Mental health, Mental Illness and Addictions in youth: What do we know about racialised youth health?

Mental health, Mental illness and Addictions in youth in Canada

At any given time 15% of children and youth are experiencing a mental health problem (Mood Disorders Society of Canada 2009). While a significant number of Canadians are living with mental health problems, few seek help. Only 30% of people with mental health problems ever seek help and many delay seeking help until their condition becomes severe (CAMH 2003). From these figures it can be estimated that up to 250,000 children and youth in Toronto are experiencing mental health problems and only about 75,000 of them will ever seek help.

Over 70% of mental health problems start in childhood or early adolescence (Mental Health Commission of Canada 2009). Eighteen per cent of adolescent Canadians (15 to 24) report a mental health problem or substance abuse problem (Mood Disorders Society of Canada 2009). The mental health problems faced by children and youth are significant and varied. Disruptive behaviours, mood and anxiety disorders typically start in childhood (WHO 2005). In 2006 nearly 65,000 youth in Toronto under the age of 19 will have experienced bouts of depression.

Suicide is a significant problem worldwide. Suicide accounts for 24% of all deaths among 15 to 24 year olds (Mood Disorders Society of Canada 2009). In 2007 suicide was the second leading cause of death for 15 to 24 years, behind accidents, and the fourth leading cause of death among children (under 15) (Statistics Canada 2010a).

Eating disorders are also a cause for significant concern. Between 1987 and 1999 the rate of increase for hospitalizations for Canadian girls under 15 with an eating disorder was 34% (Mood Disorders Society of Canada 2009).

Mental Health and Addictions in Ontario Children and Youth

Ontario students are facing many stressors as they grow up and this effects their development and mental health. Nearly half of students (47%) in the OSDUHS reported at least one problem (elevated psychological distress, hazardous/harmful drinking, a drug problem use, or delinquent behaviour), and two percent of the students reporting facing all four problems (Paglia-Boak et al. 2010).

While substance use may be the least common problem among children and youth in Canada (Mood Disorders Society of Canada 2009), in Ontario youth aged 15 to 24 are three times more likely to have a substance misuse problem than people over the age of 24 (MOHLTC 2009). Substance use has changed among youth in Ontario over time between 1977 and 2009; use of certain substances also varies depending on age and gender (Paglia-Boak et al. 2009). In 2009 the Ontario Student Drug Use and Health Survey (OSDUHS) reports that among students in grades 7 through 12 more than half used alcohol (58.2%) in the previous 12 months, nearly a quarter binge drank (5 or more drinks at one time; 24.7%) and one quarter used cannabis (25.6%) in the previous 12 months (Paglia-Boak et al. 2009). Substance use differs by gender with males more likely than females to use cannabis or alcohol and females more likely than males to use solvents or stimulants for example (Paglia-Boak et al. 2009). Substance use tended to increase with age with the exception of solvents which were used more by students in grades 7 and 8 than older students (Paglia-Boak et al. 2009). The report also shows significant decreases in use of many of the substances in the past decade (1999-2009) including cigarettes, alcohol, LSD and heroin (Paglia-Boak et al. 2009). The overall picture is a decrease in use of many substances over the length of the OSDUHS with significant less use than during peak periods with the exception of cannabis, binge drinking, solvents, hallucinogens other than LSD and PCP, and ecstasy use (Paglia-Boak et al. 2009). Current use of these drugs is significantly lower than one or both of their peak periods, however it is significantly higher compared to use in the late 1980s or early 1990s (Paglia-Boak et al. 2009).

Young people in Ontario (18-24 year olds) have been found to have the highest proportion of moderate to severe gambling problems (6.7%) – almost twice the provincial rate of 3.7% (Wiebe, Mun & Kauffman 2006). Another 12.5% of 18-24 years olds in this study were at risk of developing a gambling problem. Certain forms of gambling are more attractive and easier to access for youth. While 6% of

Ontario youth took part in arcade or video style gambling, the provincial rate was only 1.6%. Youth were approximately 4 times more likely to gamble over the internet and nearly 3 times more likely to gamble at casino tables than the average Ontarian. Wiebe and colleagues (2006) also found that a quarter of youth gambled on card games and nearly one third purchased scratch tickets.

Suicide and suicide ideation is a significant problem in Ontario. Estimates suggest that for every 100,000 people in Ontario we lose 255 years of life to suicide (MOHLTC 2009). The most recent vital statistics report that 1,100 people died from suicide in Ontario in 2007, which is an age standardized mortality rate of 8 per 100,000 people (Statistics Canada 2010b). Among students in grades 7 through 12 in 2009 about 10% reported seriously considering suicide in the past year and 3% reporting attempting suicide in the past year (Paglia-Boak et al. 2010). This means that roughly 99,000 Ontario students considered suicide the year before this study and 29,000 attempted suicide (Paglia-Boak et al. 2010).

5-9% of Ontario school-aged children may have Attention-deficit/hyperactivity disorder (ADHD). ADHD occurs more commonly in boys than girls at a rate as high as 3-4 times (CAMH 2003). About two-thirds of children who have ADHD will continue to have symptoms into adolescence. Recent work showing a significant increase in mental health visits from 1999 to 2009 (Paglia-Boak et al. 2010) suggests either an increase in mental health problems among youth or the recognition of mental health problems and the need to seek appropriate services.

The costs of mental health and addictions in Ontario including health and social care spending as well as lost productivity has been estimated to be 39 billion dollars a year (MOHLTC 2009).

Racialised children and Youth in Toronto – the stats

Over half of the population of Toronto was born outside of Canada and nearly half are visible minorities[1]. One hundred thousand new immigrants settle in Toronto annually (City of Toronto) and these new immigrants are as diverse as the current population.

[1] Persons other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour. Source: Statistics Canada, 2006 Census Dictionary.

In 2006 there were 1,631,500 children and youth (0 - 24 years) living in the Toronto Census Metropolitan Area (CMA) according to the Census 22% were immigrants and 50% visible minorities (Statistics Canada 2008a). However this may not properly reflect the situation. In the same year the Toronto District School Board (TDSB) conducted a census of their students. (Yau & O'Reilly 2007). Figure 1 shows the racial/ethnic composition of the TDSB student population.

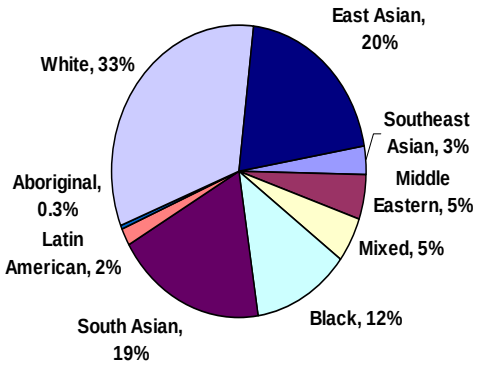

Figure 1: Racial/Ethnic Distribution of Grade 9-12 Students (2006)

Source: Yau & O'Reilly. 2007. *2006 Student Census, Grades 7-12: System Overview.*

This study reported that 30% of students in grades 7-8 and 42% of students in high school were born outside of Canada (Yau & O'Reilly 2007). Perhaps more importantly, most of these students had at least one parent who was born outside of Canada (80%) and the majority of these parents were first generation Canadians (71%) (Yau & O'Reilly 2007). Sixty-seven per cent of high school students and 69% in grades 7 and 8 belong to visible minorities (Yau & O'Reilly 2007).

Mental Health and Addictions Problems among Diverse Youth

Ethnicity is not routinely collected in administrative data and so the actual rates of mental health problems and mental illness for different racial or ethnic groups is not known. There is surprisingly little research into mental health and addictions problems in immigrant, refugee, ethno-cultural and racialised (IRER) children and youth. This is especially true for Canadian-born ethno-cultural and racialised groups. Often the results are only reported as part of a larger study involving all IRER group members. The fact that racialised youth in Ontario are more likely to be exposed to the social determinants of health would, however, be a cause for concern.

Risk factors for mental health and addictions problems in children and youth can include: physical, emotional and/or sexual abuse; experiences of or witnessing violence or warfare; suffering from intellectual disability; homelessness; migration from rural to urban areas; international migration; living in poverty; poor housing; perceived discrimination; lack of social support or weak networks; and language, cultural and educational barriers (WHO 2005; Tyyskä 2009; Hansson et al. 2010).

The realities of migration to another country often add stressors to an individuals' life. In a study of Ontario students, Hamilton, Noh & Adlaf (2009) found that foreign-born students reported more symptoms of psychological distress compared to their Canadian-born counterparts. However, their results showed no consistent improvement or deterioration of psychological and behavioural outcomes across immigrant groups (Hamilton, Noh & Adlaf 2009).

These pre- and post-migration factors, such as experiencing trauma, war, resettlement in a new country and learning a new language, can affect levels of stress and depression. In one study of Ethiopian immigrants and refugees to Toronto, individuals who were exposed to trauma and refugee camp internment had significantly higher prevalence rates of depression (Fenta, Hyman & Noh 2004). These risk factors often have greater impact on youth as this study showed the younger Ethiopian immigrants and refugees had the greatest risk for depression (Fenta, Hyman & Noh 2004). Similarly, Tousignant and colleagues (1999) found that refugee adolescents in Quebec experience higher rates of simple phobia, conduct disorder, and depression than Canadian-born adolescents.

Our experiences with mental health and addictions problems are not always consistent or expected, and for various reasons the help-seeking patterns of IRER groups differ. Hamilton, Noh and Adlaf (2009) found that the odds of harmful drinking and illicit drug use increased across immigrant generations. For example, third generation Ontarian adolescents engage in more harmful drinking and illicit drug use than first and second generation immigrants (Hamilton, Noh & Adlaf 2009). Perhaps this is a factor of acculturation, however, it is unknown if these differences existed within or across the immigrant groups based on ethno-cultural or racialised groups.

Despite higher levels of social anxiety among immigrant Chinese University students, Hsu and Adler (2008) found they tend to delay or avoid seeking mental health treatment until their conditions are more severe as compared to European heritage students.

Discrimination, racism and alienation are often significant factors in mental health problems (Chakraborty & McKenzie 2002). Factors which reduce feelings of belonging can impact the likelihood that someone will seek help before problems become severe.

A study exploring the sense of belonging among students in Toronto found that 56% of immigrants and 90% of Canadian-born students considered themselves Canadian; however, when disaggregated further there were racial differences in that one quarter of Canadian-born Blacks, one fifth of Canadian-born Middle Easterners, and one fifth of Canadian-born West Asians felt they were not Canadians (Wood & Wortley 2010). The more students agreed that their racial group was discriminated against by the police, by employers, or by educators the less likely they thought of themselves as being Canadians (Wood & Wortley 2010). Furthermore, the more one experiences violence because of racial or ethnic background the less likely one thinks of themselves as Canadian (Wood & Wortley 2010). This lack of feeling Canadian, despite in many cases being born here, may increase one's risk for mental health problems, or lead to substance use or misuse. Noh and colleagues (1999) have shown that perceived discrimination among refugees greatly affects levels of depression and that this is inversely related to age. So that the younger refugees who felt they were discriminated against reported higher levels of depression. Furthermore, stronger identity with an ethnic minority (for example identifying as Chinese over Chinese-Canadian) interacted with level of perceived discrimination to intensify the link with depression (Noh et al. 1999).

The reality of mental health and addictions problems among children and youth is complex. Based on International studies in the UK and the US, prevalence of mental health and addictions problems may and do differ across age groups, racial/ethnic groups, or within groups (Stansfeld et al. 2004; Breslau et al. 2006; Bhui et al. 2008; Li et al. 2010; Merikangas et al. 2010a; Merikangas et al. 2010b). In order to understand these phenomena, Canada needs to consider national studies in which groups can be disaggregated to develop prevalence rates for comparison at regional and local levels. The factors which protect or create risk can differ from one group to another. However we need to be clear that there may be diversity within ethnic groupings. In the UK "White" is an ethnic grouping in the census. This is a bit like Canada where the White populations would be those who are not a "visible minority". In the UK one study compared "white" girls who were of non-UK origin (largely of Irish, Turkish or Greek heritage) and those whose origins were in the UK. Those of non-UK origin had higher rates of

depression than White UK girls, or girls of Bangladeshi, Pakistani, Indian, or African and Caribbean origins (Stansfeld et al. 2004).

Identity is important in the process to protecting or creating risk. How children choose to express their identity and the level of comfort with their identity may influence risk of later mental health problems (Bhui et al. 2008). In order to better understand these concepts, Canada needs to have a strategy which addresses the multiple issues faced by our children and youth and be able to track and understand the different patterns of mental health and addictions problems within our diverse society.

Recommendations Going Forward

It is apparent that we lack a clear understanding of the rates of mental health problems faced by IRER children and youth in Canada. Many of the same stressors, risk factors and protective factors are experienced by all children and youth but children and youth who belong to IRER groups often have unique experiences which may affect their mental health.

There are a number of serious concerns for the mental health and well-being of the current and future IRER youth in Canada. Suicide is a great concern and the rates may be increasing, it is worrisome that so many youth in Ontario have ideas of suicide and have attempted suicide. What work we do have does not disaggregate children and youth of IRER groups but we know that this is the second leading cause of death among youth and from studies among adults we can see that rates differ across ethnic groups (Clarke et al. 2008). Rates of ideation, plans and attempts are higher among some IRER groups and lower in others (Malenfant 2004; Kennedy et al. 2005). Substance use and misuse may be decreasing overall among youth but the work of Hamilton, Noh and Adlaf (2009) shows that these rates differ across generations among immigrants. This highlights a greater need for disaggregated rates. There is also evidence that gambling problems are an issue among youth and refugee youth experience higher rates of mental health problems. We know from studies among IRER adult populations that they are less likely to seek help for mental health problems (Whitley, Kirmayer & Groleau 2006; Kirmayer et al. 2007). IRER communities have expressed that youth should be on the top of the list when considering mental health prevention, promotion and services (Hansson et al. 2010).

Education is one key to the whole process as it cuts across issues of promotion, prevention, intervention and research (Foresight Mental Capital and Wellbeing Project 2008; Hansson et al. 2010; Kutcher &

McLuckie 2010; Government of Ontario 2011). In the recent MHCC Evergreen Framework, educators, family members and young people with lived mental health experience emphasized the need for better education to help increase understanding and knowledge, and decrease stigma (Kutcher & McLuckie 2010). Health promotion specialists, policy makers and leaders also need to continue to educate themselves to effectively engage and reach young people in today's multi-media and digitally connected society (Kutcher & McLuckie 2010). A multi-faceted approach that is not siloed but instead focuses on creating a basket of services that gets children and youth into services sooner but also transitions youth when ready, if needed, into adult services is likely the best framework. In fact, with the right information, training and supports, educators indicated that they "may be the best positioned to challenge stigma, enhance mental health literacy and raise awareness of child and youth mental health" (Kutcher & McLuckie 2010: 20). In order to address gaps and uncertainties, the knowledge needs to be generated through a long term strategy that incorporates large scale longitudinal studies (Foresight Mental Capital and Wellbeing Project 2008). Programs aimed at schools for the promotion and prevention of mental health and mental illnesses are vital but if government policies and choices do not nurture the wellbeing in a wider population so that everyone can flourish we are still just addressing a part of the problem. Any framework or strategy needs to look at the complex needs of young people which are addressed through agencies, organizations, institutions and Ministries/Departments working together with each other and alongside young people, their families and their communities (Hansson et al. 2010; Kutcher & McLuckie 2010).

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