



EDITORIAL

Shared Care for Suicidal Youth

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This issue marks our first *online only* edition of the *Journal*. While this may seem like the dawning of a new era, it is not. We are simply aligning ourselves with the practice of our peer group of similar sized Journals. The best thing about it is that we don't have to limit ourselves to a certain page count so more articles should be ready to read in a timely fashion.

This particular issue also affords me a significant challenge to write an editorial that does justice to the immense breadth and impact of the research that is presented. Each article contains content with direct clinical relevance – which I know is of great importance to the majority of our readers. I encourage you to at least review the abstracts of the papers as you will likely find that the content reflects the work that you do, which is both affirming and a form of replication which adds to the external validity of the research that is presented.

Because the studies are likely to be read independently, I will take this opportunity to review something of concern to me as a clinician researcher in our great country: How can we help increase access to mental health care for young people who have suicidal thoughts and behaviours? These youth and families spend a lot of time in acute care settings or waiting to see psychiatrists and both situations are generally aversive.

I have thought about this for many years, and indeed have preoccupied myself with studying the needs of these youth in tertiary care settings because much knowledge is still needed to reduce the intensity and duration of their hospital service use. The provision of urgent access services such as assessment and follow up clinics as well as community mental health nurses has helped significantly, but these are hospital extensions.

What about kids never seen in hospital? What do they need? This is my opinion, although I can confirm there is indirect published and unpublished research data to back it up. They

need adults in their home communities who know how to assess and intervene (in other words, have a productive conversation) about suicidal thoughts and behaviours as easily as for any other mental health difficulty. These adults include social workers, child and youth workers, nurses, primary care physicians (PCPs) and pediatricians working in non-hospital settings. Each professional has a similar role to play: to establish a relationship of non-judgement and curiosity that helps to contain the youth's anxiety and desperation about their current situation. If there is a suicidal plan, the professional must be directive about what needs to happen to ensure their immediate safety; otherwise, their primary role is commitment to seeing the youth through the process of noticing improvement in suicidal thoughts, and if not, referring appropriately. It is then that the psychiatrist can be most useful.

Loneliness, disconnection and hopelessness are the most immediately actionable problems of suicidal youth and being able to fill a gap is the role of the clinician. Until there is a shared understanding between the youth and the clinician about the suicidal behaviour - its triggers, consequences and associated coping strategies - there is no need to be preoccupied with perceived priorities such as diagnosis (unless a youth is manic or psychotic).

How do we help our colleagues be prepared to do this? Training and ongoing supervision. There is no way that a clinician can become comfortable with this role without supervision which means that they have access to a colleague who has equal or more skill than they do at the task. The complexity of these youth and their associated mental health symptoms is formidable and indeed there is a subset of youth who are only best managed in tertiary care until they have achieved an ability to manage their symptoms with minimal support.

How can we help train and then supervise the front line work? There are probably many wonderful models out there

but the most promising one I have heard of is the model of Project ECHO, or Extension for Community Healthcare Outcomes. Project ECHO was developed at the University of New Mexico and is a model for the dissemination of health care information and training from specialists to primary care physicians using technology. Drs. Kathleen Pajer and Bill Gardner have brought ECHO to Ontario for purposes of Child and Youth Mental Health education to primary care providers (www.cheo.on.ca/en/project-ECHO-ontario-CYMH). Providers are invited to participate in Project ECHO which consists of a series of virtual but real time small group didactic sessions with a child and youth mental health expert pertaining to a variety of pertinent child and youth mental health topics. They work through cases and are encouraged to practice the strategies and report on how

it went. They also can contact their group leader outside of the sessions. Currently, Dr. Pajer and her colleagues are providing 24 week didactic sessions to almost every LHIN in Ontario. Not only is this amazing, but it will likely result in what it aims to achieve: to avail (suicidal) youth of the quality of psychiatric care they might receive in a tertiary care centre - at least in the workup and maintenance phases of care for their suicidality.

Project ECHO is a great solution to this mammoth problem. If most community mental health professionals felt more comfortable with the discourse approach, they would take on such discussions with as much interest and hopefulness as we CAPs do. It is an approach that can make a tremendous difference to kids and their families.