't need anything at all), one individual may be provided with support that meets their need for the current situation/environment and another individual can be provided with nothing that meets their needs and/or have circumstances removed that worsen their challenges/experiences (i.e.: removing more ground from under their feet).

Social justice theories inform our knowledge of the macro, or larger systemic issues, of racism, discrimination and inequity that exists specifically within the social services sector. In this regard, it is helpful to look at this image and imagine a shaky, unstable ground that all three columns must exist upon. Its unstable nature represents the disproportionate funding opportunities (i.e.: 6% vs 30% as mentioned above), bias of service providers transferred to the 'work' and unequitable and often racist policies and procedures within agencies, organizations and all levels of government, we as service providers attempt to counteract everyday through supportive intervention practices.



Another example as per the picture on the left, is imagining the barrier (i.e.: Fence) being removed entirely and in this regard, all participants are free to see the activities without issue.

However, it can be argued that the fence is not entirely removed (is it possible to remove all barriers, for every person?) Therefore, are we truly liberated from social injustices when the barrier is explicitly removed, as depicted in the picture below?



A practical example of systems lacking necessary change can be pulled from the Manager/ Supervisor of Front Line Youth Worker needs assessment disseminated online in 2018, with one respondent noting the following:

"...in the end I think what we're seeing is that the needs of young people and family are just increasing, and they're becoming more challenging, they're becoming more diverse, but the people that are doing the work? Their qualifications are not."

At the most fundamental level, it is critical that front line youth workers are qualified through formal and informal educational means in order to provide interventions that meet standards of service and principals of best practices. The above quote can be an example of necessary systems change and advocacy efforts to ensure our educational practices are meeting the ever-changing, multi-faceted demands of mental health challenges.

Variable to Success: **This could be an opportunity to ask participants to reflect and share their thoughts. Do participants feel their educational qualifications and/or professional development are meeting, or exceeding, the services they are expected to provide? A prompt could be to reflect on experiential learning opportunities (i.e.: student placements) and knowledge transfer opportunities provided on the job by team members or senior staff? There is no right or wrong answer here, however an opportunity to prompt participants to begin thinking of this- strengths and deficits and let them know it will prepare for the intervention activity and provide an opportunity to share their knowledge/expertise during the case study segment.**

Income, location, race, education, and many other factors have a profound influence on our physical and mental wellbeing. In general, people with higher incomes, more education, and stronger relationships tend to be healthier than those who do not have such advantages. Some groups in particular face more discrimination and stigma, or require stronger access to services and supports. These can include:

- Immigrants, refugees
- Black and racialized individuals
- Lesbian, gay, bisexual, transgender, queer and two-spirited (LGBTQ2S) communities
- People with differing abilities
- Those living in the North or in remote communities and identify as Indigenous, First Nations, Inuit or Metis

We need to recognize the strengths of diverse peoples. Because every community, and individual, is different, community-specific services should be tailored even further to provide a truly "person-centered approach" to mental health. Oftentimes, we refer to entire communities as having similar values, beliefs and experiences.

Different cultures often have unique ideas about mental health that can sometimes make it difficult to start the conversation about mental health issues. This was identified in evaluation findings reported and discussed within this curriculum. Also, cultural and spiritual identities can offer protective elements and varieties of interventions beyond Western standards. Overall, we must listen and engage in an individual's experiences to determine the most supportive steps to healing.

Mental health professionals must have access to training on how to deliver culturally safe, appropriate services and ensure support services are welcoming to people from all backgrounds. This is especially critical for young people who may not experience support and nurturing around their mental health challenges within their family. Young people may respond well to professionals who 'look like them' or who have similar lived experiences, but especially important is a professionals ability to express empathy and compassion for the young person's truth- pertaining to how they feel and what they need.

Variable to Success: Ask participants to reflect on their agencies of work, or the agencies who provide supports in their communities. Do programs and services reflect the needs of the communities? Are service providers reflective of the culture, race, lived experiences and realities of those who access services? Are translation service available if languages are not represented? Are these areas considered when entering into communities, developing new programs or hiring staff for specific programs?

It is important to note that individuals belonging to some ethno cultural, religious and racial communities are not comfortable accessing services by providers who share a similar background. This can increase concerns over stigma and enhance feelings of shame.

However, when providing supports to vulnerable communities and individuals, social justice practices inform us these areas should be considered and explored.

For the purpose of this curriculum, we advise familiarizing yourself with **The City of Toronto Long Term Care & Services Report (2017).** This report robustly provides knowledge on allyship and organizational culture/awareness amongst other important learnings, such as:

- Professionals may not identify as LGBTQ2S but understand the importance of collaboration, empathy and client centered supports
- Professionals work to identify, name and seek further collaboration within organizations and communities to enhance understandings of discrimination, stigma and violence experienced by individuals within vulnerable/marginalized communities

Further, programs and services should not be 'tokenistic' in their outreach to LGBTQ2S individuals and communities. For example, signage and promotional materials should identify safe and welcoming spaces for LGBTQ2S participation. This also symbolizes an organization's capabilities to support the experiences of participants and an openness to learn.

As noted above, individuals within communities require client centered approaches in order to address challenges they experience. Advocacy against social injustices pertaining to the marginalization and discrimination of groups can be a part of an ally's efforts - but a large focus remains on our abilities to empathize with the lived experiences that reside within individuals and these broader communities.

Mental Health Disorders

It is important for facilitators to introduce this section and inform participants we are not providing robust information on all mental health challenges and disorders. Based on the evaluation findings, we are providing information relevant to what respondents identified wanting to know more about as well as discussing the intersections between a specific challenge or disorder and young person's ecology.

It may be relevant to provide definitions of ecology, mental health challenge and mental health disorder before continuing:

1. Ecology:

The relationships between people and things; often when speaking about an individual's ecology we are referring to the patterns and balance within interactions.

2. Mental Health Challenge:

Most easily understood as negative signs and symptoms outside of 'normal' or common behaviors, importantly this includes 1) Decreased control of thoughts/feelings/emotions;

2) potentially harmful to oneself or others; 3) Abnormal or maladaptive behaviors. Experiencing mental health challenges may warrant interventions.

3. Mental Health Disorder:

Mostly experienced when challenges disrupt a person's ability to carry out their usual activities and relationships. Formal mental health challenge diagnosed within the DSM-5 (2017).

Depression:

This section will provide information relevant to young people's general experiences of depression. Depression is known as a mood disorder and is often termed clinical depression. Within the same category of mood disorders, bipolar disorder will also be discussed here.

Clinical Depression:

Often associated with feelings or symptoms that are uncommon to the individual and last longer than two weeks. Clinical depression affects an individual's ability to engage in activities and relationships they may have once took enjoyment in.

For young people, a sign of depression could include no longer wanting to go to school, sport practices and games, activities and clubs they would have otherwise been attending. There may be a preoccupation with staying in bed and feeling the need to sleep, limited eating or over eating behaviors that did not exist before the on-set of symptoms. Individuals can no longer be interested in their peer group and/or expressing uncommon, negative thoughts and feelings about their friends/families.

Symptomology can often be located within the body, creating physical pains not explained through injury or recent activity. This can include headaches, aches and pains and muscle cramping that previously did not exist.

Depression can/will effect a young person's thought patterns and cognitive functioning. For example, lessons in school that previously did not pose difficulties could begin to be challenging, understanding cues and interactions from peers and family members may also pose challenges. This is not to say depression effects a young person's ability to understand language or human interactions, but their ability to process and connect information may be limited and slower than usual.

Symptoms:

- **Emotions:** hopelessness, sad, mood swings, anxious feelings, anger
- **Thoughts:** critical, pessimistic, negative, suicide
- **Behavior:** isolation & withdrawal, low/no motivation, neglect personal appearance, lack of enjoyment in activities
- **Physical:** lack of energy, sleep pattern changes (too much/too little), weight loss/gain

Bipolar Disorder:

This disorder is not often associated with young people. However, symptomology can be suspected to align with bipolar disorder even though diagnosis under the age of 18 is uncommon. Bipolar disorder is characterized by the cycling of behavioral patterns, between mania (manic episodes) often associated with psychosis and depressive states.

Diagnosis occurs when enough evidence (or cycling patterns exist) to identify the distinction of both states. The duration of the behaviors/feelings and the severity can be tracked. This cycle will occur at different rates for different people and persist much longer then common energy changes throughout a day. Individuals can live within a state of mania for days, weeks, months and sometimes years before entering into a state of depression or returning to their 'normal' mood for a period of time.

Symptoms: The depressive state of bipolar disorder is described on the previous page. Mania can be identified as an extreme opposite of a depressed state, such as:

- Increased energy and over activity
- Sleeping less (Up all night, busying oneself)
- Delusional behavior and thoughts (Adults have been known to buy luxurious items, take out loans they cannot afford, believe they are the next 'big thing', gamble all money away)
- Increased sense of irritability (especially when called out on any delusional behaviours and thoughts)
- Rapid thinking and speech

Risk factors for Depression

It is important to note to participants that there is no way to create a truly exhaustive list of risk and protective factors because our social location, lived experiences and genetics are so diverse. For some there are situations, specific environments and elements that exist beyond our control that increase the risk of developing clinical depression. Examples of this are:

- Side effects of medication/drug use
- Having another mental health disorder (i.e.: some anxiety disorders can often lead to depression)
- Family History
- Hormonal changes (premenstrual)

Weather/Seasonal changes- winter months can bring lack of exposure to bright light/vitamin D. Known as Seasonal Affective Disorder, it could be important to factor in time of year when working with young people who exhibit symptomology of depression.

- Medical conditions and disability
- Bullying/victimization
- Abusive relationships/domestic settings
- Divorce/breakdown of parental relationships
- Death of loved ones (including pets)

After child birth- Post Partum Depression is a recognized mental health disorder experienced up to one year postpartum. We sometimes support young women who give birth, have children and may or may not be parenting their children full time or at all. When supporting young women who have experienced child birth and regardless of their current parenting status, it is important to ask them about their postpartum mental health.

- **Variable to Success #1:** Facilitators do not need to list every example on this page- feel free to highlight certain ones or ask participants what their perceptions are of approximately 5 risk factors.
- **Variance to Success#2:** It is important to differentiate between sadness and depression, a simple way of doing this is to ask participants if they can explain the difference between the two.

Sadness: Everyone can experience sadness, it is often time limited and controlled to a specific situation/experience. Experiencing sadness does not mean someone is depressed.

Depression: Longer term (2 weeks), applicable to many/all elements of everyday life and negatively impact common, usual activities, lifestyles and relationships.

Inform participants of the importance of active listening and asking questions (when appropriate) of histories of feelings i.e.: how long have you been feeling this way? It sounds like you are feeling pretty sad, have you thought maybe it could be more than that, like depression?

Statistics presented by Youth Mental Health Canada from 2018 report that 5% of males and 12% of females between the ages of 12-19 have experienced a major depressive disorder, 61% had talked to a professional about their symptoms in their lifetime. Statistics Canada (2012) reports young people between the ages of 15-24 had a higher rate of depression than any other age category. Within the same study, 14% of participants had suicidal thoughts at some point in their life, with 6% within the last 12 months.

Statistics Canada (2012) notes in the Canadian Community Health Survey- Mental Health, young people (15-24) were increasingly seeking out support and were identified as speaking to their family and friends about their feelings. Young people reported feeling they felt 'a lot' or some help when they sought support. Another point of importance is recognizing speaking with a professional may increase the likelihood young people will feel comfortable speaking to family and friends down the road.

Depression & Suicide:

Suicide as a crisis intervention is detailed below but facilitators are highly encouraged to promote all participants discuss a suicide intervention training with their managers, this could include SafeTalk, ASIST or workshops through Safeguards or the Crisis Trauma Resource Institute.

Facilitators should prepare participants when suicide is going to be discussed. Inform the room if they become uncomfortable or negatively impacted they are free to take some private space outside. This is also a good time to remind participants to share a 'thumbs up' if they need to leave and not doing so will alert facilitators a follow-up is necessary.

There are important points about suicide intervention all front line youth workers should be made aware of:

Individuals who contemplate suicide are suffering and in pain, most often individuals do not actually have a desire to die but they wish for the pain and suffering they experience to end.

Even though it can be uncomfortable, if you perceive an individual to be contemplating death by suicide it is best to be direct and ask them. An example of this could be "It sounds like you are really struggling right now, are you thinking about suicide?" Asking them directly will not put the idea of suicide in their head if they are not already thinking about it.

When asked directly, you may get a response out of shock from the directness with a clear 'No', however it is important to continue to explore the idea of suicide with the individual, directly and indirectly. **Examples of this could be:**

- So when you get down like this, what do you think about?
- Have you ever thought about hurting yourself? This can establish a direct history of behavior.
- Do you know anyone who has died by suicide? This can establish direct association to suicide.

Variable to Success: It is important to inform participants that previous history to end one's life by suicide and being connected to individuals who have engaged in suicidal behavior increases an individual's likelihood of completing suicide. If this is determined, this greatly increases the risk factor for the individual and should be told to any first responder, interventionist and parent/caregiver who becomes involved.

4. If the person says yes, they are thinking about suicide there are three main areas that are explored next- When, Where and How. This can be achieved by asking them if they have ever thought about how or when the suicide would take place. If the individual can identify when, where and how this details a plan and should be taken very seriously. It is critical in this moment to let the individual know you are thankful they shared this with you, they are not alone and their life is important. It is also important to ask about supportive networks- who knows they are feeling this way?

Is there someone the individual feels comfortable sharing this with besides yourself? It is important to support the individual in identifying a safe and trusted adult ally who can be informed and engaged in the safety plan. At this point, the main priority for all involved is preservation of life.

5. It is critical for service providers to understand they do not have to engage in conversations of suicidal ideations on their own. This can be a very troubling time in the relationship between young people and front line youth workers, however, it is critical the service provider show leadership and confidence in their intervention. If there are elements of the interview the provider is unfamiliar with, uncomfortable with and/or could use emotional support with then they should seek out a colleague or manager. The provider should ask the individual if they are comfortable with the provider stepping out (if the individual is in

a safe place) and informing a colleague (for example) of what is going on. The provider would let the young person know how much they want to help and how much they think this second individual will be able to support. If the individual agrees, the provider would speak to their colleague and be clear on the situation at hand and how support could help. This is important for boundary setting and ensuring service providers continue to show leadership in front of the individual. If the individual says no, it is important to convey that this is not a time for secrets and if it means helping them to stay alive seeking help beyond this conversation is key.

INTERVENTIONS FOR SUICIDAL BEHAVIOR

1) Ask the individual directly
2) Explore risk:
- Plan: Where, When, How
- History of Suicide (Direct/Indirect)
- Support Networks

3) For Service Providers: Ask for help, Support as needed.
4) Safety plan with the individual 24/48 hour plan.

The latter statement may appear extreme, however, when considering preservation of life, there is no time for secrets and laws surrounding confidentiality are not in action when contemplating harm to self and/or others.

Variable to Success: This is a key opportunity to discuss particpant's comfort level and thoughts about asking someone directly if they are thinking about suicide.

6. If you believe the person is at imminent risk to die by suicide then proper interventionists should be contacted this can include 911, a mobile crisis team for further assessment (stay with the individual until they arrive), tend directly to a hospital emergency room.

If the individual does not have a plan however you feel they are at risk safety planning is the next key step. Safety planning works with the individual to create a plan that will last anywhere from 24-48 hours, until further assessment and intervention can take place.

Support the individual to identify others they trust and feel safe with (if possible, contact at least one of those people before the session is over to fill them in). Supporters should be clear on their role within the safety plan i.e.: coming to pick up the individual, staying with them overnight, supporting the individual to tell other people (family/friends) about their challenges.

Identifying activities the individual enjoys is important in this process. See a sample dialogue below for example:

- **Youth Worker:** Is there a certain time of day you feel the most down?
- **Individual:** Yes, at night when I am alone, I can't sleep.
- **Youth Worker:** It's common for people to feel the most down, or sad or depressed at night. Is there an activity you like to do that may make the nights a bit better for you?
- **Individual:** I like to listen to music and paint. Sometimes I do that.
- **Youth Worker:** Do you think you could try doing that tonight if you start to feel overwhelmed, or really down?

It is most helpful to identify 2-3 activities the individual can engage in on their own. We know often individuals feel the most down/depressed is when they are alone with limited options for contact. This increases their ability to locate their self-care in themselves and can increase their feelings of resiliency and empowerment.

The box to the left lists examples of programs individuals can contact with phone, app and online options.

Safety planning is essentially making an agreement with the individual, their support person and sometimes yourself on what everyone's role is for the next 24-48 hours until further support can be identified.

The Youth and Family Mental Health Report (2018) provides the following insight from young people:

PROFESSIONAL/PEER SUPPORT

- **Kids Help Phone:** 1-800-668-6868
- **Always There App:** connect with live counselor
- **LGBT Youthline:** 1-800-268-9688 Or https://youthline.ca/#
- **GOOD2TALK:** 1-866-925-5454

- "*..for me it's probably writing.. that's what works for me... also listening to music completely changes my mood.*"
- "*There is a place by my school.. and every time like I'd stress out whatever, I would just go and sit there and watch the water, just listen to it, listen to the nature…*"
- "*..when I'm suicidal, I just, physical exertion. Just anything to drive my energy…*"
- "*…,so the more healthier way that I think of is like smoking (marijuana), instead of hurting myself physically.*"
- "*…I tell my brother cause he can relate and also I don't feel comfortable talking about things that are in my house with other people.*"
- "*..I go to like my friend because we are very, like we're both, very messed up.. it's nice to have somebody that could also relate with.*"

Variable to Success #1: Facilitators can inform participants how youth respondents identified community workers, religious figures and school-based social workers as being figures of support. Connection to religion is identified as a protective factor for many mental health challenges, however, lack of connection to religion is not identified as a risk factor. While school social workers and guidance were mostly identified as individuals of support, school supports generally were identified as being challenging and harmful, with young people discussing feelings of judgement and discrimination from school.

Variable to Success #2: Often, front line youth workers feel responsible for monitoring individuals beyond their professional roles and responsibilities when they are struggling, for example: taking calls in the middle of the night. It is important to validate this commitment to young people, however, just as important is reminding participants that while they have expertise and relationships that are beneficial to the safety planning process, they are not solely responsible for preservation of life. It is important to talk with a supervisor about boundary setting and the challenging emotions often experienced when supported individuals are in crisis.

It is important for facilitators to highlight the challenges of supporting individuals who express a desire to die by suicide. More importantly, what occurs if someone who is being supported does die by suicide at any time during or after engaging in supportive services, with or without a safety plan in place? Or what happens if a young person dies by suicide with no observed challenges that need to be addressed? Youth workers often ask "how did this happen," or feel it "makes no sense" and commonly individuals look to blame others.

It is very difficult to determine the 'trigger' or specific incident that causes an individual to engage in an act that ends their life. Individuals can appear to be happy with clear, collected thoughts directly before dying by suicide. Most often, death by suicide occurs because in a specific moment the pain and suffering is too much to bear as the reminder, trigger or voice inside themselves takes over any logical thinking. Understand that this is a common challenge experienced by the loved ones of those who have died by suicide.

This is a good time in the day to take a break. However, given the seriousness of the topic facilitators should remain present and alert to any discomfort or challenging emotions experienced by participants. Facilitators should remind participants they are available during the break for any follow-up.

Anxiety Disorders & Trauma Related Disorders:

This section will provide information related to Anxiety and Trauma related disorders.

Facilitators can begin this segment by informing participants anxiety can be a common process, experienced by any person connected to situations and environments identified as stressful, new or changing. Examples of this could be an upcoming test/exam, worrying about a sick family member, and the breakdown of relationships (divorce, separation, peer issues) and situations that may be dangerous or threatening.

The box below serves as the reminder for indicators of a more serious mental health challenge. When working with individuals who express concerns about feelings of stress or anxiety, it is important to reflect on the three areas noted below that can represent a mental health disorder and inquire if any of them are relevant to their experiences.

An anxiety disorder can often be characterized by an excessive level of anxiety that interferes with day to day living. The cause of the anxiety can be unknown with uncontrollable feelings often difficult to predict.

It is important to identify rational vs irrational thought patterns:

- I might fail this exam and I'm stressed vs
- I'm going to fail, flunk out of school and everyone will hate me.

Variable to Success: Ask participants to provide other examples of the difference between rational and irrational thoughts.

MENTAL HEALTH DISORDERS

1) Decreased control of thoughts/feeling/emotions
2) Potentially harmful to oneself or others
3) Abnormal or Maladaptive behaviour

There are many types of anxiety disorders that require expert intervention and assessment in order to be properly diagnosed. When working with an individual who suffers from disordered anxiety it is critical to identify further professional interventions (doctors, counsellors/therapists) for possible ongoing intervention. A key intervention for anxiety disorders is planning and preparation. For example, how can an individual prepare in advance for the upcoming test? How to plan for the family or peer outing that is causing nervous feelings? Planning and preparation based activities is something front line youth workers can engage in however the biggest challenge for individuals who suffer from anxiety disorders is

readiness for this stage of intervention. This is further complicated if anxiety is sparked by a traumatic experience. While front line youth workers are not responsible for diagnosis it is important to be familiar with different forms of anxiety.

Generalized Anxiety Disorder:

Symptoms for more than 6 months, general worries that can involve any aspect of life when no concrete, identifiable problem exists.

Panic Disorders:

Experience panic attacks (hard time breathing, racing heart, feel out of control, feel dizzy), the fears are inappropriate for the circumstances they are attributed to. The physical symptoms cause increased anxiety which adds to the panic/anxiousness.

Agoraphobia:

Mostly associated with the fear of going outside - however it is actually the fear of experiencing a panic/anxiety attack outside of the home and not being able to control it. It is the fear of being in a situation or environment with limited means to leave/escape in the event of a panic/anxiety attack and avoiding places all together that may attribute to the onset of an attack.

Separation Anxiety Disorder:

Can be categorized as excessive anxiety brought on by thoughts or experiences of separation.

Specific Phobias:

Restricting activities and avoiding situations/environments out of fears that are persistent and unreasonable. Phobias can include heights, certain animals, and textures/materials. Individuals may have a fear of something (i.e. heights) and not a phobia. The focus is on the extent of avoidance and the excessiveness of the fear. The rational thought may be “I’m afraid of heights” without any specific or constant avoidance of high elements. An irrational example would be avoiding all high elements because you ‘know’ the bottom will fall out.

Social Anxiety Disorder:

Can be identified as the fear of social settings i.e. the mall, movie theatre. This is a common anxiety disorder where individuals feel others think negatively of them and fear embarrassment and humiliation. This can also be known as a social phobia whereby individuals avoid social settings.

Trauma Related Disorders:

There are two common trauma related disorders, Post Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD). While there are other disorders that fall within this category, they are not as commonly discussed. With both disorders, individuals do not necessarily experience anxiety and therefore they have their own distinction outside of anxiety disorders. Trauma related disorders can occur after a single incident or repeated exposures.

Language of PTSD is often used to describe symptomology after a traumatic event. Individuals may say “I have PTSD” when referring to a difficult situation they experienced. Or there is a common perception amongst service providers PTSD is almost expected for individuals who experience a dangerous or threatening situation.

SIGNS & SYMPTOMS

- Can look similar to depression (withdrawn, isolation, loss of enjoyment, unsatisfaction)
- Flashbacks
- Avoidance of people, places, environments related to the Traumatic event
- Emotionally withdrawn
- Fear/Anxiety
- Anger, aggression, irritability
- Lack of sleep

Variable of Success: Facilitators can ask how they perceive people use the language of PTSD in their environment - personal and professional. Is it a common informal diagnosis passed down amongst service providers?

- **Acute Stress Disorder:** Symptoms arise and resolve within 4 weeks of exposure
- **Post-Traumatic Stress Disorder:** Symptoms last longer than 4 weeks from exposure.
- **Complex Post Traumatic Stress Disorder (Complex Trauma Disorder):** Prolonged, repeated exposure to trauma often within interpersonal relationships as children or adults.
- **Secondary Traumatic Stress (Vicarious Traumatization, Compassion Fatigue):** Associated to first responders and care providers who hear about the traumatic experiences of others. There is often shame and stigma associated with secondary traumatic stress due to fear of being viewed as incompetent and not able to manage professional responsibilities. There appears to be a shift happening toward improved workplace mental health wellness and this includes breaking down stigma associated with professional trauma.

Variable to Success: Facilitators are encouraged to ask participants if they would like to discuss their experiences of compassion fatigue and vicarious trauma. Participants can be told there will be components of self-assessment and self-care discussed later on.

Stressful live events such as abuse and violence increase an individual's risk to experience anxiety or trauma related disorders. Substances (cannabis, alcohol, opiates) are often used to ease emotional pain, decrease flash backs and bring a sense of relaxation. However, ongoing use can create habits and increase addictive tendencies that do not benefit the signs and symptoms long term. Concurrent Disorders (co morbidity) exist when individuals live with both addiction and mental health disorders.

Statistics Canada (2015) reports women are more likely than men to develop anxiety and trauma related disorders and twice as likely to experience a panic disorder.

Depression is an example of a mental health disorder that can increase the symptomology of anxiety disorders - the two disorders can be interrelated with depression being a symptom of anxiety and vice versa, with anxious tendencies developing out of depression

Psychotic Disorders:

Psychotic disorders mostly refer to mental health challenges that cause individuals to lose touch with their reality. Included in this are severe disturbances in thinking and exhibiting erratic behavior and emotional responses that can appear threatening and violent to others. Psychotic disorders are not as common as other mental health disorders and for the purpose of this knowledge exchange facilitators will not provide a robust breakdown of disorders.

RISK FACTORS FOR ANXIETY & TRAUMA RELATED DISORDERS

- Stressful life events
- Substance use
- Gender
- Family History
- Other mental health
- Challenges/Disorders

The most commonly known psychotic disorder is schizophrenia, effecting more men than women. It is classified as disordered thoughts and perceptions with behavioral changes that are uncommon to what could be identified as baseline behaviors. Typical onset of symptoms for men is 18-25 years and 25-mid 30's for women.

Psychotic disorders are treatable conditions that can require consistent monitoring from medical professionals (doctors, psychiatrists) as individuals are commonly treated with medication (Anti Psychotics, for example). Intervention and treatment at the earliest point of symptom onset increases opportunities for more productive and sustainable wellness outcomes. With treatment, recovery is possible.

Variable to Success: The biggest driver in successful service provision with individuals who are diagnosed or may be suffering from symptoms of a psychotic disorder is the promotion of healthy relationships with medical professionals. Frontline youth workers can create and maintain positive relationships and provide supportive services (referrals, counselling, and necessity of life – food security, housing supports) but we should not be identified as the interventionists. Frontline workers, family and friends can all play a key role in ensuring positive relationships and 'fit' between individuals and medical professionals. Trusted, safe relationships with individuals who are challenged and living with a psychotic disorder are a key element to recovery and wellness.

Substance Induced Psychosis:

More research is currently being completed on the linkages between early onset psychosis, a form of substance induced psychosis, given the recent legalization of cannabis in Canada. It is important to remember that many substances can induce psychosis (ex., alcohol, amphetamines, opioids) not just cannabis. The age of the user, when they started using the drug, the amount of the drug consumed and genetics can play a role in the onset and development of psychosis. These will be considered at the time of assessment. At times, stoppage of drug use can decrease symptoms of psychosis and promote a return to baseline. However, while anti-psychotic medication is prescribed to also facilitate a return to baseline, medications can increase the experience of other mental health disorders (i.e.: depression and anxiety). It is important to treat all symptoms of mental health challenges throughout the intervention and recovery process.

Similar as above, a leading intervention of front line youth workers, family and friends is promoting healthy relationships with compassionate health care providers. It is also critical to remember family and friends may experience hardship, stress and lack of understanding as symptoms can be quick to arise and at times appear disassociated and sometimes aggressive in nature toward themselves or others.

Ecological Perspectives to Youth Mental Health Challenges:

Beginning to understand the impacts of youth mental health challenges across 'system' involvement is critical to ensure we are finding ways to optimize wellness outcomes. This is completed in two primary ways, 1) Understanding a young person's diverse ecology and 2) Multi systemic collaborations.

Variable to Success: Power point slides are completed for Multi Systemic Collaboration and Case Management. Facilitators can reflect on both of these sections and determine if the sections are incorporated and the possible length of time given to each. These sections are important to a comprehensive service model and should be a key component to training and supervision of front line youth workers. Soundly understanding how to implement these actions promotes better wellness outcomes for young people and families. However, they were not key components of the evaluation study findings.

Slides 33 & 34 are presented as 'hidden' within the power point presentation however can easily be identified and used.

Oftentimes, frontline youth workers can feel they work within a silo, or bubble of their own interventions, or there are broader challenges to partnerships and collaborations at the frontline and/or agency level. However, a strong network of partners and effective case management can monitor and intervene on multi systemic areas of challenges.

Understanding a Young Person's Ecology:

Service Providers often have varying degrees of assessment processes to determine risk and protective factors of those we support. For this knowledge transfer, we will utilize the bio/psycho/socio/spiritual model to determine areas of intervention and support. This model is identified as being one that can focus on health and wellness. This model can examine deficits and strengths of individuals.

Confidentiality of clients can be difficult to navigate. If you do not belong to a regulatory body (i.e.: Ontario Association of Social Workers, Ontario College of Social Workers and Social Ser-vice Workers, Ontario Association of Child and Youth Care) it is best to consult with your agency regarding policies and procedures of confidentiality and consent. However, most agencies follow protocols guiding confidentiality at 12 years of age as the determining age for informed consent as long as participants/clients understand the premise

and goals of the program and role of the support provider. Harm to self or others is not included in this protocol and will immediately spark duty to report protocol as discussed in the depression and suicide section of this knowledge transfer. If an individual under the age of 16 cannot provide informed consent/understanding due to a cognitive impairment parent/guardian consent to participate or sharing of information is expected. It is always important to inform confidentiality and consent policies for all partners involved in service. School boards and medical professionals will often require signed consent on behalf of caregivers/guardians to share information of young people under the age of 16 with anyone, including service partners.

This is relevant as we know throughout the assessment process young people can disclose information and specifically ask for it not to be shared with their parents. In this case, a key factor in appropriate, positive client/worker relationships is to determine if there are risks to the young person, if parents/caregivers are informed of the information or if the relationship of youth /parent is severely impaired. If this is not the case, youth workers should promote benefits of informing and engaging with parent/caregivers on the challenges youth experience.

Bio (Biological): This area examines that biological factors of an individual. Physical health and genetic disorders/challenges/symptomology can be explored here. When thinking about this, identify things the individual essentially cannot change about themselves, i.e. Things that were 'given' or passed down to them. Intergenerational trauma as mentioned below could have both spiritual and biological components to it.

Psycho (Psychological): This area will examine the signs and symptomology of mental health challenges and wellness. What areas experience challenges (i.e.: not sleeping, feeling sad, negative thoughts) and what areas experience wellness (no thoughts of suicide, identifies enjoyment in some activities/people), understanding the history of psychological challenges and wellness is also a critical component of this.

Socio (Social): From a community perspective, the social level of assessment is a critical component. While understanding the personal and biological elements are important, the social allows us to examine strong and challenged relationships within a young person's system. This area identifies specific people as supportive, helpful and on the other end, triggering, dangerous and disconnected. This group of people can include peers, professionals (i.e. School administrators, social workers, program leaders, coaches etc.) and adult allies (neighbours, parents of peers) and family (biological and chosen).

Historical and current relationships with family members is often a key element to any assessment and intervention plan.

Multigenerational trauma:

As mentioned above, family history can often play a role as a risk factor in determining the mental wellness of individuals throughout generations. It refers to the complex mechanisms of 'passing down' traumatic experiences, reactions and means of coping to secondary generations. These processes can continue throughout lifespans with similar symptomology (i.e.: anxiety, depression, trauma responses) most commonly by observed behavioral patterns within interpersonal relationships.

Below are comments derived from the Youth and Family Mental Health Report from front line youth workers, young people and parents regarding their mental health capacity

- *".. sometimes adults.. cause generation is so different.. I feel like whenever we are stressed out or we're talking about mental health or there is some issue that is arising some adults are quick to be like "that's not even that big of deal, we went through slavery and we went through this.."*
- *"We're seeing- like even parents, they're not well, they don't even know how to deal with their youth."*

It is important to recognize the interconnectedness of some parent-child relationships regarding both individual's mental health wellness.

- "*.. youth mental health challenges can destroy families.. let's say if my daughter gets better I would be performing okay, I will be okay in my work and with my friends… you starting isolating yourself, you start creating mental health problems for you.. because I suffer a lot…I was getting concerned about my.. mental health.*"
- "*..it was like we're just going back and forth at making these phone calls during not only a stressful time for him but I think also for me as his parent. It was affecting my mental wellness cause.. having to repeat the incident or just the emotional trauma over and over again.*"

Variable to Success: The key message for participants is in order to effectively case manage and provide direct support to young people who are challenged by a lack of mental wellness is to question, prompt and get to know their family members who live amongst these challenges. Working within a silo is not just applicable to agency program partners- true multi systemic perspectives take into account the risk, protective and wellness factors of

individuals in the young person's life. There is rarely 1 'client' when supporting young people in this way- moving toward programs and systems that educate, train, supervise and allow for multi systemic interventions and productive case management is key for ongoing success.

Spiritual: This is an addition to the model of assessment that includes religious and spiritual beliefs/connections that are mostly deemed as protective factors. As mentioned in the latter portion, lack of spiritual/religious connection is not identified as an immediate risk factor, however radicalized or disclosed negativity toward religious involvement/individuals could be identified as a risk factor.

Multi Systemic Collaborations:

Strong partnerships and relationships with multi sectorial stakeholders are a key deliverable to effective case management.

Partnership building should be a consistent process within any program- one that is thought out, intentional and planned for. This should include processes for biannual review, clear documentation of programs/services/contacts and ongoing methods to stay connected and in touch. Partnerships are not simply tools to meet program objectives.

1 True Partnerships are based on reciprocity of achieving goals. For example, you may not refer youth to my program but you expedite their acceptant into the essential programs they require. This allows for programs and individuals to achieve their goals in a variety of ways.

2 Individuals involved in partnerships have a mutual respect for each other as service providers. This is exhibited by being honest about the challenges and struggles that may exist within the interconnections of programs.

3 True partnerships appreciate the struggle of the social services sector. We listen, collaborate and identify ways of supporting while understanding the complexities of agency mandates and our roles and responsibilities. In the end, if we engage in partnerships in a genuine way, support comes naturally.

4 Partnerships can have formalized memorandum of understandings (MOU's) or letter of support in place that details the roles and responsibilities of each party. This allows for bounda-ry setting, managing conflict, review periods and termination. Some programs require part-nerships to be in writing, formalized in some capacity as a deliverable. Oftentimes, this is not the case but there should still be mechanisms in place to create clarity and accountability processes.

Variable to Success: Strong partnerships lead to better wellness outcomes for those we support. We must work toward and encourage partnerships and relationships within the sector that are collaborative and effective- not negative and siloed.

Effective Case Management:

Practical examples of effective case management are built into the afternoon activity. However, we will detail principles of case management to coordinate increased wellness outcomes for those we support.

Deliverable #4 in Principles of Strong Partnerships is important when creating case management for those we support that *should* include the support of program partners.

Variable of Success: Inform participants case management is being discussed as it is essential to providing ongoing support to young people, especially when working toward interventions in mental health challenges. Systems navigation, strong partnerships who can help achieve goals and ongoing monitoring is an integral component. It is also helpful to inform participants that case management is a form of 'direct practice' in the social services sector. Commonly, community based practice and the not for profit sector is identified as a source of indirect practice - in this instance, they can co exist and interact.

Below are further thoughts on principles of case management:

1 **Identification & Eligibility:** This includes program outreach and confirmation of eligibility for the program. This would include an informal assessment as you garner referral based information of the individual.

2 **Assessment:** Consider the bio/psycho/social/spiritual assessment as mentioned above. As-sessments can be done across more then one meeting and lay the groundwork for intervention. Assessment is an ongoing process throughout someone's care plan as needs an abilities fluctuate.

3 **Planning:** A participatory process that is client focused and identifies strengths. It is important to consider safety, risk, resources (human and financial) and lived experiences. Plans should be multi-systemic in nature and identify supporters within the ecology.

4 **Implementation:** Do what you plan to do! Consider roles and responsibilities of everyone identified in the planning stage. This is the stage of case management that often becomes challenging. Holding partners, clients and ourselves accountable the achieving goals, consistent monitoring and follow up on processes and needs and managing the deliverables of stakeholders are elements that decrease wellness outcomes and where individuals we support often 'drop off.' When implementation works well and when it is challenging is a key element to clinical supervision with your supervisor- establishing processes for change and/or continuation of effective service delivery.

5 **Evaluation:** Monitor and identify areas of improvement and change as often as possible. Imbed evaluation into meetings and follow up with partners and clients.

Clinical Interventions

This section is a participatory activity whereby participants can learn about therapeutic interventions based on their own skill set and comfort level and identify areas they would like to learn more in. It has been determined a participatory model asking for personal reflection and connection to the goals, methods and outcomes of specific interventions will be most useful to participants.

Variable to Success: **Inform participants the purpose of this activity is to not directly increase the knowledge of participants on therapeutic interventions by providing a robust description of therapeutic interventions; it is to connect them further to skills they are most comfortable with and how to further those skills through alternative opportunities.**

Activity instructions: Participants will be provided the fundamentals of intervention on flip chart paper located around the room. Therapeutic interventions will not be named at the beginning; participants will be asked to stand in the area of the room that best represents their current focus when intervening on youth mental health challenges, after participants have identified and are standing beside an intervention will a facilitator name the therapeutic intervention. Before the clinical intervention is revealed, have participants share their thoughts about why they choose a specific intervention style.

This activity will consider participants who engage in clinical based conversations but it is also accessible for participants who do not. This activity confirms that we all engage in what are known as attending skills and have the ability to have therapeutic, helpful conversations with individuals we support.

Below are the therapeutic interventions identified in the Youth and Family Mental Health (2018) report for increased consideration.

Cognitive Behavioral Therapy: Focuses on the way we think, feel and behave. Commonly used to treat anxiety, depression and trauma related disorders, individuals engage with clients on an ongoing basis and work toward better understanding, challenging and changing negative thought patterns. Homework can be a large part of CBT, whereby participants are often asked to identify negative thoughts and beliefs they maintain throughout their day/week, what those thoughts are attributed to and where they may have come from.

CBT is a solutions focused therapy that encourages participants to deploy strategies to improve thought patterns to boost happiness.

Service providers who utilize CBT for clients are encouraged by not solely focusing on histories and reasons behind the ways we think and feel but by engaging in processes that, while potentially time consuming, can create sustainable change in an individual's thinking.

Trauma Focused Cognitive Behavioral Therapy: Focuses on resolving emotional and behavioral challenges related to single, multiple and complex trauma experiences. Therapy is often shorter term (up to 16 sessions) and individuals focus on abilities to better process emotions and thoughts related to traumatic events. TF CBT can be focused on children and adolescents and encourages (*requires) participation of parents/caregivers. TF CBT is highly solutions focused, supporting with strategies to relieve the negative thought processes that often lead to anxiety, stress and depression. We know that individuals who experience trauma often engage in unhealthy solutions to manage harmful memories and emotions, TF CBT supports in creating healthier strategies.

Service providers who utilize TF CBT appreciate the complexities and opportunities that exist in parent/child relationships and can provide supportive options to all parties. This includes safety plans, knowledge transfer on parenting skill development and dual parent/child sessions as applicable. TF CBT is not a siloed approach and requires the participation of key stakeholder (family) to support with wellness outcomes.

Service providers who utilize TF CBT appreciate the complexities and opportunities that exist in parent/child relationships and can provide supportive options to all parties. This includes safety plans, knowledge transfer on parenting skill development and dual parent/child sessions as applicable. TF CBT is not a siloed approach and requires the participation of key stakeholder (family) to support with wellness outcomes.

Anti Oppressive Practice: Rooted in the social work profession, the primary focus of AOP is ending socio economic oppression. This perspective identifies and names the oppression experienced by individuals and groups and shows the interconnections between oppression, trauma and marginalization. Power and control are definitive aspects of AOP with interventionists, advocates and allies looking to equalize the power imbalances experienced in society.

Feminist theory and interventions fall within the AOP framework which seek to understand the nature of gender inequality and identifies how women experience, and are experienced, in our social world.

Anti Black Racism is another example of an AOP perspective focusing on improving outcomes for Black communities. The legacies of racism and discrimination within our systemic structures (education, health, child welfare, etc) have equated to a lack of and/or challenged access to essential opportunities, services and supports.

Peer Support: While not a formal clinical practice, peer support is a highly recognized intervention that heavily relies on the lived experience of the service provider. Service provider/client relationships are grounded in the common experiences between individuals and the formal/informal learnings of the service provider (or Peer Support Worker) which they share with the client. Peer support programs are very helpful in increasing social and personal con-nections amongst individuals who may have a history of isolation and loneliness due to their challenging experiences.

Service providers who employ a peer support model rely heavily on their own lived experiences, inclusive of challenges and growth, to promote the possibilities of recovery. Individuals may, or may not, have received specialized training from a peer support program. Peer

support methods could also be identified as a form of peer mentorship and utilized in service when necessary as the most relied upon 'tool' in our 'tool box'. Service providers understand the flexible and ongoing nature of peer support relationships and utilize many forms of contact in order to access clients and provide necessary supports. Peer support roles are generally recruited and hired very intentionally for participant needs and project outcomes.

Narrative Therapy: Highly client focused that sees individuals as separate from the challenges they experience. Narrative therapy allows individuals to 'rewrite' their own stories by creating opportunities that challenge how they perceive themselves and their problems. For example, identifying themselves as depressed (I am depressed) eludes to depression as a whole part of their identity. Narrative therapy can remind individuals that while symptoms of depression make up some of their identity there are other aspects of themselves that may not.

The usage of language is a key determinant to successful narrative practices. For example, police reporting and court identification of sexual assaults- Jane Doe engaged in unconsensual sex with the assailant. This should be changed to identify that Jane Doe was raped by the accused. The usage of words "engaged" and "unconsensual" counteract each other and are harmful to survivors of trauma, leading them to believe they some how took part in their own assault- creating harmful results for their identity.

Service providers who utilize a narrative approach are keen on identifying alternative 'stories'/solutions to challenges and are capable of prompting, through questioning, individuals to tell different variations of certain problems/challenges they experience. Service providers are patient and do not identify as the expert in another's life, instead they allow for the individual to reach conclusions on their own.

Crisis Intervention: There are many different crisis intervention models a service provider can be trained on. Oftentimes, crisis intervention education is an offset training or certification an individual takes as part of their education or employment. Crisis intervention is essentially the rapid assessment of a client problem or environmental situation that is generally identified as potentially harmful and the deployment of instructions and/or resources is the hope of restoring a sense of normalacy. Crisis intervention most often requires a sound professional knowledge in the field and understanding of the specific environment(s) one acts within. Such interventions must take into consideration the individual(s) primarily influenced by the situation and all stakeholders.

Service providers who engage in sound crisis intervention methods most often are not emotionally based reactors and remain calm and rational in what can be very troubling and dangerous situations. Crisis interventionists are clear on their perimeters and when to contact first responders and identify the key roles other professionals play in any crisis I ntervention plan- crisis interventionists can provide clear instructions to others and are not siloed in their interventions.

Facilitators should see the attached appendix for the terminology that should be documented on each piece of flip chart paper.

The intersections of interventions and how it relates to skill, knowledge and the changing needs of individuals who experience mental health challenges will be a critical discussion in this section. Once participants have identified an area of intervention by standing beside it facilitators can go through each intervention individually highlighting the points documented above. Participants should be reminded again this is an exercise to name the clinical approaches and promote further learning in professional development.

Practical Learning: Case Studies

The case studies provided were created specifically for this knowledge transfer opportunity and highlight the challenges often associated with specific mental health disorders. The disorders that are channeled through the case studies will be identified as such within the case study or within the corresponding response/answer.

> **1.** You are a front line youth worker with approximately 3 years experience in the field. You have been working casually with a young male for around 1 year, he is 17- he will often come see you in your office after school to chat and he attends a recreation program your program offers once a week. One afternoon you observe him at program standing against the wall, muttering to himself and fidgeting with his hands, you approach and ask him how he is and he doesn't respond to you, instead turns and looks at you without an acknowledgement that you are a known and trusted individual. What are your initial thoughts?

- **a.** 4 days later, the young man comes to your office- he appears to not have showered and his clothes are dirty. He is still fidgety and tells you he hasn't been sleeping and believes people are following him. How do you respond?

- **b.** You see his mother in the community, you ask her how she is doing and mention you've noticed some changes of behavior in her son. She says she doesn't know what you're talking about. Thoughts?

- **c.** 3 days later, his mother calls you and says her son is not going to school and refusing to leave his house. She explains it's like he is having conversations with people who are not really there and he becomes aggressive (yelling, hitting things) when she told him he was acting crazy. What intervention do you provide?

Response:

1. Youth workers could feel and experience this situation in different ways. As a facilitator it is important to prompt participants to identify the feelings behind this interaction. A common response for some workers would be to immediately begin hypothesizing on what is 'wrong' with the young man given this behavior is uncommon for him.

1 A) An appropriate response would be to gather more information by prompting the young man to tell you more- how long have you been feeling this way? Have you told anyone else about this? are you feeling unsafe? Let him know you are worried or concerned about what he is saying and would like to help. Further, it would be important to identify strategies he can engage in when he is feeling this way and possibly another trusted ally he can talk to other then yourself.

It is not important to identify his lack of hygiene and unclean clothes at this point - however one could comment on his appearance as reference to your concern for him. Maybe there is another concerning factor that would be brought up connected to lack of income, water has been turned off so laundry is difficult, etc. However, it is important to not press the issue as it could be a trigger point and complicate the situation.

1 B) This is an example of how judgements can be easily made about engagement in parenting and knowledge parents have about their children. As facilitators, allow participants to unpack how they would feel in this situation- maybe there is an example from their lived professional experience that has been similar.

In this situation, we must respect the confidentiality of the young man given his age and because he is not threatening to harm himself or another. It is appropriate to suggest he was 'off' or didn't appear to be himself the last time you saw him, you can slightly probe-

has he been going to school? He hasn't mentioned anything to you? Regardless of her response, provide your contact information and let her know to contact you if anything comes up in the future- you are available to support.

1 C) This is a key opportunity to provide an appropriate intervention. As a front line youth worker, entering into anyone's home to assess the situation unattended and without approval from a manager is not advised. It appears this young man is suffering from the initial symptoms of a psychotic disorder and early intervention is key for his overall wellbeing. It would be appropriate for the mother to meet the worker at an office (if it is safe and appropriate to do so)- from there, support her in making a phone call to a crisis or mental health intervention team from a local hospital or not for profit (ie: Scarborough Hospital, Fred Victor) to support in the assessment and making arrangements for the young man to immediately be seen at a hospital with referral to a psychiatrist for further assessment. Because of the quick escalation of symptoms and if available this would also be an acceptable 'situation' at Toronto FOCUS table which would provide intensive, quick response. If it is believed he will cause harm to himself or someone else or there is another quick escalation of symptoms, 911 can also be called for paramedic intervention- in this situation police services would also likely attend. At a later date, it would also be supportive to speak to his mother about her use of language and potential triggers for her son. While her son's behavior may appear to be 'crazy' to her, such language may be stigmatizing and isolating for her son.

Variable to Success: A big role for the facilitator of this case study is to identify the important role of youth workers as members of community care plans as allies and agents of support, this includes for both youth and their families. But individuals who experience such symptomology require interventions that include medical professionals from the beginning.

> **2.** Hamad is a 15 year old male and is in grade 10 at West Hill Collegiate. He lives in Morningside Heights with his father, older sister, and two younger brothers. Hamad's mother passed away when he was 9 years old. Hamad has always enjoyed going to school and obtained average grades. His father was worried about his transition into high school, however Hamad's transition into grade 9 was smooth. He says his sister helped him with the transition because she was already a student there. He doesn't have a lot of friends, but he is close with the friends he does have. Since November, Hamad's grades have been dropping. He failed half of his midterms. Since receiving his midterm marks, Hamad's father receives calls from the school at least three times a week saying that he is absent. His father doesn't understand what's going on because

his sister says they leave for school together every morning. The truth is that his sister leaves without him sometimes because Hamad can't wake up in the morning but she's afraid to tell her father. Hamad tells his father that he's at school every day and the calls to his father must be a glitch with the automated calling system. When his father asks him how he's doing, he says he's okay and he's just feeling tired so he's not studying as much. Hamad swears that he will start studying more and bring up his grades. Three months pass and nothing has changed. Hamad just can't get out of bed and bring himself to go to school.

Response:

2 A) Speak with Hamad one-on-one without his family involved about his health ie: difficulties sleeping, sleep schedule. It is important to gauge is general sense of wellness and listen for any mention of pain or discomfort located in the body that may seem unusual or unwarranted. It is important his father provides verbal consent for you to speak with his son without his presence. It is also important for Hamad's father to speak with him before to attain Hamad's consent and interest to speak with you as well.

2 B) This is a great opportunity to take an ecology approach to assessment- identify any positive relationships he may have ie: his relationship with his sister/father, any previous/ current positive supports at school, peers/neighbors he may identify as positive. It would be helpful with signed consent to speak to a representative at his school and potentially his previous school (if applicable). In this case, it may also be significant to have a conversation with his sister, with permission, independently of the father and brother.

2 C) Hamad's lack of participation in social activities, lack of performance and improvements in behaviors could mean he is suffering from depression. Given the passing of his mother and grief experienced from this loss it is likely there are unresolved/unsupported feelings he may need to work through. Identify if Hamad has spoken with anyone recently regarding any challenges and/or if he can identify a positive person he would like to speak with. If Hamad is uninterested in speaking with someone another point of direction would be to speak with his father about making a doctors appointment as a first point of contact with a professional.

2 D) Importantly, we can communicate with Hamad our desire to support him in achieving his goals and experiencing increased wellness. Front line youth workers can create an ongoing schedule to visit him in the home with the hopes of moving meetings to the community

and hopefully the school. You must confirm with your manager agency policies related to entering into people's homes for service, this may include check in procedures. It is also crucial to identify any behaviors/feelings of concern that may signal risk of suicide or harmful behavior. If this is present, notify a parent or senior level manager in your agency for ongoing direction and follow the steps advised in this knowledge exchange. In times of low feelings and struggle, it is important to work with Hamad to identify healthy activities he can engage in to improve his emotional wellbeing until he can ac-cess ongoing support.

> **3.** Shania is a 21 year old female, she did not graduate from high school due to attendance and peer issues and is excited to start a new chapter with meaningful employment. Shania has a history of abusive relationships and clearly states that she has trust issues with others. She also has a history of being bullied by her peer group.
>
> Shania informs you she has never had a job before. What type of employment program do you think is beneficial?
>
> Shania has two small children in her custody and care and she expresses challenges with her OW worker, lack of appropriate resources to meet her household needs and no consistent support from the father of her children or family. How do you support her with these challenges?
>
> After the second day of training in the program, Shania stops attending because she feels anxious about taking the bus during rush hour times and doesn't feel comfortable being in a group at pro-gram. She shares that she feels everyone is always looking at her or talking about her. Shania wants help finding a job on her own and doesn't want to be in the program anymore because she doesn't want to deal with groups of people. Shania is seeking your support to help her find a job outside of the program.

Response:

3 A) First, meet with Shania one on one to gather more information about her employment goals and identify her job readiness. Given she has never been employed, before you advise her of a program that can assess and reinforce her job readiness, speak with Shania regarding her past experiences with anxiety and what has provided her a sense of relief in the past. If possible, reconnect/introduce Shania to anything she may find helpful. It would be helpful to take a CBT approach to intervention – identifying how her thoughts, feelings and behaviors are connected. With the information you receive, you identify Youth Job Connection as productive employment program for her needs.

3 B) Being solely responsible for the upbringing of children can be increasingly stressful and impact our abilities to engage in activities that benefit our wellness and our futures. We must assess what household needs she is referring to and identify the severity. The stress of not being able to meet our household needs when it concerns children is harmful from a child welfare perspective. Explore any previous or current history of Children's Aid involvement, however, asking directly about CAS involvement in the early stages of conversations with Shania may be off putting and create strain in the relationship. Another way of asking this would be to explore any past or current workers/support people who are involved in her life. If there is a history further the conversation by requesting information regarding the length of involvement, worker relationship and contact information. Similarly, request information regarding income case manager (OW/ODSP), history and contact information. For resource acquisition, it is important to identify how much funds and other benefits she receives, if she has updated tax filings and if she is missing any information. As a frontline youth worker, refer Shania to a tax clinic (ie: Agincourt Community Services Association for example) if necessary and while with Shania contact her income case worker to further explore challenges and options.

It is important to remember Shania suffers from anxiety and may have great difficulties confronting her challenges or having productive conversations with individuals in positions of power. As front line youth workers, we must acknowledge Shania may have identifiers (race, complex histories, behavioral challenges) that further complicate her interactions. From a social justice perspective, it is our responsibility to name, educate and advocate for essential services.

3 C) Express the need for Shania to address concerns even if she is not part of the program (taking the bus, speaking to people, etc.) As questions regarding her feelings, are these new experiences? When has she felt this way before? It may be helpful to work out a timeline of Shania's days when she is attending programs to identify when challenges present themselves and if there are any precipitating factors.

Further, it would be beneficial to connect with Shania and a YJC program staff to discuss her challenges and request possible accommodations. Showing our clients advocating for our needs is possible, and at times essential, is a skill young people are often not taught, unaware of or previous attempts of advocacy have been harmful experiences. If interested, Shania may benefit from seeing a mental health professional who can focus and unpack her anxiety challenges and support in strategies of wellness and recovery.

4. Nathan is a 20 year old male and was recently hospitalized for his first psychotic episode after attacking his sister with a knife. Nathan and his sister were smoking marijuana one evening and shortly after, Nathan thought his sister was threatening to kill him. In what he believed to be self-defence, Nathan grabbed a knife and attempted to attack his sister. Nathan's sister called 911 and he was taken to the hospital where he was told that he had a drug-induced psychotic episode. Nathan felt very paranoid about his surroundings and safety, and was prescribed an antipsychotic medication. After a few months of taking the medication and not using any street drugs, Nathan was no longer feeling paranoid but not interested in anything – his friends, sports, music, work, school, etc. His sister reached out to you because she doesn't know what is wrong with him and wants her brother to get better.

Variable to Success: There are two clients in this situation- Nathan and his sister. Since you have not spoken directly to Nathan and have no first hand knowledge of this situation his sister is the primary client. It is critical she feels safe and confident in having any form of conversation with Nathan regarding outreaching for additional support and communicating her concerns. If she does not feel safe, she continues to be the primary client and plans are created to ensure her physical and emotional safety.

If she is comfortable to speak with Nathan, encourage that conversation happens before you be-come involved. Once this has occurred, arrange a time to meet with both Nathan and his sister (if it is determined this would be the most comfortable way of meeting for Nathan).

4 B) In the initial conversation, the goal is to assess Nathan's understanding of any changes to his thoughts, behaviors and actions. At this point, you only have the viewpoint from his sister. It is important to determine if Nathan identifies the noted changes as meaningful to him.

From a client centered perspective, it is important to differentiate between Nathan and his sister's viewpoints on the challenges presented.

Variable to Success: It is suggested to have this conversation with Nathan's sister in private as we do not wish to create a 'couples counselling' type of environment where individuals in the need of healing are sharing feelings that cannot be managed appropriately. While this may be an option to happen in the future, this would not occur during an initial conversation.

The next step is to learn about what professionals and allies were involved in Nathan's diagnosis and who is currently involved in his ongoing care. Are there opportunities to re engage any professionals or allies for Nathan for reassessment or possible engagement in social activities? So far there has been no mention of their parents/guardians- are they present and aware of the situation? Is it worth requesting to speak with them to garner more information and support for Nathan and his sister?

4 C) If Nathan notes negativity in his thoughts, behaviors and actions since beginning his medication (as noted by his sister) discuss with Nathan any goals he has (before/after medication) and what he would like to do in the future (before/after medication). This helps in further identifying marked changes in Nathan's thoughts, behaviors and actions. This information would be helpful to share with professionals in the future.

4 D) The main form of intervention would be for Nathan to attend an appointment with the medication prescriber (family doctor, psychiatrist). If applicable, attend this appointment with him. If Nathan does not identify marked changes in his thoughts, actions and behaviors it is important to discuss with him how people around him are noticing a change and are worried about him. The goal may not be to change his medication, but it is important to have a medical professional aware of the concerns of those around him so it can be monitored closely.

4 E) Importantly, we must reflect on the various reasons Nathan is no longer engaging in social activities he did before. This could be because of stigma related to any diagnosis he has received, his own challenges in processing events related to his situation or maybe he previously engaged in activities while under the influence of marijuana unbeknownst to those around him and doesn't know how to continue to engage while sober. These are just examples, but it is worth further exploring why this shift has happened. Moving forward create plan with Nathan and other professionals to engage Nathan in social activities after identifying any barriers he identifies

> **5.** Sydney is a 15 year old female who is not attending school regularly. Her mother is worried about activities she engages in when she is skipping school and hanging out with youth who are not known to her mother and appear to be a bad influence. Her mother suspects Sydney is using drugs and having sex. For the past three weekends, Sydney has not returned home and tells her mother she is at friend's house and doesn't provide any information on this friend. The school social worker reaches out to you on behalf of Sydney's mother who is desperately seeking support for her child. You respond to the social worker and arrange a time to meet with Sydney's mother and school support to learn more and begin an intervention plan.

A. During this meeting, Sydney's mother informs you her father is currently in jail for child abuse against Sydney. He has been in jail for approximately 5 years stemming from incidents that began when Sydney was 6. His sentence is up in approximately 5 more years. There are incidents of both physical and sexual abuse. You learn Sydney and her mother attended counselling when she was around 11 years old for approximately 2 months, but her mother didn't think it was helping or necessary so they stopped. You learn at the same time Sydney was speaking to a social worker at her middle school which she enjoyed and engaged positively in.

B. You were told there was an incident during a school meeting approximately 2 months before- during a meeting with school support, the Vice Principal, Sydney and her mother Sydney was asked by the VP why she wasn't attending school. Sydney did not respond or engage in the meeting and seemingly frustrated the VP asked Sydney if she was trying to get pregnant and inquired into how many 'men' she had been having unprotected sex with. You learn no other adult intervened at this point in the conversation and it slowly drifted to a close.

C. You realize through information shared about Sydney's peers you began supporting one of her female peers approximately 3 months before and those interactions appeared to be going well.

Response:

It is important to note it would be inappropriate to invite Sydney to the initial meeting given the concerns presented by the school and her mother. We also do not want to place any more stress on the situation by requesting her presence at this time given she is not attending school regularly. If this is communicated (as it often is) it is our responsibility to set the stage for success with all attendees.

5 A) As a front line youth worker, the discloser of sexual and physical abuse is a very serious thing. Upon receiving this information it is important to ask about the Children's Aid Society involvement and if Sydney was ever removed from the home. Physical and sexual abuse is severely traumatizing and young people and families can continue to be traumatized as they are involved in the child welfare system. This is also helpful to garner an understanding of the history of this experience. Are there other children in the home? How were they impacted by Sydney's abuse? Was there partner/domestic abuse in the home? These are questions that should be entered into very lightly and we must use our own judgement if it is more fitting to ask questions in a private setting.

Variable to Success: Asking permission before you inquire about something difficult and possibly re-traumatizing is key to setting a safe and comfortable environment. Let Sydney's mother know you have a few questions that may help you put Sydney's recent behavior into context. It is very critical we provide a rational for asking questions on traumatic situations. For instance you can say, "I have some further questions about the impacts of Sydney's abuse and your family, is it okay to ask them now?" OR "Are you comfortable with answering any other questions I may have about Sydney's abuse and the impacts on your family?" It is very important to use our empathetic skills and preface any questions with statements like "I'm so sorry this has happened to your family", "It sounds like you reached out to get Sydney some support, which is a great thing," "Thank you for sharing this with me, I can imagine how difficult this has been."

You have been given a key insight into a possible future intervention during this conversation. Despite not working at Sydney's current school, if the previous social worker is still employed with the school board she can be utilized for engagement and possibly provide supportive services. Explore this option during the meeting by gathering the name of the social worker and the current Manager of Social Work responsible for the school. Work with the current social worker to determine who the best person is to gather more information on this possible intervention- yourself, or the current social worker. We do not always have to 'reinvent' service when it is not necessary- given there is a supportive professional who is identified, the first step is to determine if you can engage this individual again.

5 B) This addition to the scenario was added as a reminder young people experience social injustice and can be discriminated against/victimized by individuals who are in positions of power. As a front line youth worker, it is important to confirm the attendees of this meeting and their names and how Sydney's attendance/school participation has been since this meeting. As an advocate and ally for youth justice, even though Sydney is not at the current meeting and she is yet to be a client, identify how unfortunate this incident is and identify that there is no room for such conversations with a young person in such a formal, public setting. From an Anti Oppressive, Feminist lens, Sydney's sexuality holds no barring to her right to receive an education in a setting that fits her needs. As a male Vice Principal asking her this question further victimizes her and adds to the oppressive nature of scenario- Sydney could now feel unsafe and unprotected as it is mentioned the other attendees did not intervene or end the meeting at that time. Such statements toward Sydney are further harmful and not trauma informed. As a front line youth worker, this incident should be considered when discussing school participation with Sydney in the future. Further investigation may also be warranted as Sydney's mother way wish to make a formal complaint or speak with the Vice Principal directly about the incident again.

Variable to Success: Remember, most parents want to be a strong ally to their children however need support in determing the appropriate route to take. We cannot immediately conclude the adults in Sydney's life are not able to advocate for her best interests.

5 C) Having an 'in' with a peer group can be very helpful when trying to potentially engage a young person. However, it is critical we do not disclose the personal information of young people amongst that network, despite having multiple relationships. As a front line youth worker, there may be an opportunity to engage Sydney through the peer you are already working with. Are there similar risk factors? What are the goals and current intervention plan for her peer? Now that you have met with the school social worker maybe there is an opportunity to build a school based, or after school community based program that would build in some goals/activities relevant to Sydney's peers. It would be important to inform the peer she is able to bring some friends along- providing incentives can also be helpful (Snacks, meals, bus tickets/presto card.) This could support you meeting Sydney in a non confrontational way. While this is just an example, since Sydney is not currently engaged in any programming or connecting with an adult ally, this may be the most practical way to meet and connect with her.

Compassionate Caring:

Working with young people, families and communities can be challenging. Understand this and appreciate the commitment individuals undertake when going into this field. It is important that front line youth workers, managers/supervisors, agencies and the social services sector as a whole engage in naturalizing some of the difficulties experienced by professionals. Only then will there be professional services where clients and professionals feel supported with means of seeking help and safe places to discuss their experiences.

There are important points to consider when thinking about our own wellness as professionals:

Most people have been compelled to this profession based on their personal histories and lived experiences- it is not often you will find a professional or community stakeholder that supports individuals who cannot identify a personal connection to why they chose this profession.

Compassion Satisfaction is the satisfaction we receive as individuals in doing the 'work'. These are the experiences that keep engagement in the profession high and encourage work as 'helpers'. Struggling to identify the joy we derive, past and present, for our work as a 'helper' is a key indicator we may need support.

Language of 'burnout' is often over used and over normalized. The truth is, there are stages to burnout that may not be linear but can be identified and intervened upon. What is known as the compassion fatigue trajectory does not begin and end within a specific moment.

Stages of burnout are not thoroughly discussed in this knowledge exchange, there are tools you can personally engage in to promote a connection to your physical, emotional, spiritual and mental wellness. These tools are provided as examples, if you determine you are not experiencing optimal wellness we promote speaking with your manager/supervisor, trusted colleagues and/or friends and potentially an Employee Assistance Program for further support.

- **GAD Assessment- Generalized Anxiety Score:** Short scale directly identifying potential experiences of anxiety;

- **Professional Quality of Life Score:** Formal assessment providing enhanced clarity on compassion satisfaction, burnout and secondary traumatic stress.

- **ACE Score (Acute Childhood Experiences):** We have been restricted to learning about ACE scores mostly in relation to individual clients and general populations. Knowing our ACE score gives a look into our potential risk factors and what we could be bringing into the work with us.

- **Wellness Gauge:** The example wellness gauge for this knowledge exchange is provided by Caring Safely, created by Charlene Richard. A wellness gauge examines various aspects of our life (for example body, thoughts, mood, relationships, sleep, food) relational to varying de-grees of wellness- from abundance to low. Often 'working' documents, indi-viduals must engage in the process reflecting critically on their own actions and behaviors and the document can change over time.

How we take care of ourselves in order to rest and recover is variable and very personal. Otherwise known as Self Care, we are often asked to speak about our actions/activities in fixed terms and we struggle to connect to self care with the possibility it can change, the possibility it can be unsure and the possibility self care can be a difficult and painful process to connect to. Because of this, we enter into conversations about self care lightly, allowing individuals to self direct their needs and deter-mine supports that spark meaning and comfort.

Conclusions and Closing:

Provide participants with their USB key and share the content and the hopeful purpose of usage. As a reminder, participants are provided copies of this knowledge transfer curriculum and all materials (PowerPoint, appendix) in order to facilitate and share information with their professional teams.

Variable to Success: It should be noted, participants should seek permission if they wish to use any of the information provided beyond professional discussions- this may include grant submissions, mental health reports and future knowledge transfers. Requests can be made directly to the consultant via the contact information noted on page two of this curriculum.

As the knowledge transfer comes to a close, it is important for facilitators to draw the content to an end. This can be classified as 'take home' messages. Importantly, facilitators should discuss with the group their own 'take home' messages. Facilitators are encouraged to identify their own learnings as the knowledge transfer takes place. Within a reciprocal learning environment, facilitators are in a position of learning and it is important this is communicated to the group.

Prompts for facilitators to engage in this process are:

1 What is something new you learned from the participants today?

2 How did the material you presented change based on the feedback and discussions with participants?

3 Was there an 'ah-ha' moment for you during today's session?

4 Is there something you would change about how you facilitate this material in the future based on today's knowledge exchange?

After facilitators have shared, encourage participants to share with the group what their 'take home' learning has been. Importantly, not all participants enjoy sharing, this is not a mandatory activity but an opportunity to share their feelings about the knowledge transfer.

Some prompts for participants could be:

5 Was there something specific that stood out for you?

6 Do you envision making a change to the way you currently provide support to young people?

7 Thank Participants for attending this knowledge transfer event. It is also appropriate for facilitators to share an email address or other means of contact if participants have questions.

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Appendix

Clinical Intervention Terminology Activity

The following identifying words are documented on individual flip chart papers that correspond to the appropriate clinical intervention. Facilitators will utilize a separate sticky note to place on the flip chart paper with the named clinical intervention once participants have completed the selection process.

- **Cognitive Behavioral Therapy:** Ongoing client relationships, challenging negative thinking, identify sources of difficulties, homework, participatory model.
- **Trauma Focused Cognitive Behavioral Therapy:** Shorter term relationships, processing emotions and feelings, solutions focused, healthy coping strategies, can prioritize involve-ment with stakeholders (parents/guardians).
- **Anti-Oppressive Practice:** Naming discrimination and stereotyping, focusing on power imbalances, advocacy and ally ship, intersections of lived experiences.
- **Peer Support:** Personal lived experiences, social and personal connection, utilizes many forms of contact, flexible and ongoing relationships
- **Narrative Therapy:** Separating challenges from the entire individual, changing how we identify, focusing on language and self-talk, asks many questions, prompts individuals to deeply explore their identities and numerous ‘stories’.
- **Crisis Intervention:** Leader, quick thinking fast action, capable of smooth delegation, safety of self & others is #1 priority, sound professional knowledge, and calm approach, consider all individuals and stakeholders in decision making.

The Wellness Gauge

Wellness Level	Body (Aches/Mobility Digestion, Tension/ Energy)	Thoughts (Scattered/ Clear Rapid/Slow)	Mood (Happy/ Hopeful Sad/Hopeless Angry)	Relationships (Quality time/ Isolation Communication/ Connection)	Sleep How many Hours? Solid or Broken?	Food Healthy/ Unhealthy Too much/little Regular/ Scattered
Abundance						
8-10						
5 (half way)						
2-3						

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T____ = ____ + ____ + ____)

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

COMPASSION SATISFACTION AND COMPASSION FATIGUE (PROQOL) VERSION 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

_____ 1. I am happy.
_____ 2. I am preoccupied with more than one person I *[help]*.
_____ 3. I get satisfaction from being able to *[help]* people.
_____ 4. I feel connected to others.
_____ 5. I jump or am startled by unexpected sounds.
_____ 6. I feel invigorated after working with those I *[help]*.
_____ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
_____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
_____ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
_____ 10. I feel trapped by my job as a *[helper]*.
_____ 11. Because of my *[helping]*, I have felt "on edge" about various things.
_____ 12. I like my work as a *[helper]*.
_____ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
_____ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
_____ 15. I have beliefs that sustain me.
_____ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
_____ 17. I am the person I always wanted to be.
_____ 18. My work makes me feel satisfied.
_____ 19. I feel worn out because of my work as a *[helper]*.
_____ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
_____ 21. I feel overwhelmed because my case [work] load seems endless.
_____ 22. I believe I can make a difference through my work.
_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
_____ 24. I am proud of what I can do to *[help]*.
_____ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
_____ 26. I feel "bogged down" by the system.
_____ 27. I have thoughts that I am a "success" as a *[helper]*.
_____ 28. I can't recall important parts of my work with trauma victims.
_____ 29. I am a very caring person.
_____ 30. I am happy that I chose to do this work.

YOUR SCORES ON THE PROQOL: PROFESSIONAL QUALITY OF LIFE SCREENING

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental health care professional.

Compassion Satisfaction _____

Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Burnout_____

Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Secondary Traumatic Stress_____

The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional.

WHAT IS MY SCORE AND WHAT DOES IT MEAN?

In this section, you will score your test so you understand the interpretation for you. To find your score on **each section,** total the questions listed on the left and then find your score in the table on the right of the section.

Compassion Satisfaction Scale

Copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

3. ____
6. ____
12. ____
16. ____
18. ____
20. ____
22. ____
24. ____
27. ____
30. ____

Total: ____

The sum of my Compassion Satisfaction questions is	So My Score Equals	And my Compassion Satisfaction level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Burnout Scale

On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. "I am happy" tells us more about the effects of helping when you are *not* happy so you reverse the score

You Wrote	Change to
	5
2	4
3	3
4	2
5	1

*1. ____ = ____
*4. ____ = ____
8. ____
10. ____
*15. ____ = ____
*17. ____ = ____
19. ____
21. ____
26. ____
*29. ____ = ____

Total: ____

The sum of my Burnout Questions is	So my score equals	And my Burnout level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Secondary Traumatic Stress Scale

Just like you did on Compassion Satisfaction, copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

2. ____
5. ____
7. ____
9. ____
11. ____
13. ____
14. ____
23. ____
25. ____
28. ____

Total: ____

The sum of my Secondary Trauma questions is	So My Score Equals	And my Secondary Traumatic Stress level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High