Synergy
RESEARCH AND EDUCATION IN MENTAL HEALTH
VOLUME 13 • NUMBER 1 • WINTER 2009

IN THIS ISSUE

DEPRESSION AND SLEEP APNEA: INVESTIGATING THE LINKS

By Aisling Fitzpatrick
Undergraduate University Student

Ruzica Jokic, MD, FRCP
Assistant Professor of Psychiatry,
Queen's University

Introduction

Obstructive sleep apnea (OSA) and major depressive disorder (MDD) have many clinical, neuropsychological and functional features in common. Both patients with OSA and those with MDD experience fatigue, chronic pain, and mood and anxiety symptoms. The Mood Disorders Research and Treatment Service team at Providence Care Mental Health Services is conducting a study, funded in part by Queen's University, that is designed to examine the prevalence of OSA in patients diagnosed with treatment resistant depression (TRD). We will also assess the effects on mood and cognitive function of adding continuous positive airway pressure (CPAP) to the current psychiatric treatments of patients diagnosed with both TRD and OSA. This is, to our knowledge, the first study designed to examine the co-morbidity of OSA and TRD in a population referred to a tertiary mood disorders clinic.

The interaction between sleep, disordered breathing and mood is complex, multidimensional, and still not fully understood (Bardwell et al, 2003). Our study will investigate this interaction as we focus our attention specifically on the relationship between TRD and OSA.

According to the Canadian Community Health Survey of Mental Health and Well Being (Patten et al, 2006) the lifetime prevalence of MDD ranges from 6 to 18 per cent. Patients diagnosed with MDD experience symptoms that severely limit daily function. Moussavi and colleagues (2007) studied two hundred fifty thousand respondents in 60 countries and found that MDD produces a greater decrement in health than other chronic diseases such as angina, arthritis, asthma and diabetes. Furthermore, MDD in combination with any one of these diseases produced a disability score worse than that produced by any pair of these physical diseases.

Most individuals diagnosed with MDD respond to pharmacological treatment, resulting in improved mood and capacity to function in daily life. However, there is a subgroup of patients, with clinical symptoms of TRD, who are unable to achieve remission following at least

Continued on Page 3

TABLE OF CONTENTS

Editor's Note

By Philip Burge, PhD
Social Worker, Associate Professor of Psychiatry, Queen's University

As we begin a beautiful winter in southeastern Ontario I am happy to introduce another excellent edition of Synergy. This issue is comprised of articles which offer readers an array of important information about mental health research, practice and policy.

We are delighted to present our cover article by Ms Aisling Fitzpatrick and Dr. Ruzica Jokic on their important groundbreaking examination of sleep apnea and treatment resistant depression. Ms Tracey McMullen's article on autism and key issues in the diagnosis and treatment of comorbid mental health concerns provides a valuable summary of practical information for the new and seasoned professional. We know you'll enjoy reading Ms Sandra Lawn's thoughtful commentary on child and adolescent mental health policy developments in our Policy Corner. As well, you'll appreciate Ms Karen Gagnon's practical encouragement on how mental health practitioners can meet the challenge of assisting information-seeking consumers in accessing reliable mental health information on the Internet in our Librarian's Corner.

I wish to thank our new and continuing Editorial Board members for their work on this issue and for their contributions to improving Synergy to make it more relevant to its readership all the while keeping our costs down. In our efforts to save paper and respond to readers' requests we are now sending out electronic copies of Synergy far and wide. If you have received such a copy and prefer a paper copy please let us know at: robertk4@providencecare.ca . Finally, I extend a special thank you to our outgoing Assistant Editor, Ms Barbara Theman, whose dedication to Synergy over several years was exemplary and inspiring. Barbara has recently retired and we wish her all the best in her retirement endeavours.

We look forward to hearing or reading your feedback on this issue of Synergy.

WEBSITE INFORMATION

Frontenac Community Mental Health Services
www.fcmhs.ca

Hotel Dieu Hospital
www.hoteldieu.com

Kingston General Hospital
www.kgh.on.ca

Ongwanada
www.ongwanada.com

Providence Care
www.providencecare.ca

Queen's University Department of Psychiatry
meds.queensu.ca/psychiatry

Southeastern Ontario Addictions and Mental Health Services & Information
www.recoveryconnections.ca

DEPRESSION AND SLEEP APNEA: INVESTIGATING THE LINKS

Continued from Page 1

one adequate trial (with appropriate dose and duration) of an antidepressant treatment. TRD has been estimated to contribute to half of the total treatment costs for depression (Parker et al, 2005). Moderate treatment resistance is defined as an inadequate response to a single antidepressant trial, while more severe treatment resistance is either failure of two monotherapy trials or one or more augmentation trials.

OSA is a condition characterized by intermittent, partial or complete collapse of the upper airway during sleep. This causes decreased blood-oxygen saturation, increased heart rate, and sleep fragmentation. Patients experiencing these events describe feelings of non-refreshing sleep, cognitive difficulties (including difficulty concentrating), daytime hypersomnolence, and fatigue (Fogel et al, 2004). When left untreated, OSA is associated with an increased likelihood of severe motor vehicle accidents, arterial hypertension, myocardial infarction, stroke and premature death (Peppard et al, 2000).

Although OSA was first recognized almost 40 years ago, its prevalence has only been investigated during the last two decades. Recent studies suggest that approximately 1 in 5 adults have mild OSA, and about 1 in 15 adults have moderate to severe OSA (Young et al, 2002). The prevalence of OSA is much higher in some populations. For example, patients with congestive heart failure have a 50 per cent chance of being diagnosed with OSA (Newman et al, 2000). Unfortunately, by current estimates, only about 10-20 per cent of OSA-affected individuals have been diagnosed (Young et al, 2001). Studies show that 75-80 per cent of undiagnosed cases of OSA would benefit from treatment (Young et al, 2002). This apparent under-diagnosis of sleep apnea (especially mild and moderate cases) can be explained partly because many cases do not present with typical OSA symptomology (i.e., somnolence and snoring). For this reason, symptoms of sleep apnea are incorrectly identified leading to misdiagnosis and ineffective patient treatment.

Numerous studies demonstrate a high prevalence of depressive symptoms among patients with OSA (Peppard et al, 2006). One recent preliminary study examined sleep-related breathing events in a small sample of individuals with MDD as compared to controls and determined a significant difference in the number of episodes of nasal airflow limitation and oxygen desaturation between the two groups. The authors postulated that disordered breathing during sleep may play a more important role in MDD than previously recognized, and that it may contribute to, or exacerbate, symptoms in individuals predisposed to MDD (Deldin et al, 2006).

Since its introduction in the early 1980's, continuous positive airway pressure (CPAP) has been considered the gold standard treatment for OSA. CPAP acts as a pneumatic splint which forces the upper airway open during sleep (Baldwin et al, 2001). Most studies indicate that treating OSA leads to improved quality of life as well as a reduction in depressive symptoms and cognitive impairment associated with OSA (McMahon et al, 2003; Schwartz et al, 2005).

We hypothesize that daytime functioning is more severely impaired in patients with TRD and OSA receiving routine psychiatric treatment when compared to patients with TRD only. We also hypothesize that patients with TRD and OSA receiving CPAP treatment (in addition to the

psychiatric treatment) will have a significant improvement in mood symptoms and daytime function as compared to patients receiving routine psychiatric treatment only.

Our Study

Our study is using a prospective, single-blind, randomized, parallel group design to evaluate the effect of treatment with CPAP on the daytime function in patients with TRD and co-morbid OSA. Consecutive patients with TRD of either gender, between the ages of 18 and 65, with elevated Hamilton Depression rating scale scores, i.e., HAM-D > 18 (Hamilton, 1967) are invited to participate in the study. A variety of experiences or co-morbid conditions exclude some patients from participating in the study. As well, participants are administered a variety of other measures at predetermined intervals and randomly assigned into the CPAP or no-CPAP arms of the study if diagnosed with sleep apnea. For the duration of the study, the dosage of psychotropic medications is held constant and no medication or psychological treatment changes are allowed during this period.

To date over 50 patients with TRD have been screened for inclusion in this study and approximately one third of them have been diagnosed with OSA of varying degrees of severity as confirmed by polysomnography.

To date over 50 patients with TRD have been screened for inclusion in this study and approximately one third of them have been diagnosed with OSA of varying degrees of severity as confirmed by polysomnography. Based on preliminary study results, screening patients diagnosed with depression (especially those with TRD) for sleep apnea will be of great importance to physicians as untreated OSA has the potential to inhibit recovery from depression in many patients.

For further information about this ongoing research please contact us at Providence Care Mental Health Services in Kingston.

References

Baldwin CM, Griffith KA, Nieto FJ, O'Connor GT, et al. The association of sleep-disordered breathing and sleep symptoms with quality of life in the Sleep Heart Health Study. Sleep. 2001;24(1):96-105.

Bardwell WA, Moore P, Ancoli-Israel S, et al. Fatigue in obstructive sleep apnea: driven by depressive symptoms instead of apnea severity? Am J Psychiatry. 2003;160(2)350–55.

Deldin PJ, Phillips LK, Thomas J. A preliminary study of sleep-disordered breathing in major depressive disorder. Sleep Med. 2006;7(2):131-39.

Fogel RB, Malhotra A, White DP. Sleep. 2: Pathophysiology of obstructive sleep apnoea/hypopnoea syndrome. Thorax. 2004;59(2):159-63.

Hamilton M. Development of a rating scale for primary depressive illness. Br J Soc Clin Psychol. 1967;6(4):278-96.

McMahon JP, Foresman BH, Chisholm RC. The influence of CPAP on the neurobehavioral performance of patients with obstructive sleep apnea hypopnea syndrome: a systematic review. WMJ. 2003;102(1)36-43.

Moussavi S, Chatterji S,Verdes E, et al. Depression, chronic diseases and decrements in health: results from the World Health Surveys. Lancet. 2007;370(9590):851-58.

Newman AB, Spiekerman CF, Enright P, et al. Daytime sleepiness predicts mortality and cardiovascular disease in older adults. The Cardiovascular Health Study Research Group. J Am Geriatr Soc. 2000;48(2):115-23.

Parker GB, Malhi GS, Crawford JG, et al. Identifying "paradigm failures" contributing to treatment-resistant depression. J Affect Disord. 2005;87(2-3):185-91.

Patten SB, Wang JL, Williams JVA, et al. Descriptive epidemiology of major depression in Canada. Can J Psychiatry. 2006;51(2):84-90

Peppard PE, Szklo-Coxe M, Hla KM, et al. Longitudinal association of sleep-related breathing disorder and depression. Arch Intern Med. 2006;166(16):1709-15.

Peppard PE, Young T, Palta M, Skatrud J. Prospective study of the association between sleep-disordered breathing and hypertension. N Engl J Med. 2000;342(19):1378-84.

Schwartz DJ, Kohler WC, Karatinos G. Symptoms of depression in individuals with obstructive sleep apnea may be amenable to treatment with continuous positive airway pressure. Chest. 2005;128(3):1304-9.

Young T, Finn L, Palta M. Chronic nasal congestion at night is a risk factor for snoring in a population-based cohort study. Arch Intern Med. 2001; 161(12):1514-9.

Young, T., P. E. Peppard, and D. J. Gottlieb. Epidemiology of obstructive sleep apnea: a population health perspective. Am J Respir Crit Care Med. 2002; 165(9):1217-39.

MENTAL HEALTH ISSUES IN AUTISM: EXPLORING COMPLEXITIES

By Tracey McMullen, MA
Doctoral Student, York University

Autism is a lifelong and pervasive disorder, emerging in early childhood with hallmarks of social and communicative impairments and odd or intense patterns of interests and behaviours. As children with autism develop, they become exceptionally vulnerable to a variety of mental health disorders (Bradley et al, 2004); especially in individuals without intellectual disability (Szatmari et al, 1989). This paper briefly discusses some of the key challenges in diagnosing comorbid mental health disorders and important considerations for effective mental health treatment of people with autism.

Anxiety disorders are the most common co-occuring psychiatric diagnoses associated with autism and they are usually the first to develop.

Diagnosis of comorbid psychiatric conditions in people with autism can be complicated for several reasons. First is the issue of diagnostic overshadowing – the tendency to attribute all problems and symptoms to the primary diagnosis of autism. As well, psychopathology in autism can sometimes have a different presentation than would be expected in individuals who have a history of typical development. A further complexity is that some of the characteristics of autism (impaired or unusual communication, abnormalities in affect, and poor access to internal mental states) can make diagnosis of additional psychiatric disorders difficult. These same characteristics of autism can also create barriers to treatment.

To lessen the unique barriers to diagnosis and treatment, mental health professionals may have to obtain consent so as to enlist the assistance of collateral sources of information. As the patient with autism may be less able to communicate his/her emotional state or have the self-monitoring skills to describe change, family members or support workers can help to establish the historical baseline for the individual and determine any changes. For example, social aloofness is common in autism but a family member might note that there has been an increase in social withdrawal over recent months.

The ability to ascertain comorbid psychiatric disorders in autism is important for earlier intervention because currently up to 50 per cent of people with autism will have contact with psychiatric hospitals for co-occurring mental health problems in there lifetime (Mouridsen et al, 2008).

Anxiety

Anxiety disorders are the most common co-occuring psychiatric diagnoses associated with autism and they are usually the first to develop. Anxiety may be considered a feature of autism, with up to 84 per cent of individuals meeting criteria for at least one anxiety disorder (Muris et al, 1998). These can include specific phobias, generalized anxiety disorders, social phobias, panic disorder attacks, and obsessive-compulsive disorder (OCD). For an anxiety diagnosis, comorbid symptomology should be at a threshold greater or qualitatively different than would be accounted for by the primary autism diagnosis.

It can be difficult to differentiate the obsessions and ritualistic behaviour typically associated with autism from the obsessions and compulsions best accounted for by OCD. Obsessions in autism are not ego-dystonic (Baron-Cohen & Wheelwright, 1999), if they are, one would be alerted to a possible comorbid OCD. Up to 2 per cent of individuals with

autism also receive a comorbid OCD diagnosis. Preliminary studies have demonstrated that standard OCD treatment with SSRIs and modified relapse prevention cognitive-behavioural therapy (CBT) are also effective for individuals with autism and OCD (e.g., Lehmkuhl et al, 2008).

It is important that practitioners take anxiety seriously in autism. Untreated, anxiety creates an additive effect to the disabilities associated with autism. For instance, as they develop, young adults with autism often have an increased desire for social connectedness. Unfortunately, an emergent social anxiety problem can interfere with their opportunities to learn and practice underdeveloped social skills (Bellini, 2006). Untreated anxiety puts the individual with autism at increased risk for developing a secondary depression (Howlin, 2000). Evidence for the effectiveness of modified CBT for anxiety disorders in autism is promising (Sofronoff et al, 2005). Additionally, SSRIs are effective in the psychopharmacological treatment of anxiety in autism with the caveat to be aware of the possible side effect of agitation (Kolevzon et al, 2006). There is some evidence that benzodiazepines can have a paradoxical effect in autism with increased nervousness and aggression (Marrosu et al, 1987).

Depression

From the first descriptions of autism by both Kanner and Asperger, depressive symptoms were present in some of the cases. Depression, like other forms of mental illness can be easily missed in autism (Ghaziuddin & Greden, 1998). The expected vegetative symptoms may be present but identifying changes in mood can be difficult. Special features of depression particular to autism can include an even greater tendency toward social withdrawal than usual for that person, irritability, increases in self-injurious behaviour, a regression in skills, and the repetitive behaviours and interests typical of autism can change as well (Ghaziuddin, 2005). For example, repetitive behaviours and interests may increase or take on more of a ritualistic quality or the content of the interests may transform to contain more frightening, nihilistic, or death themes. Even though these symptoms may not be typical of non-autistic depression they may still be ameliorated by anti-depressive medications (Clarke et al, 1999).

It is important that practitioners take anxiety seriously in autism.

Catatonia

There is accumulating evidence that adolescents and adults with autism are at relatively high risk for developing catatonia (i.e., up to 1 in 7; Wing & Shah, 2000). It is important that appropriate and early intervention is taken as permanent effects of the deterioration can persist and treatment with antipsychotic medication can cause a worsening of symptoms. Autism-specific catatonia intervention has been well established to include large doses of benzodiazepines with the use of electroconvulsive therapy in more resistant cases (see treatment protocol in Fink et al, 2006)

Schizophrenia/Psychosis

There have been conflicting results regarding whether adults with autism are at increased risk for developing schizophrenia. For the most part, a diagnosis of autism precludes a diagnosis of schizophrenia in the absence of frank delusions or hallucinations. Most studies have concluded that people with autism are not at higher risk for developing schizophrenia (Ghaziuddin, 2005). Misdiagnosis of schizophrenia can occur in autism due to diagnostic overlap (Konstantareas & Hewitt, 2000). Confusion in differentiating autistic symptoms from schizophrenic symptoms for clinicians and from the research has likely arisen due to the similarity of the surface presentation of symptoms. A few recent studies have done an excellent job of disambiguating this overlap, particularly in the area of paranoia and thought disorder.

Paranoid and persecutory ideation can often be elevated in people with autism (Blackshaw et al, 2001). The paranoia tends to arise from theory of mind deficits in autism and is different from the paranoia of schizophrenia because individuals with autism do not have a pathological attributional style (Craig et al, 2004).

People with autism may also exhibit loose associations, clanging, neologisms, and illogical thinking. Although these symptoms are typically associated with the thought disorder in schizophrenia, research has shown that they can arise from the underlying disability associated with autism (Solomon et al, 2008). This same study demonstrated that what looks like thought disorder in autism was directly related to communicative-pragmatic difficulties typical of individuals with autism.

Ultimately, the cognitive and linguistic style of people with autism can account for symptoms that look like schizophrenic symptoms. This differentiation is very important because treatment with antipsychotics can worsen the symptoms of autism. That is, the side effects associated with antipsychotics can cause mental slowing, lack of energy, and decreased facial expressiveness, all of which can be detrimental to a person who both does not have schizophrenia and who already needs to put forth much effort to be engaged in the social world (D. Tantam, personal communication, April 15, 2008).

On occasion though, an individual with autism may demonstrate an acute and transitory psychotic episode in reaction to the experience of increased stress (Tantam, 2000). When this includes the presence of frank delusions or hallucinations an additional diagnosis of brief psychotic disorder would be warranted. Usually, the episode is precipitated by an event that is perceived by the individual as stressful (e.g., increased demands at school). The DSM-IV modifier of "With Marked Stressor(s)" may still be appropriate even though a person without autism might not perceive this same event as particularly stressful.

Although current studies do not show a predisposition in autism toward developing schizophrenia, the prognosis for individuals diagnosed under the more recently expanded autism diagnostic criteria may be different. Children whose symptoms were previously described as schizoid (Wolff & McGuire, 1995) or borderline (Demb & Koskin, 2000) are more likely to receive a diagnosis of pervasive developmental disorder - not otherwise specified or Asperger's disorder by current diagnostic standards. These children, under previous diagnostic classifications, were at increased risk for developing schizophrenia as adults (Wolff, 1992). Practitioners should be aware of diagnostic subtype differences in an individual's developmental history when the possibility of an additional schizophrenia diagnosis is being considered.

Prescribing physicians should also be alert to the possibility of paradoxical responses...

Prevention and Treatment Issues

There has been very little research in what contributes to the increased vulnerability to mental illness in autism. Typically, mental health is viewed as being affected by the interplay of biological and environmental factors. Autism is a neurodevelopmental disorder so life begins with certain biological disadvantages. These neurodevelopmental differences interface with stressors and social supports. Because of their social disability, people with autism can not take full advantage of social supports. Additionally, they have more difficulty in coping with stress and in regulating their emotions (Baron, Groden et al, 2006). Ninety per cent of people with autism experience the acute and chronic stressor of bullying which continues into adulthood for most (Tantam, 2004). Additionally, there is the autistic tendency to be less tolerant to change. The extreme reactivity to changes in life circumstances (e.g., increased stressors at school, loss of job, death of parent,) is exacerbated by impoverished coping strategies. To observers, people with autism seem to become very distressed by minor events and this reaction can persist longer than expected. These responses to stress can include reactive versions of OCD, anxiety, depression, and brief psychotic reactions. As a result, threats to mental health can be predictably associated with transitions and crises in the life of the person with autism. Prevention can play a large role in safeguarding the mental health of an individual with autism by preparing well for transitions, having extra support during crises, and learning stress management strategies.

For the most part, individuals with autism respond as well to the same established psychopharmacological interventions associated with specific psychiatric diagnoses as do people without autism. This is only the case though if a correct differential diagnosis has been made. Prescribing physicians should also be alert to the possibility of paradoxical responses and unpredictable dose-sensitivity due to underlying neurodevelopmental differences (Tantam, 2000).

Psychotherapy can prove unhelpful without appropriate modifications. There is mounting evidence that specially modified CBT can be beneficial in the treatment of anxiety for people with autism (Sofronoff et al, 2005). Deficits in the ability to self-monitor require that the therapist be particularly flexible and remain problem-focused; using situations that arise in the present as "teachable moments". People with autism may be unable to identify specific negative thoughts so thought-restructuring may be impossible to do. Instead, additional focus is paid to learning to identify emotional distress and learning self-soothing techniques. Due to difficulties with

abstract thought and language, therapists have found the addition of visual aids to be beneficial as well. Trying to help the individual see other people's perspectives can be futile and may threaten the therapeutic relationship so should be attempted cautiously. (For specific guidelines on therapy, see the following books: Counselling People on the Autism Spectrum; Cognitive-Behavioral Therapy for Adult Asperger Syndrome; Exploring Feelings-Cognitive Behaviour Therapy to Manage Anxiety.)

People with autism continue to gain skills as they develop into adulthood (Howlin, 2000). Unfortunately their developmental potential and prognosis can be impeded by mental illness. Awareness of the special predispositions and profiles of psychiatric disorders in autism is the first step in intervening. Autism-specific treatments are being tested and the evidence base is just beginning to accumulate. Special care by parents, schools, and health care providers may go a long way to lessen specific stressors and build resilience in young people with autism.

References

Baron MG, Groden J, Groden, G, Lipsitt LP, editors. Stress and coping in autism. London: Oxford University Press; 2006.

Baron-Cohen S, Wheelwright S. 'Obsessions' in children with autism or Asperger syndrome. Content analysis in terms of core domains of cognition. Br J Psychiatry. 1999 Nov;175:484-90.

Bellini, S. The development of social anxiety in adolescents with autism spectrum disorders. Focus Autism Other Dev Disabl. 2006 May;21(3):138-45.

Blackshaw AJ, Kinderman P, Hare DJ, Hatton C. Theory of mind, causal attribution and paranoia in Asperger syndrome. Autism. 2001 Jun;5(2):147-63.

Bradley EA, Summers JA, Wood HL, et al. Comparing rates of psychiatric and behavior disorders in adolescents and young adults with severe intellectual disability with and without autism. J Autism Dev Disord. 2004 Apr;34(2):151-61.

Clarke, D, Baxter M, Perry D, et al. The diagnosis of affective and psychotic disorders in adults with autism: seven case reports. Autism. 1999 June;3(2):149-64.

Craig JS, Hatton C, Craig FB, et al. Persecutory beliefs, attributions and theory of mind: comparison of patients with paranoid delusions, Asperger's syndrome and healthy controls. Schizophr Res. 2004 Jul 1;69(1):29-33.

Demb HB, Noskin BS. The use of the term multiple complex developmental disorder in a diagnostic clinic serving young children with developmental disabilities: a report of 15 cases. Ment Health Aspects Dev Disabil 2001 Apr-Jun;4(2):49-60.

Fink M, Taylor MA, Ghaziuddin N. Catatonia in autistic spectrum disorders: a medical treatment algorithm. Int Rev Neurobiol. 2006; 72:233-44.

Ghaziuddin M. Mental health aspects of autism and Asperger syndrome. London: Jessica Kingsley Publishers; 2005.

Ghaziuddin M, Greden J. Depression in children with autism/ Pervasive Developmental Disorders: a case-control family history study. J Autism Dev Disord. 1998 Apr;28(2): 111-5.

Howlin, P. Outcome in adult life for more able individuals with autism or Asperger syndrome. Autism. 2000 Mar;4(1):63-83.

Kolevzon A, Mathewson KA, Hollander E. Selective serotonin reuptake inhibitors in autism: a review of efficacy and tolerability. J Clin Psychiatry. 2006 Mar;67(3):407-14.

Konstantareas MM, Hewitt T. Autistic disorder and schizophrenia: diagnostic overlaps.

J Autism Dev Disord. 2001 Feb;31(1):19-28.

Lehmkuhl HD, Storch EA, Bodfish JW, et al. Brief report: exposure and response prevention for obsessive compulsive disorder in a 12-year-old. J Autism Dev Disord. 2008 May;38(5):977-81.

Marrosu F, Marrosu G, Rachel, MG, et al. Paradoxical reactions elicited by diazepam in children with classic autism. Funct Neurol. 1987 Jul-Sep;2(3):355-61.

Mouridsen SE, Rich B, Isager T, et al. Psychiatric disorders in individuals diagnosed with infantile autism as children: a case control study. J Psychiatr Pract. 2008 Jan;14(1):5-12.

Muris P, Steerneman P, Merckelbach H, et al. Comorbid anxiety symptoms in children with pervasive developmental disorders. J Anxiety Disord. 1998 Jul-Aug;12(4):387-93.

Solomon M, Ozonoff S, Carter C, et al. Formal thought disorder and the autism spectrum: relationship with symptoms, executive control, and anxiety. J Autism Dev Disord. 2008 Sep;38(8):1474-84.

Sofronoff K, Attwood T, Hinton S. A randomised controlled trial of a CBT intervention for anxiety in children with Asperger syndrome. J Child Psychol Psychiatry. 2005 Nov;46(11):1152-60.

Szatmari P, Bartolucci G, Bremner R, et al. A follow-up study of high-functioning autistic children. J Autism Dev Disord. 1989 Jun;19(2):213-25.

Tantam D. Psychological disorder in adolescents and adults with Asperger syndrome. Autism. 2000 Mar;4(1):47-62.

Tantam D. The challenge of adolescents and adults with Asperger syndrome. Child Adolesc Psychiatr Clin N Am. 2003 Jan;12(1):143-63.

Tantam D. Asperger syndrome: another challenge for the general psychiatrist. [cited 2004 November 24]; Available from:

http://www.aspergersyndrome.info/Documents/Articles/Asperger_syndrome_in_adulthood.pdf

Wing L, Shah A. Catatonia in autistic spectrum disorders. Br J Psychiatry. 2000 Apr;176:357-62.

Wolff S. Psychiatric morbidity and criminality in 'schizoid' children grown-up: a records survey. Eur Child Adolesc Psychiatry. 1992 Oct;1(4):214-21.

Wolff S, McGuire RJ. Schizoid personality in girls: a follow-up study--what are the links with Asperger's syndrome? J Child Psychol Psychiatry. 1995 Jul;36(5):793-81.

Policy Corner

By Sandra Lawn, MPA
Community Representative

Public policy on mental health in Canada is unfolding within a complex context where truly adroit leaders "must patiently allow the path forward to reveal itself. They need to probe first, then sense, and then respond.[1]" In the field of child and youth mental health policy in Canada, leaders such as Simon Davidson are doing just that.

Dr. Simon Davidson is Executive Director of the Provincial Centre of Excellence for Child and Youth Mental Health, Children's Hospital of Eastern Ontario (CHEO), Ottawa; Chief of Psychiatry, CHEO; Chair, Division of Child and Adolescent Psychiatry, Department of Psychiatry, University of Ottawa. Child and adolescent mental health policy and practice are his life's work.

As a key member of the Southeastern Ontario Mental Health Implementation Task Force (2000-2002), Dr. Davidson passionately encouraged policy changes in the fragmented "quasi" system for children and youth. He was instrumental in persuading the nine Ontario task forces to consider mental health reform "across the entire lifespan."

The Mental Health Commission of Canada (MHCC) was established in November 2005 and is believed to be the most significant national health policy initiative since the end of World War II. The chair of the MHCC, former Senator Michael Kirby, when announcing the appointment of Simon Davidson as the chair of the MHCC's 16-member Advisory Committee on Children and Youth described Dr. Davidson as the best Canadian in his field.

In his new role, Simon Davidson continues to press for a clear "path forward." In his many presentations across Canada[2], he urges that we must either "have exceptional collaboration and communication between the many ministries and agencies dealing with Child and Youth Mental Health (CYMH) or centralize all CYMH within one ministry."

He continues to identify problems including: high prevalence of psychiatric disorder (13 to 22%), cross-sectoral overlap, high demand for service and limited access and utilization of service, no action or implementation plan for Ontario's policy framework, lack of resources, no continuity of care and imbalance between universal, targeted and clinical programs.

"We need to go beyond traditional boundaries; there are few standardized approaches to care," stated Dr. Davidson to an attentive Brockville audience in June 2007.

Public education should include children, youth, families and neighbours. Training about mental health and illness, child development and parenting, is essential for front line professionals such as general practitioners, police, teachers, judges, emergency physicians and mental health practitioners.

And there is progress! The pilot youth court project in Ottawa is creating a true intersection of the mental health and justice systems. This was described at the November 13, 2008 "Ottawa Youth Mental Health Court Forum; 'the first Piloted Youth Mental Health Court in Canada.'" In commenting on this overwhelmingly successful initiative Simon Davidson stated "More than 75% of all young offenders have diagnosable mental health problems, including substance abuse…it all begins with children. More than 70% of adults living with mental illness had onset before age 18."[3] "This court based approach is going to

Continued on Page 11

Librarian's Corner

By Karen Gagnon, MLIS
Director of Library Services,
Providence Care

Our information seeking behaviours have certainly changed over the last decade. We still talk with colleagues and look to the print literature, including books and journals, for information. But increasingly, we are turning to the Internet for information, and often, as our first starting point. This is particularly so for the current generation, who have grown up having access to the Internet. An interesting study from the U.S. (Grunwald Associates, 2003) found that 65 per cent of American children between the ages of 2-17 use the Internet from either home, school or a library. The result is a generation who will look up information on the Internet as easily as we looked up information in Encyclopedia Britannica.

This shift in information seeking behaviours will also be seen in people seeking mental health information and in people suffering from mental illness. In a recent general population survey, Powell and Clarke (2006) found that 10 per cent of respondents used the Internet as a source of mental health information. The use was even higher, at 20 per cent, among those respondents with a past or current history of mental health problems. Berger et al (2005) noted that the Internet may have a particularly important role to play in mental health for the anonymity it offers to people for whom stigma may be a barrier to accessing mental health information. In a later study, Powell and Clarke's (2007) research highlighted that privacy was an important benefit for accessing mental health information via the Internet. The Internet allows for anonymity and private access by people in their own home. Their research also found other motivators for using the Internet: including hearing other people's experience with mental health problems. Users felt that they were not alone with their problems, and they obtained understanding and empathy from others in similar situations. As well, respondents' other main motivator was for personal research into the causes of their illness, alternative diagnoses and treatment options, as they felt their health or mental health practitioner did not provide them with the information they needed. Another interesting aspect of Powell and Clarke's research is that they found that respondents trusted certain websites and that these tended to be related to organizations they would trust in the real world. Respondents recognized that there are websites with poor or inaccurate information, but they were confident in their ability to evaluate the accuracy of these sites.

The use of the Internet to find mental health information ties into health literacy, which the Canadian Public Health Association (2008) defines as the "skills to enable access, understanding and use of information for health". A recently released study by the Canadian Council on Learning (2008), found that the average health literacy level in Canada is low: "60 per cent of adult Canadians lack the capacity to obtain, understand and act upon health information and services and to make appropriate health decisions on their own". This is somewhat contrary to the Mental Health Literacy in Canada report (Canadian Alliance on Mental Illness and Mental Health, 2007) which identified that "Canadians appear to have reasonably good mental health literacy regarding prevalence, awareness of warning signs, and ability to identify a mental disorder as such".

There is an opportunity for health care professionals to share reliable mental health websites with their clients, encourage the use of the Internet thereby empowering clients and guiding them towards increased health literacy levels. This will be especially important and relevant with the current "computer savvy" generation, who will feel empowered by using the Internet for health information.

References

Berger M, Wagner TH, TH, Baker LC. Internet use and stigmatized illness. Soc Sci med 2005;61:1821-1827

Canadian Alliance on Mental Illness and Mental Health. Mental health literacy in Canada: phase one report mental health literacy project. Ottawa: CAMIMH; 2007 [cited 2008 Feb 14]. Available from http://www.camimh.ca

Canadian Council on Learning. Health literacy in Canada: A healthy understanding. Ottawa: CCL; 2008 [cited 2008 Feb 20]. Available from http:\\ccl-cca.ca

Canadian Public Health Association; n.d. [cited 2008 Feb 20]. Available from http://www.cpha.ca/en/default.aspx

Grunwald Associates. Connected to the future: A report on children's Internet use from the Corporation for Public Broadcasting; 2003 [cited 2008 Feb 14]. Available from http://cpb.org/ed/resources/connected

Powell J, Clarke A. Internet information-seeking in mental health: population survey. Br J Psychiatry. 2006 Sep;189:273-277.

Powell J, Clarke A. Investigating internet use by mental health service users: interview study. Medinfo. 2007;12(Pt 2):1112-1116.

POLICY CORNER

Continued from Page 9

allow for many more youth to get intervention" as many have drug addiction, some are depressed, even suicidal. Justice Diane Nicholas remarks that these assessments "rip my heart out."

Dr. Davidson and his collaborators across Canada are promoting a clear path forward; we eagerly await further policy changes and implemented action plans, so essential to a mental health system for children and youth that puts them truly in the centre!

[1] Snowden, David J. and Mary E. Boone. November 2007. "A leader's framework for decision making," Harvard Business Review, p74.

[2] for example: Simon Davidson presentations: "Child and Youth Mental Health; Toward Collaboration and Integration" at the AGM of the Child and Youth Wellness Centre of Leeds & Grenville, June 6, 2007 and "Leading the Way Out of the Shadows Together," Brantford, October 3, 2008 and "Child and Youth Mental Health Matters - the Initiatives of the Child and Youth Advisory Committee (CYAC) of the Mental Health Commission of Canada (MHCC)" Banff, Alberta, November 13, 2008.

[3] Butler, Don, "Mental health court proves a huge success; Youth initiative 'most satisfying work I've ever done,' judge says;" Ottawa Citizen, November 14, 2008 p F3.

SYNERGY SUBMISSION GUIDELINES

Synergy invites submissions from members of the mental health community in the Southeastern Ontario region and beyond. We encourage articles that report on research activities, program initiatives or projects and educational events. Scholarly articles which review the professional literature and summarize the state of the knowledge in a given area of mental health are also encouraged. Articles can range from 300 – 1,000 words. Occasionally, longer research articles may be accepted (maximum 2,000 words; excluding references). Please note: references should be kept to a minimum and cited in the text in APA format and be compiled in a reference section using Vancouver style.

Articles may be submitted in the form of a Microsoft Word document, as an email attachment. Deadline for the Summer 2009 issue is February 20th, 2009.

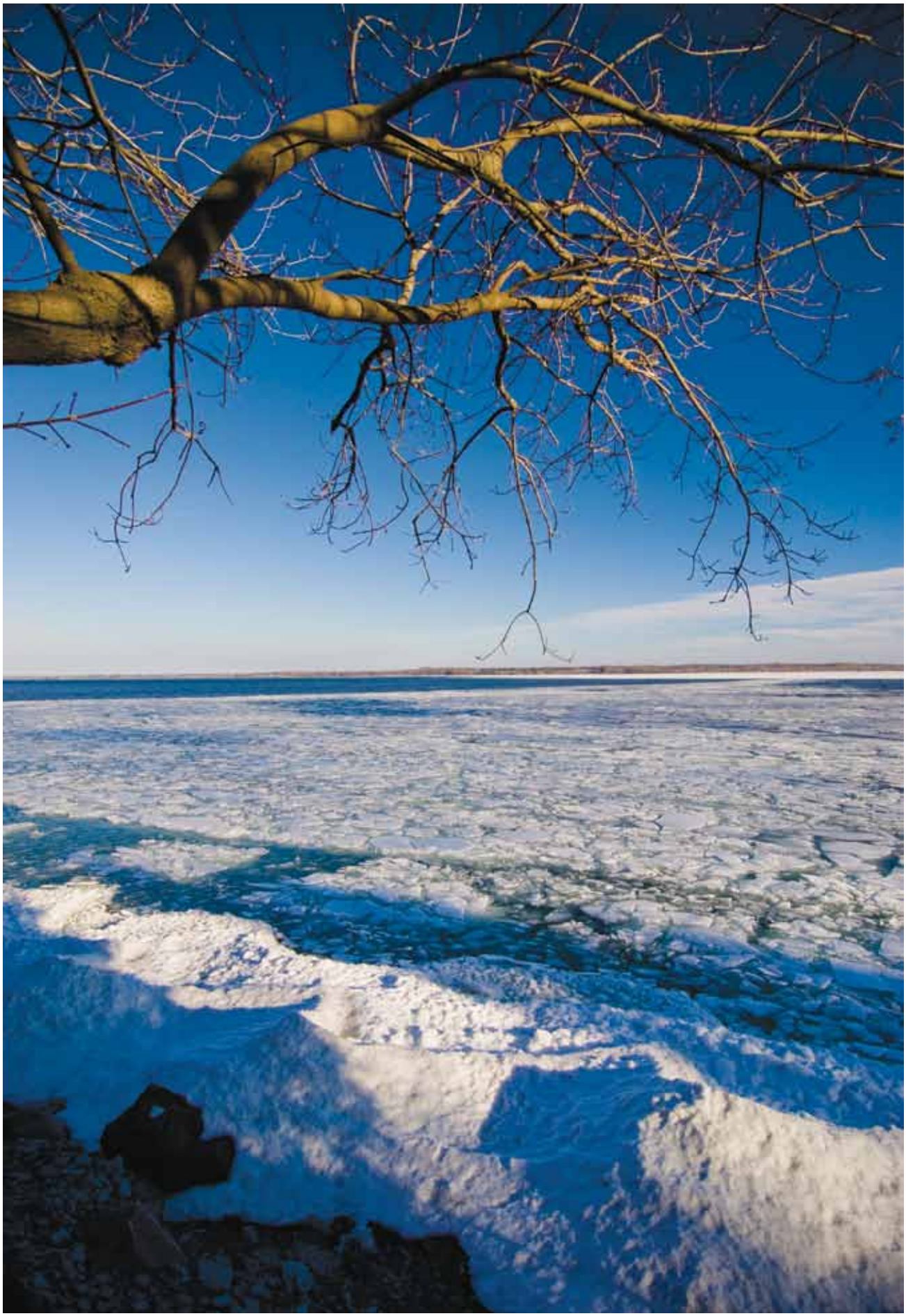

Photo by Tim Forbes, FORBES CREATIVE