

crosscurrents

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The Journal of Addiction and Mental Health

COLLABORATIVE CARE

Building partnerships
with primary
care providers

SHARING ADDICTION CARE

Primary care settings move
to the forefront of treatment

OPENING THE LINES OF COMMUNICATION

Mentoring network
supports family physicians

COLLABORATION ONE-ON-ONE

A nursing perspective

TAKING CARE TO THE STREETS

Shared care teams reach out
to people who are homeless

Big boys don't cry

Depression looks
different in men

Women and

substance use

The challenges
of meeting
unique needs



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Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

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Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

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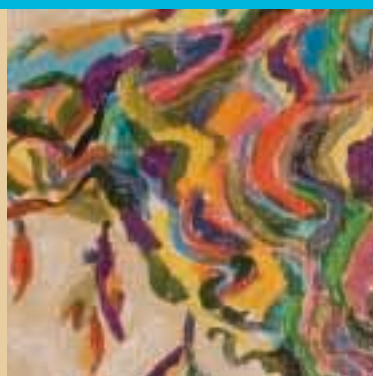
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My Roots Are Deep, Lynne Jenkins, acrylic on canvas, 15" x 15"

Lynne is a self-taught artist and has been painting for 15 years. She works in every medium but prefers acrylic. Lynne identifies nature by colour and the energy of it.



Health professionals have a long-standing history of working together to deliver quality, sustainable health care for Canadians and to ensure the optimal use of resources. But as the demand for health care increases, new models are being explored. There is a growing consensus that interprofessional collaborative practice will result in better health, improved access to services, more efficient use of resources and better satisfaction for both clients and health care providers.

As part of its Primary Health Care Transition Fund, Health Canada funded the Canadian Collaborative Mental Health Initiative, which validated important hallmarks of a primary health care approach, including interprofessional collaboration.

Collaborative mental health and addiction care (also called shared care) involves family physicians working with health care providers like nurse practitioners, social workers and psychiatrists. Collaborative programs are used when a family doctor determines that a person is experiencing mental health or substance use issues, or when a person indicates to their doctor that

they are experiencing these issues. In these situations, the family doctor may refer the person to a mental health or substance use professional or team of professionals, who then work together with the person to address their health needs.

The articles in this issue of *CrossCurrents* illustrate some of these concepts and models in action, and highlight opportunities and challenges in moving collaborative care to the forefront of primary health care. Dr. Roger Bland, a long-time proponent of collaborative care, introduces the concept and describes the key features of a successful collaboration. Anne Ptasznik describes a mentoring network that links psychiatrists and family doctors. Collaborative care in addiction settings involves unique issues, which are discussed in Kim Goggins' article. In a one-on-one interview, Carol Rupcich, a nurse practitioner, provides insights into the practical experience of working in collaborative care. Anne Ptasznik visits a Toronto shelter to see a collaborative care team in action in the community. Next, a collaborative care team in Calgary shows us just how it works with children and youths. In the



Q&A, Dr. Nick Kates, a Canadian leader in collaborative care, discusses the promise of family health teams. Dr. Ty Turner winds up the issue, challenging us to confront the barriers that remain to implementing collaborative care in Canada.

Enjoy this issue of *CrossCurrents*. We always welcome your feedback and suggestions.

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a view from CAMH

Is there anyone left still opposed to collaborative and interdisciplinary care with colleagues? For too many years, the experience of primary care physicians and other health professionals regarding referral for psychiatric care has been either lack of access or the Bermuda Triangle of communication. A patient accepted for psychiatric care by an individual practitioner or even in a hospital or community agency setting would commonly be placed in what secret agent Maxwell Smart (for those of you who watched TV in the 1960s) called "the cone of silence"; under the rubric of confidentiality, other health providers, families and friends were often kept in the dark. A similar veil of secrecy often surrounded addiction care. But if communication is the first step to collaborative care, it is certainly not the last. A variety of models exists not only to enhance communication among health professionals but also to

extend the reach of care and hopefully to improve clinical outcomes.

This issue of *CrossCurrents* focuses an important spotlight on this area with specific examples from across the country demonstrating different models. It also identifies important barriers and raises questions regarding evidence.

The extent to which these various models of collaborative care enhance communication and awareness of the common human problems of mental illness and addiction may have a further benefit: the reduction of stigma. Comfort among health professionals in detecting, discussing and treating these problems may lead to less shame and secrecy on the part of the people who experience them. The apparent higher standard of confidentiality around mental health information versus physical health

information has always irked me as a reflection of that stigma. There should be one standard for all human problems.

Collaborative care does many things, including getting health professionals to communicate with one another more directly and more often than in our traditional models. While it would be difficult to tease out the specific components of collaborative care that directly improve clinical outcomes, it's hard to imagine how this enhanced communication among health professionals could do anything but help.

David S. Goldbloom, MD, FRCPC

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Program leverages technology to increase medication safety

An award-winning program in British Columbia is using leading-edge technology to improve the lives of people with mental illness who have very complex medication regimens by focusing on medication safety.

The program was implemented by Coast Mental Health, a community agency, in partnership with Catalyst Healthcare, a pharmacy and technology services company specializing in medication management for residential care. Coast wanted to improve client safety by reducing staff and pharmacy medication errors at Community Homes, the 11 licensed care homes Coast operates for adults with mental illness in the Vancouver area.

Coast zeroed in on supply chain management, from drug production to pharmacy dispensing, delivery to the home and administering the medication, says Heather Edgar, associate executive director of Coast. Most medication errors stemmed from packaging, specifically the 35-day blister-pack cards widely used in healthcare.

Staff errors included punching out the wrong medication, which isn't difficult when each client takes multiple medications, and double dosing from improperly matching the pills to the day. A lot of waste occurred if medication or dosages changed a few days into the month because the rest of the supply would be returned to the pharmacy, where it often couldn't be reused.

Pharmacy errors included mislabelling of dosage times, incompletely filled blister cards and delayed removal of clients' discontinued medications.

Coast's new medication system would have to accommodate the needs of two groups. Community Homes' 111 residents range in age from the late teens to the 90s. Some have been residents for over 25 years. Renay Bajkay, director of residential services for Community Homes, says the goal with these clients is to help them maintain their health and dignity without going into long-term care. Medication is distributed by mental health workers under supervision of a manager.

Younger residents, on the other hand, expect that within a couple of years, they will have the skills to live independently. Some administer their own medications, if not at the residence, then when they attend school or take social leave on weekends. "Taking your own medication and understanding it is a big part of moving into independence," says Edgar.

Catalyst vice-president Harvinder Johal likens the PACMED system to a giant vending machine with up to 500 canisters with a specific drug in each. At the pharmacy, the machine retrieves the client's prescription information, then sequences the medication and places it in strip packaging. Each package contains all the pills the client needs for one dose time and shows relevant information like the drug name and when it is to be taken. The medication pouches are barcoded for scanning in and out of inventory and for verifying that the client is receiving the right drug in the right dose at the right time.

This multi-strip packaging phase, launched in August 2006, has yielded impressive results. Within six months, staff and pharmacy medication errors dropped by 73 per cent and 24 per cent, respectively. This year, Coast and Catalyst won the Award for Excellence in Pharmaceutical Supply Chain Management from the Canadian College of Health Service Executives.

The new system also gets top marks from staff and residents. For staff, simplified packaging makes it easier to distribute meds, particularly during hectic periods like mealtimes. And in the past, if a resident was going away for the weekend, staff had to punch out the individual pills, put them in envelopes or baggies and write on the package. Now it's rip and read – staff simply tear off the appropriate pouch and dispense the meds. Nurse managers say clients who self-administer find this system much easier to use.

Community Homes staff received training that included a train-the-trainer module for nurse case managers. Coast has also introduced a mentoring program, where staff who have made repeated medication errors work on improvements one-on-one with a manager. The system also provides 24-hour access to an on-call pharmacist.

Community Homes is now switching from a paper-based system to an electronic medication administration record, linking the barcode on a client's medication package to an electronic record with photo ID.

Medication safety is key to client safety. As Johal says, "Taking these medications and being compliant with them is really a big part of therapeutic success."

Avril Roberts



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Depression: It's different for men

NATE HENDLEY

Walter never admitted he was mentally ill, even after being hospitalized seven times in four years. He had a steady job at the General Motors plant in Oshawa, Ontario. He was happily married, with a son. But in the late 1990s, Walter began showing serious signs of mental instability. "He didn't want to talk," recalls his wife, Christine. He always said, "I'm fine." Walter blamed physical ailments and job-related stress for repeated hospital visits. But clearly, Walter wasn't fine on the day in November 2002 when he walked into the path of an oncoming train, ending his life at age 49.

Walter's story reflects a perplexing reality: While depression is more common in women than men, men die by suicide at four times the rate of women, according to Health Canada. It's a tragic paradox: Depression, after all, is one of the strongest risk factors for suicide, says Dr. John Ogrodniczuk, an assistant psychiatry professor at the University of British Columbia.

The relationship between men's low rate of reported depression and high suicide rates raises questions about men's beliefs, their mental health "literacy" and behaviours and how they experience depression.

Ogrodniczuk and John Oliffe, an assistant professor in the Department of Nursing, are examining these issues. The goal of the research, the first of its kind in Canada, is to "better understand how men experience and express depression in order to improve our detection of depression among men," says Ogrodniczuk. The researchers have recently completed a small pilot study and plan to soon launch a province-wide study.

Gender stereotypes and narrow medical definitions might partly explain the paradox. Men are conditioned to be robust, uncomplaining and strong. Acknowledging any kind of perceived weakness, like depression, may be difficult.

The few studies of male depression that exist suggest that male depression may go undiagnosed because it may look different. "Researchers and clinicians are questioning whether the traditional signs of depression like crying and sadness accurately represent men's experience" says Ogrodniczuk. "Depression in men may be masked by

behaviours like overworking, irritability, substance abuse and promiscuity."

A study on "hidden depression" in men, published in a 2005 issue of the *Australian and New Zealand Journal of Psychiatry*, found that depressed men were more likely than women to engage in risk-taking and antisocial behaviour such as fighting, multiple random sexual encounters, gambling, drunk-driving and substance abuse.

The very nature of therapy itself, particularly its reputation as a confessional, "touchy-feely" process, might make men reluctant to seek help. "Stereotypical male traits such as difficulties with identifying and speaking about emotions, admitting vulnerabilities and being comfortable with emotional intimacy can complicate the therapeutic process," says Ogrodniczuk.

Making therapy "male-friendly" might be a good way to get more men into counselling, says Dr. Chris Kilmartin, a psychology professor at the University of Mary Washington in Fredericksburg, Virginia.

Instead of focusing on self-confession and feelings, therapists should encourage male clients to tell stories and anecdotes. "Men are good at story-telling," says Kilmartin. "You get them to tell stories, then you highlight emotional themes in those stories." Kilmartin also advises patience, understanding and recognition of "how difficult it is for men to ask for help and engage in the therapeutic process."

Ogrodniczuk and Oliffe hope findings from their research will lead to gender-appropriate treatment approaches that may include workshops, coaching, mentoring or online chat rooms and support.

But before therapy can begin, men must acknowledge they need help, as Walter's wife, Christine, knows too well. For Walter, "depression seemed extremely personal," she says. However, with new insights gleaned from research into men's depression, perhaps the personal will become public, raising awareness and breaking down barriers to help and support.

MEN AND WOMEN: WHAT'S THE DIFFERENCE?

Based on his clinical work with men, California psychotherapist Jed Diamond highlights common differences between male and female depression.

FEMALE DEPRESSION

- Blames herself
- Feels sad, apathetic and worthless
- Feels anxious and scared
- Avoids conflicts at all costs
- Always tries to be nice
- Withdraws when feeling hurt
- Has trouble with self-respect
- Feels she was born to fail
- Slowed down and nervous
- Chronic procrastinator
- Trouble setting boundaries
- Feels guilty for what she does
- Uncomfortable receiving praise
- Easy to talk about weaknesses, doubts
- Strong fear of success
- Needs to blend in to feel safe
- Uses food, friends, "love" to self-medicate
- Believes her problems could be solved only if she could be a better spouse, co-worker, parent, friend
- Wonders, "Am I loveable enough?"

MALE DEPRESSION

- Feels others are to blame
- Feels angry, irritable and ego-inflated
- Feels suspicious and guarded
- Creates conflicts
- Overtly or covertly hostile
- Attacks when feeling hurt
- Demands respect from others
- Feels the world set him up to fail
- Restless and agitated
- Chronic compulsive time keeper
- Needs control at all costs
- Feels ashamed for who he is
- Frustrated if not praised enough
- Terrified to talk about weaknesses, doubts
- Strong fear of failure
- Needs to be "top dog" to feel safe
- Uses alcohol, TV, sports, sex to self-medicate
- Believes his problems could be solved only if his spouse, co-worker, parent, friend would treat him better
- Wonders, "Am I being loved enough?"

Province-wide evaluation identifies challenges and successes in providing women-specific substance use treatment

AVRIL ROBERTS

A recent evaluation of Ontario's substance use treatment services is yielding insights into how well Ontario's addiction agencies are serving the needs of women. The study, commissioned by the Jean Tweed Centre in Toronto, looks at how well substance use treatment agencies are doing in adopting the best practices standards outlined in *Best Practices in Action: Guidelines and Criteria for Women's Substance Abuse Treatment Services*, a document released by the Ontario Ministry of Health and Long-Term Care in 2005 (see the Spring 2006 *CrossCurrents* for an example of best practices in action).

"We wanted to better understand what the province looked like in terms of serving women," says Debbie Bang, a member of the survey's steering committee and manager of Womankind Addiction Service in Hamilton, Ontario.

The survey was distributed to 120 agencies that provide substance use treatment services for women in mixed-gender or women-only settings and yielded 77 replies. Representatives from 17 agencies were also interviewed to add breadth and depth to the results.

Substance use treatment services often fail to address women's unique needs. Workers in the field interviewed for this story say women's participation is often hampered by lack of childcare, fear of losing children to child welfare, social isolation and stigma. The path to addiction is often paved by trauma from physical and sexual abuse or by prescription drug use – women are more likely than men to be prescribed benzodiazepines and other psychoactive medications. The physical and mental health effects for women are often more pronounced. "The fact that women spend a long time caregiving at home before they decide to access treatment leads to increased health challenges by the time they actually get into treatment," says Norma Medulun, president of Addictions Ontario. "Serving women requires a different level of intensity and more nurturing."

The evaluation found that Ontario's substance use treatment system is experiencing positive change in six key areas:

- greater attention to women's treatment issues and to gender-specific and gender-appropriate programming;
- increased awareness of the inter-relationships of trauma and substance use and the implications for treatment;
- efforts to broaden admission policies and build expertise to meet the needs of women with co-occurring mental health problems;
- increasing acceptance of methadone maintenance therapy as an essential treatment option;
- building collaborative relationships with allied sector services; and
- development of early childhood development addiction programs for pregnant and parenting women.

The review attributes these positive changes to the leadership of agencies providing specialized services for women, ministry interest and support for newer treatments like methadone maintenance and funding for early childhood development programs and to stabilize core services. Dissemination of the best practices guidelines has also helped raise awareness of best practices, as indeed not all agencies surveyed were familiar with the document.

The areas where Ontario agencies didn't fare as well included:

- providing women-specific services and women-facilitated or co-facilitated groups;
- relationships with child welfare agencies;
- meeting the needs of clients with concurrent disorders; and
- methadone treatment availability.

Bang cites funding, resources, philosophy and training as challenges to implementing the best practices guidelines.

Janet Pearce, executive director of Options for Change, a mixed-gender addiction treatment agency in Kingston, knows the challenges well. Her agency's intensive treatment program has a 2:1 ratio of men to women. "A women's-only day treatment program would be valuable, but we don't have the staff or don't always have the numbers," says Pearce. After completing the mixed-gender treatment program, women can join a women's group that meets weekly with a woman facilitator to discuss sensitive topics

like sexual abuse, relationship problems and children, and to engage in self-care.

Staff are trained in women's addiction issues, for example, the connection between trauma and substance use, but Pearce says they need more training in areas like concurrent disorders. While awaiting ministry funding for a concurrent disorders worker, the agency works closely with and makes referrals to community mental health services.

A recent injection of annualized funding for the Motherwise program, which provides addiction treatment services to pregnant women and mothers of young children, means that Kingston now has its own worker, one of two, reaching out to women in their homes and community agencies and shelters across southeastern Ontario, but it's just not

HOW TO ACHIEVE BEST PRACTICES IN WOMEN'S SUBSTANCE USE TREATMENT

The Review of the Women's Substance Abuse Treatment System in Ontario, available at www.jeantweed.com, lists various recommendations, including:

Co-ed agencies provide, as part of their core services, gender-specific approaches and access to female staff.

All agencies that provide services for women develop written policies to ensure sound and basic practices for pregnant and parenting women, for example, giving admission priority to pregnant women and linking children whose mothers are substance-involved with appropriate community agencies.

Agencies providing assessment/referral and community treatment services develop approaches to reduce barriers for pregnant and parenting women through strategies such as providing off site and/or co-located services.

All agencies seek opportunities to build competencies for providing appropriate services for diverse populations of women.

possible for them to reach everyone because of time and travel, says Pearse. In a related move, Options for Change and the Kingston Children's Aid Society are developing a protocol for collaboration, which they are implementing this autumn.

At Hope Place Women's Treatment Centre in Milton, program manager Tisha Shea says financial constraints prevent her agency from achieving its vision of extending its residential treatment program from 24 to 28 or even 90 days. She believes the centre could easily double its number of beds from the current 10, which includes two emergency beds for pregnant women. The centre is building an addition to accommodate two more beds for pregnant women. "We would love to be a facility where women could bring

their children and learn how to nurture them and receive childcare," says Shea.

Hope Place partners with community services to offer a 12-step program on site (the treatment centre has an abstinence requirement), as well as aerobics and yoga, and harnesses the art skills and training of one of its counsellors to offer monthly art sessions. "We're trying to teach women different ways to cope with stress," says intake counsellor Yvonne Bouma.

From a satellite office in Oakville, Hope Place sends counsellors into the community to meet with pregnant and parenting women with children up to age six. Shea credits this Baby's Best Beginnings program with reaching women who would otherwise have remained isolated in their own cultures. "It has been amazing to have these women share their experiences and the impact of culture on addiction. With more of that outreach, women can know recovery is available."

Illustrating the scarcity of women-specific services across the province is the fact that the few women-only withdrawal management units are concentrated in Toronto, Hamilton and Niagara Region. "For the rest of the province, it really doesn't exist, which is a challenge when you want to provide women-specific programming but you can't even initiate it with a first-step program," says Medulun of Addictions Ontario. She also notes that, while best practices recommend methadone maintenance as a treatment option, it isn't available throughout Ontario.

Medulun sees hope in leveraging the policy-planning and funding capabilities of Ontario's new local health integration networks (LHINs) "to work together and say, 'Here are the best practices guidelines – what can we do within our area to implement them?' and just assign the work. We need to do this with all of our partners." By which she means other groups that influence treatment – social justice, family services, child welfare.

Across the country, substance use treatment services are grappling with similar issues and developing innovative strategies: in British Columbia, teaming up with transi-

tion houses to offer the Seeking Safety program to women fleeing domestic violence; in Alberta, delivering an Enhanced Service for Women program to pregnant and parenting women; and in Nova Scotia, co-facilitating, with a mental health nurse, a group for women with concurrent disorders attending a prenatal-postnatal clinic.

"We are starting to think about how we can deliver this care in partnership, in ways that encourage more people to access and receive substance use support," says Nancy Poole, a senior researcher with the British Columbia Centre of Excellence for Women's Health. "But it is certainly a challenge before us still. We need more energy at the front end of the system, to really promote health and help prevent substance use problems."

Debbie Bang views the survey findings as a good basis for measuring future change, but notes some limitations to the study: Agencies may have rated themselves higher than their performance merited. Also, some questions or terminology may have been too broad. For example, in response to the guideline on having partnerships in place for integrated assessment, treatment planning and intervention for women with concurrent disorders, 48 per cent of respondents said they had fully achieved this; another 44 per cent reported partial achievement. However, subsequent interviews with key informants suggest this was likely an overestimation, due to differing interpretations of "partnerships" or "integrated."

Some replies were simply confusing or troubling. Regarding the best practices requirement that only female staff conduct bed checks, 60 per cent of respondents saw this as "not applicable," even though mixed-gender residential services were among those surveyed. Also, 20 per cent of respondents reported no achievement in incorporating trauma-informed approaches into their programs, despite the prevalence of trauma in women's substance use.

Despite these drawbacks, Bang is encouraged that the review may open the door for more addiction treatment agencies to use the best practices document to examine their own performance and move

All agencies examine their capacity to be more flexible in admission criteria, particularly around policies for accepting women who are taking medications, have co-occurring mental health problems or are receiving methadone maintenance therapy.

Closed cycle programs or groups examine options for providing more flexible service options through strategies such as continuous intake, telephone pre-treatment supports and extended stay. Agencies that struggle with this issue seek advice from agencies that have succeeded in this area.

All agencies undertake training and clinical supervision to ensure that staff and services are "trauma-informed."

All agencies provide gender-specific approaches as indicated by the guidelines (e.g., provide information about physical health aspects of substance use), whether group or individual counselling modalities are used.

Agencies engage in activities to reduce stigma through strategies such as media tools to increase awareness of addiction as a health issue and continued education and collaboration with child welfare agencies to create solutions to issues faced by pregnant and parenting women with addictions.



Anger compatible with rational thinking

Although anger is usually associated with irrational thinking, new research indicates that anger can actually contribute to rational and analytic thinking. Researchers at the University of California, Santa Barbara, enrolled 550 college undergraduates in three experiments. Participants were asked to assess the validity of persuasive arguments after anger was induced in some of them by either asking them to recall past events that made them angry or by exposing them to criticism. In one experiment, participants were presented with statements making the counterintuitive argument that college students have good financial habits. Angry participants proved better than those in neutral moods at differentiating between weak and strong arguments, indicating better analytical thinking. In a second experiment, participants evaluated an argument advocating the introduction of mandatory comprehensive exams as a graduation requirement for college seniors. Anger elicited analytic reasoning in individuals who ordinarily processed information non-analytically. In a third experiment, the financial habits argument was repeated, and participants were told that the source of the argument was either the Agency for Financial Responsibility or the Agency for Medical Responsibility. Here, the angry participants were more likely to ignore the irrelevant source, indicating analytical thinking and selective use of appropriate heuristic cues. The authors note that intense anger accompanied by high levels of arousal could limit analytic reasoning, and such arousal was absent in this study.

Personality and Psychology Bulletin, May 2007, v. 33: 706–720. Wesley G. Moons and Diane M. Mackie, Department of Psychology, University of California, Santa Barbara, California.

Alcohol and social disorder may contribute to partner violence

Alcohol consumption and neighbourhood social disorder can contribute to intimate partner violence (IPV), according to research from the Pacific Institute for Research and Evaluation in Berkeley, California. Researchers interviewed 19,035 married or cohabiting adults (10,445 women and 8,590 men). The study focused on those who engaged in mutual IPV and excluded those who reported only IPV victimization or perpetration. Participants were asked about their experience of IPV, alcohol consumption and their perceptions of crime, drug use and other signs of disorder in their neighbourhoods. Just over three per cent of men and women reported mutual IPV. Men who experienced mutual IPV reported more drinking days over the previous year than men who did not experience mutual IPV (87 days versus 69 days). For women, the comparable figures were 51 days versus 36 days. Men who had engaged in heavy drinking during the previous month were 6.6 times more likely to experience mutual IPV, and women heavy drinkers were 6.3 times more likely to experience mutual IPV. Men who lived in disordered neighbourhoods were 1.6 times more likely to experience mutual IPV, but women in disordered neighbourhoods were less likely to experience mutual IPV (odds ratio: 0.8). The author concludes that the results “underscore the importance of understanding how and why neighbourhood conditions, such as social disorder, affect drinking and IPV behaviours.”

Alcoholism: Clinical and Experimental Research, June 2007, v. 31: 1012–1019. Carol B. Cunradi, Prevention Research Center, Pacific Institute for Research and Evaluation, Berkeley, California.

Parental substance abuse affects adult children's anxiety disorders

Adults with social phobia and panic disorders are more likely to experience relapse if their parents had substance use disorders, according to a study from Case Western Reserve University in Cleveland, Ohio. Researchers recruited 618 participants from the Harvard/Brown Anxiety Research Project, from 11 different clinical treatment facilities in New England. Participants were interviewed at baseline and every six or 12 months over 12 years. One hundred and eleven (18%) participants reported that at least one of their parents had a history of substance use disorders (92 mothers and 24 fathers). Among mothers with substance use disorders, 68 per cent had alcohol abuse/dependence, 15 per cent had drug abuse/dependence and 16 per cent had both. Among fathers with substance use disorders, 63 per cent had alcohol abuse/dependence, 20 per cent had drug abuse/dependence and 17 per cent had both. Twenty-three per cent of participants reported that one of their parents had an anxiety disorder. Among participants who had recovered from social phobia, the likelihood of relapse was 4.1 times greater among those who had a parent with a history of substance use disorder. Participants who had recovered from panic disorder were 3.4 times more likely to suffer a relapse if one parent had a substance use disorder. The authors recommend that clinicians assess parental substance use when treating individuals with social phobia, and that they consider long-term maintenance therapy to prevent relapse.

Substance Abuse Treatment, Prevention, and Policy, 2007, online, doi: 10.1186/1747-597X-2-13. Maria E. Pagano et al., Department of Psychiatry, Division of Child Psychiatry, Case Western Reserve University, Cleveland, Ohio.

Gender and income affect brain development

The first report of the Magnetic Resonance Imaging (MRI) Study of Normal Brain Development from the National Institute of Health provides interesting insights into the effects of gender and income on the development of children's brains. Six American pediatric study centres in Boston, Cincinnati, Philadelphia, Los Angeles, Houston and St. Louis collected data on 385 healthy children aged six to 18. The children underwent MRI scans and neuropsychological tests measuring cognitive and behavioural function. They were evaluated at baseline and at two and four years later. Girls performed better in tests of processing speed and motor dexterity, and boys were better at perceptual analysis. Girls also had a slight advantage on tests of verbal learning, but this advantage diminished through adolescence. Although children from low-income families had lower IQ scores, the low-income group in this sample outperformed population norms. Low income was also associated with lower scores on tests of reading comprehension and calculation, but not single-word reading. This suggests that integrative skills (reading comprehension and calculation) are more vulnerable to the effects of low income. Overall, test scores improved dramatically between age 6–10, and then levelled off between age 10–12, suggesting that children were already approaching adult levels of performance by early adolescence. The intention of the study is to create a coordinated database of imaging, neuropsychological, neurological and psychiatric data for researchers.

Journal of the International Neuropsychological Society, 2007, v. 13, online, doi: 10.1017/S1355617707070841. Deborah P. Waber et al., Department of Psychiatry, Children's Hospital, Harvard Medical School, Boston, Massachusetts.

Parents often source of alcohol for young adolescents

Parents and guardians are a primary source of alcohol for young adolescents, according to a three-year study from the University of Minnesota. Researchers used data on 3,709 students from four waves of Project Northland Chicago, involving 63 Chicago schools. The students were followed from the beginning of grade 6 to the end of grade 8. Survey questions asked students how many times they had consumed alcohol and where they had obtained it. Seventeen per cent used alcohol at the start of grade 6, rising to 41 per cent by the end of grade 8. For students at the beginning of grade 6, parents and guardians were the most common source of alcohol (33%), followed by other adults over age 21 (16%). By the end of grade 8, other adults (23%) had surpassed parents and guardians (19%) as the most important source of alcohol. By grade 8, adolescents in the study were also increasingly likely to obtain alcohol from someone under age 21, by taking it from their own or a friend's home, or by obtaining it from commercial sources. Boys were more likely than girls to obtain alcohol from commercial sources. The authors suggest that their findings underscore the importance of educating parents about providing alcohol to children. The findings also point to the need to take into account the changing pattern of alcohol sources over the course of early adolescence in designing prevention programs.

Preventive Medicine, June 2007, v. 44: 471–476. Mary O. Hearst et al., Division of Epidemiology and Community Health, School of Public Health, University of Minnesota, Minneapolis, Minnesota.



Psychiatry residents often fail to obtain informed consent

Psychiatry residents tend not to take adequate steps to obtain informed consent for treatment from their patients, according to research from Columbia University in New York City. The study involved 108 psychiatry residents at seven New York-area training programs who were asked to respond to three vignettes, providing a total of 324 vignettes. These vignettes involved the evaluation and treatment recommendation of a patient with major depression being prescribed medication, and patients with borderline personality disorder and neurotic character traits starting psychotherapy. The researchers found that the residents' responses met minimal criteria for an informed consent discussion in only three per cent of the vignettes, and in only one per cent of the vignettes did their responses meet the criteria for optimal informed consent. However, when the criteria were loosened to give residents credit for responding to patients' inquiries rather than initiating the discussions, 53 per cent of the vignettes met the criteria for adequate informed consent. Although residents were equally likely to obtain informed consent from the three different patients, they were less likely to give the neurotic patient information regarding alternative treatments. They were also less likely to disclose relevant information about themselves to the psychotherapy patients compared with the patient receiving medication. The authors conclude that their findings may have resulted from the residents' failure to understand that informed consent is an active process, and recommend that greater efforts be made to teach residents about the informed consent process.

Journal of Clinical Psychiatry, April 2007, v. 68: 558–565. Bret R. Rutherford et al., Department of Psychiatry, Columbia University, New York, New York.

Regular smoking linked to increased risk of depression

Regular smokers are at increased risk of developing depression, according to research from the University of Helsinki in Finland. The researchers surveyed 10,977 men and women from the Finnish Twin Cohort, a database of same-sex twins born in Finland before 1958. Questionnaires were sent to participants in 1975, 1981 and 1990, eliciting information about depression and smoking. Depression was measured in 1990 using the Beck Depression Inventory. Among men, multiple logistic regression analyses showed that persistent smokers were 1.4 times more likely than those who never smoked to have depression, and those who were smokers in 1975 but had quit by 1981 were 1.7 times more likely to have depression. However, those who had quit smoking by 1975 reduced their risk to a level that was actually slightly below that of those who never smoked – only 0.9 times as likely. Among women, only those who were smokers in 1975 and had quit by 1981 had a higher risk of depression – 1.4 times more likely. Interestingly, women who were persistent smokers were no more likely than those who never smoked to develop depression. There was evidence of a dose-response relationship among the men. The results show that smokers can lower their risk to levels comparable to that of individuals who never smoked through long periods of abstinence. Among men, bivariate analysis indicated that underlying genes accounted for the comorbidity of smoking and depression. The difference in results found for women indicates that gender modifies the association between smoking and depression, possibly because smoking may be motivated by different factors among women. The apparent spike in risk among those who quit most recently warrants further research.

Psychological Medicine, May 2007, v. 37: 705–715. Tellervo Korhonen et al., Department of Public Health, University of Helsinki, Finland.



COLLABORATIVE CARE WORKS

How to make it happen

DR. ROGER BLAND

Why do we need collaborative mental health care?

The family physician is the person most people go to when seeking help for any health problem, including a mental health or substance use problem. But family physicians may have issues with psychiatry and other mental health services. For example, family physicians can have difficulty making timely referrals or accessing specialized treatment services, and are often excluded from being part of the ongoing treatment of the patient. In general, they feel that specialized mental health services are not “in touch” with the realities of primary care practice. Collaborative mental health care provides a means of solving some of these problems and improving patient outcomes.

Collaborative care is what happens when health care providers work together in a formally integrated system to provide better-coordinated services for patients. The health care providers come from different disciplines, but generally include first contact and specialized service providers like physicians, nurses, nurse practitioners, social worker, occupational therapists, psychiatrists and psychologists.

According to the Canadian Collaborative Mental Health Initiative (see Collaboration sidebar), collaborative care can involve better communication, closer personal contacts, sharing of clinical care, joint educational programs and joint program and system planning.

Collaborative care emphasizes the role of primary care, which includes, but is not limited to, family physicians, since professionals like nurses and nurse practitioners also deliver some form of primary care. Primary care providers working in a collaborative program can offer their patients on-site access to specialized services and treatments without complex, frustrating and time-consuming waits. The support offered by the specialist to the primary care service provider enhances the latter's role, and provides a more positive experience for the patient. Trust and confidence develop as a result of working together, and patients come to feel a better sense of participating in their own health care and recovery. Many patients can be managed effectively in these circumstances, with greater satisfaction for all concerned.

What works and what doesn't?

The May 2006 issue of the *Canadian Journal of Psychiatry* features a review I conducted with Dr. Marilyn Craven called “Better Practices in Collaborative Mental Health Care: An Analysis of the Evidence

Base.” The review of more than 900 articles found 38 studies that investigated the impact of collaborative mental health care using relatively strong research designs with experimental methodologies or outcome measures. Here's what works:

Collaborative relationships require time, preparation and supportive structures. Successful collaborative care arrangements often grow out of pre-existing clinical relationships. Real change, particularly at the system level, takes time to be developed and may need to be introduced gradually in a stepwise fashion. One of the best studies built on pre-existing relationships in the primary care practice and resulted in high levels of collaboration and good patient outcomes. Positive staff attitudes and “buy-in” are also critical to achieving success. Moreover, these relationships may also require system changes and some reorganization of services. Two studies showed how a potentially good intervention could fail because of poor collaboration and poor implementation.

Co-location of services is important both for providers and clients. Effective collaboration between mental health specialists and primary care providers most often develops when clinicians are co-located and the location is familiar and non-stigmatizing for patients. Plainly put, providers need to meet face-to-face to engage in collaborative relationships. Offering patients mental health care within the primary care setting engages patients more fully and lowers “no show” rates. Likewise, the literature suggests that co-location of substance abuse treatment in primary care enhances outcomes.

The actual degree of collaboration does not always predict the clinical outcome. Although positive outcomes generally occur in collaborative programs with higher levels of collaboration, some services with low levels of collaboration also show positive outcomes.

For depression, pairing collaboration with treatment guidelines results in better outcomes than either intervention alone, and the benefits are greatest for the most severely depressed patients. (See Depression sidebar.) In many cases, patients with milder forms of depression tend to improve spontaneously. In fact, treatment protocols developed for more severe disorders may not be applicable to those with minor depression.

While some studies showing poor or mixed outcomes have also used treatment guidelines and protocols, it is likely that many of these are poorly implemented. Moreover, studies that use clinical guidelines and protocols, but that do not use a collaborative approach, do not show improvements in patient outcomes over standard care.

Including systematic patient follow-up in treatment protocol predicts good clinical outcome in collaboration studies for depression. Length of follow-up seems to be critical; two studies with follow-up of 12 months or longer showed increasing clinical benefit over time. These findings suggest that health services should be organized to incorporate routine systematic, long-term follow-up into the treatment

COLLABORATION IS KEY

The Canadian Collaborative Mental Health Initiative (CCMHI) is a consortium of 12 Canadian organizations representing health care providers, consumers, families and caregivers to improve mental health care in primary care. The two-year phase 1 of the project culminated in the creation of evidence-based research papers and a series of practical toolkits for health care providers, educators and consumers. Phase 2 of the project, which aims to ensure that Canadians with mental illness and their care providers have access to and can benefit from the knowledge generated through the CCMHI, is underway. For more information about the CCMHI and to access the toolkits, visit www.ccmhi.ca. Under “Our Products,” select “Toolkits.”

protocol, rather than waiting for the patient to initiate contact when things are not going well. Patient follow-up is frequently delegated to another clinician or care manager, usually with stepped-approach mechanisms for changing the treatment when patients are not responding well.

Increased adherence to medication and better outcomes may result from collaborative arrangements between health professionals, often including practice nurses. Furthermore, at least one study reported positive patient outcomes, even though there was no improvement in medication adherence. The authors of that study speculate that the improved outcome was due to the increased emotional support provided by nurses during adherence monitoring.

Collaboration alone has not been shown to produce enhanced knowledge or skill transfer from the mental health team to the primary care

PRIMARY HEALTH CARE AND DEPRESSION

Changing how primary care settings provide care has a significant impact on outcomes for people with depression, according to a review of the literature published in the February 2007 issue of the *Canadian Journal of Psychiatry*. The authors identify key elements for team-based primary health care settings and smaller changes that can be implemented in single-physician practices.

“Chronic Disease Management for Depression in Primary Care: A Summary of the Current Literature and Implications for Practice” found that incorporating mental health care coordinators, visiting psychiatrists, changes in treatment protocols to include screening and routine follow-up and support to enable people to better manage their own problems improves care. The evidence also suggests that system changes that reinforce the impact of each of these elements in combination improve care further. For example, screening only leads to better outcomes if it is linked with treatment, and the care manager’s role is more effective if there exists regular communication with the primary care provider.

Treatment for depression must be supported by strong links with community providers, and must be based on best evidence. Best evidence may be either incorporated into the treatment plan on the client’s chart or introduced through the presence of specialized mental health providers in primary care.

In single-physician practices, where these changes may not be possible, simple interventions such as designing mechanisms to ensure regular follow-up during or after treatment can improve treatment compliance and outcomes.

team (apart from a single study demonstrating improved prescribing for depression). Where change has taken place, it has been accompanied by substantial service restructuring designed to support the changes.

Enhanced patient education about mental disorders and their treatment was a component of many studies with good outcomes. Patient education was usually done by a non-physician primary health care professional. Similarly, guided self-help was an element of many successful studies, suggesting that patients may be willing to devote time and effort toward their own recovery.

Respecting patient choices about treatment may be an important factor in the patient’s engagement in collaborative care. For instance, studies have shown that between one-quarter and two-thirds of depressed patients prefer to be treated with psychotherapy rather than medication. Moreover, treatment with (protocol-based) psychotherapy has been shown to result in sustained quality-of-life benefits, which were not found with medication.

When research protocols have been introduced using permanent staff, they were far more likely to be maintained after the study than those that involved new staff. ¹

Dr. Roger Bland is professor emeritus and former chair of the Department of Psychiatry at the University of Alberta, and executive medical director for the Alberta Mental Health Board. He has been a member of the Collaborative Working Group on Shared Mental Health Care since its inception in 1998. Visit the group’s website at www.shared-care.ca.



OPENING THE LINES OF COMMUNICATION

Mentoring network supports family physicians

BY ANNE PTASZNIK

“**D**R. CLEO MAVRIPLIS, AN OTTAWA FAMILY physician, was overwhelmed and exhausted trying to provide care for her patients with mental illness. She had trained at the Montreal Jewish General Hospital, where there was a focus on psychosocial issues, but on her own, she says, “I’d be trying to help patients, but I didn’t really know where to go, especially when resources have become so limited. You’d try to call psychiatrists to get some advice over the phone but they were very difficult to reach.” Mavriplis would refer patients in crisis to the hospital emergency department, but in less urgent situations, it could take months to obtain a psychiatric consultation or ongoing care for her patients.

Family physicians are often the first point of contact for people with mental health issues. According to the 1997 Ontario Health Survey, between 30 and 40 per cent of family practice patients have a diagnosable mental health condition. In Ontario, 35 per cent of people with mental illness are treated by their family physicians only. Yet studies have found that family physicians report problems with accessing timely psychiatric consultation, poor communication with psychiatrists and a lack of support and respect for their role. But this is slowly changing, as psychiatrists and family physicians look at ways to work more closely together.

“It’s all about the relationship,” says Lena Salach, former director of the Collaborative Mental Health Care Network (CMHCN) developed by the Ontario College of Family Physicians. The CMHCN, established in 2001, is a mentoring program that links family physicians with psychiatrist and general practitioner psychotherapist mentors in a collaborative relationship to provide family physicians with the help they need in providing care for people with mental health and substance use problems. There are currently 65 mentors and 440 mentees in 23 regional mentoring groups throughout the province and 10 groups based on common clinical interests.

The program takes a three-pronged approach: one-on-one mentoring, largely through e-mails and telephone contact; small-group learning sessions and an annual conference, which this year focused on therapeutic techniques. “The primary purpose of the group sessions and conference is to foster that relationship,” says Salach. “We’ve also seen that the more small-group sessions we’ve had and after the annual conference, use of mentors increases significantly.”

Mavriplis joined the program four years ago. “It definitely helps to be in the small group because you get to know everyone and

develop a sense of comfort. In the beginning, nobody knows one another and you may be unsure about how much you should reveal about what you’re thinking.” She says any discomfort is quickly dissipated, thanks largely to her two psychiatrist mentors, Dr. Spencer Tighe, with Ottawa’s Pinecrest Queensway Health and Community Services ACT team, and Dr. Helen Spenser, a child and adolescent psychiatrist with the Children’s Hospital of Eastern Ontario in Ottawa.

Tighe, who joined the CMHCN around the same time as Mavriplis, says their group is unique because while most of the other groups have one GP psychotherapist and one psychiatrist mentor, he was accepted to work with Spenser because of their different areas of expertise. Initially, most questions in their small group of 20 were about diagnosing and treating complex mental illnesses, including bipolar disorder and psychotic disorders like schizophrenia because physicians felt they could provide care for patients with straightforward mood disorders, but lacked training with persistent and severe mental illness.

Tighe has been committed to working with this population from his residency days at the former Queen Street Mental Health Centre’s Archway Clinic. The CMHCN allows him to support physicians who often see patients at the onset of illness and who also provide care for patients’ multiple medical issues. “I can help with a whole group of people I would never be able to see if the mentor program didn’t exist. I don’t see these people personally but I can assist in their care from a distance through the network.”

Mavriplis says she has benefited from Tighe’s knowledge of pharmacology. Now, instead of having to wait for a few months for a referral, she can start giving the patient the right medication on her own. “I have more confidence and knowledge in dealing with medications, so it’s quicker access to the right treatment, the appropriate treatment,” she says. Also, as mentees are free to contact any of the mentors, Mavriplis was able to get a quick answer from a mentor with an interest in pregnancy and antidepressants for a patient who was on Paxil and had just become pregnant.

The one challenge that Mavriplis faced was writing out her concerns about a patient. “That is a bit of a barrier at the beginning,





WHAT DO DOCTORS WANT?

In a survey of family physician satisfaction with mental health services in Hamilton, Ontario, the 147 family physicians who responded rated suggestions for improvements to services. Here's what they said:

Improvements suggested	Importance	(1 = unimportant, 7 = very important)
Listing of private psychiatrists indicating their interests and availability		6.1
Telephone access to a psychiatrist		6.0
Visits to the office by a psychiatrist for clinical consultation		5.7
Standardized intake form across the mental health system		5.7
Circulation of key articles		5.5
Visits to the office by a psychiatrist for case discussion		5.4
Joint rounds		5.1
Visits to the office by a psychiatrist for educational discussions		4.8
Workshop for family physicians about local services		4.7
Mental health worker accompanying patient to physician's office for final visit		2.7
Consultation through the Internet		2.4

Source: Nick Kates, "Family Physician Satisfaction with Mental Health Services: Findings from a Community Survey," *Canadian Psychiatric Association Bulletin*, April 2004.

getting used to having to write out the case. It takes some time to do, but once you do it, it's quite helpful."

Tighe says that he and Spenser e-mail mentees' case vignettes to all mentees in their group as a teaching opportunity. He likes to go beyond what is available in a textbook or a website and provide insight into how he thinks through a diagnosis and treatment. He says that the mentees also provide their colleagues with good suggestions. "They're using up all my tricks," he jokes. Another reason for documentation is that both mentor and mentee have some legal liability, but Salach says this has never been an issue.

Salach says that mentors are expected to respond to mentee questions within 24 to 48 hours, although when relationships become established, mentors sometimes respond more quickly. She stresses that the network is not an emergency or referral service, which is critical for psychiatrists who are already in demand. Salach says the psychiatrists are often doing this work informally and the CMHCN formalizes the relationship. Also, they enjoy doing it, want to work with family physicians and want to teach.

The commitment of the mentors shows in an evaluation report recently completed after the CMHCN's sixth year of operation. Based on pre- and post-evaluation questionnaires and mentor logs, the research shows that mentees feel they have quick access to quick clinical help and have greater confidence in treating patients with mental illness and addiction, including complex conditions. Overall, mentees were satisfied with the mentors, whom they found very easy to access. As well, the small-group case-based sessions expanded their knowledge. While Salach says the program currently lacks the resources to research any reduction in visits to emergency wards and hospitals, anecdotally, physicians report that, feeling supported, they now rely less on formal consults and more on this informal mentoring.

One surprising finding is that mentees consult with their psychiatrist mentors on average just over four times per year. Salach says some mentees contact their mentors more often, but even those who contact them less often are happy knowing that immediate access is available. But Salach admits that this remains one of the challenges the network faces: "Physicians are trained to know

everything, and they may not feel comfortable asking someone they don't know a question." She frequently advises mentors to call and e-mail their mentees regularly when they join the program. The network has also added adjunct social work mentors and distributed a resource list to address the need for better access to community resources.

Salach says the network has begun to focus on psychiatry and family medicine residents in the belief that if they work together during training, they will continue to do so when they start to practise. Last year, the CMHCN piloted a program at the University Health Network's Toronto Western Hospital. This year, it is being rolled out across all University of Toronto teaching sites.

Salach, Mavriplis and Tighe agree that it would be good to have more family physicians involved with the network. One challenge is funding. Program expenses include mentor honorariums, program support, administration and the small-group sessions. The Ministry of Health and Long-Term Care has provided the program with base funding for five years – the program is currently in its fourth year of that funding – but it is limited for expenses including mentor honorariums, program support and the small-group sessions. So while the program accepts all family physicians who apply, it has not actively promoted itself.

Mavriplis says that the ministry has gotten its money's worth with her participation. She has been willing to provide care for patients with mental illness and not use referrals to psychiatrists as much because she knows she will get the help she needs. "I feel much more ready to take on patients with psychiatric problems because I know that I can ask a question if I need to and that the response is fairly quick," she says. "It's difficult when you're stuck trying to refer to some psychiatrist who says 'I can't see the patient before two months.' Having the network helps my confidence and willingness to take on more patients like that and follow them, and feel like I'm actually doing something positive." Å

For more information about the CMHCN, visit the Ontario College of Family Physicians website at www.ocfp.on.ca/english/ocfp/cme/cmhcnc or call (416) 867-9646.

SHARING ADDICTION CARE

Primary care settings move to the forefront of treatment

BY KIM GOGGINS

WITHIN THE ADDICTION SHARED CARE (ASC) Service at St. Joseph's Health Centre in Toronto, addiction clinician Robyn Little takes the time to learn about each of her clients' struggles with alcohol and other drugs. Although the stories are different, what these clients have in common is the involvement of their family physician in their addiction treatment and the attention of a collaborative team of health care professionals.

Meanwhile, in Hamilton, Ontario, a substance use counsellor visits the Rosedale Family Medical Group as part of a pilot project that started in autumn 2006 to educate family physicians, dieticians, mental health counsellors, nurses and nurse practitioners on how to implement screening to target clients who have substance use problems while still in the early stages.

Elsewhere in Canada, physicians are brought into alcohol and drug programs outside of Whitehorse in the Yukon to provide basic medical services for clients with severe substance use issues who have no family doctor. Unlike its sister initiative in the Central Okanagan area of the Interior Health Region in British Columbia, where drug and alcohol counsellors meet with clients in family practice settings, many of these doctors in rural areas of the Yukon provide medical care where clients are treated for their substance use problems.

These moves reflect the emerging concept of collaborative addiction care, which involves primary care providers such as doctors, nurses and nurse practitioners who are supported by addiction and other health care professionals. The few programs available are as varied as the populations and needs of individual communities. Whatever form the collaboration takes, the key piece to this "wrap-around care," as Little describes it, is the training and ongoing support of primary care providers to provide screening, intervention and client-centred treatment.

"Traditionally, addiction treatment has been quite separate from the health care system," says Dr. Meldon Kahan, medical director of the Addiction Medicine Program at St. Joseph's Health Centre. "They're funded separately, they have different procedures for admission, they're on different sites, and they don't really talk to each other," he says. "But this system makes no sense because patients with addiction problems go to their family doctor first. Or they go to the emergency department. Many patients will not go to a formal addiction treatment system, and even if they did, the system does not have enough resources."

According to a recent cohort study based on the ASC service, where Kahan is the director and one of seven physicians, of the 1,084 Ontarians who participated in a population survey, only 36 per cent with a history of alcohol dependence had sought help for their condition. Of those, 30 per cent sought their physician's help and only seven per cent accessed a formal substance use program.

But although primary care providers may be the first point of contact for people with substance use issues, many are reluctant to address addiction issues because they feel ill-equipped to do so. In a survey published in 2000 by the Ontario College of Family Physicians, 65 per cent of family doctors reported that it was "often to always difficult" to diagnose and treat clients with addiction issues. Given this situation, integrating primary care providers like family physicians into addiction care makes sense.

That's the driving force behind the ASC. Once clients are referred to the service by their physician, an appointment is made to see Little, who meets with the client within three weeks for a comprehensive assessment. The client then sees an addiction medicine doctor within two weeks for further assessment. "Consult summaries are based on all of this information and sent to the family physician," says Little, who has been with the program since it launched in 2005. "Treatment plans may include pharmacotherapy or ongoing counselling, based on individual need. If there are additional referrals, we'll include them in the summary."

As with the ASC service, providing support and education to primary care providers is a key component of the Increasing Substance Use Focus in Primary Care pilot project in Hamilton. One of its main goals is to help Family Health Teams (FHTs), which bring together different health care professionals to support primary care providers (see p. 18 for more about FHTs), detect and treat the 18 to 20 per cent of clients who drink over the recommended low-risk drinking guidelines before the problem becomes chronic.



"This group costs a lot in terms of social, medical and family consequences," says the program's substance use co-ordinator, Carol Melnick. "Our pilot project is targeting that group, not just the group with alcohol dependency. They're easier to access in a doctor's office because they often don't self-identify as having alcohol-related problems so they probably won't go to an addiction agency."

Since autumn 2006, the Rosedale Family Medical Group has participated in the pilot, and initial work has begun with two other medical practices that are part of the Hamilton FHT. Melnick recruits a lead physician, who will take on more responsibility within the group of physicians, and brings together a multidisciplinary team to form a steering committee that meets regularly to discuss the needs of the primary care providers and their clients.

Routine screening at annual physicals and when flags are raised are conducted by the primary care providers. The brief intervention screening – a series of questions that can take anywhere from two to 10 minutes – determines whether further involvement is needed. A substance use counsellor with a background in concurrent disorders also works part-time in the practice to answer doctors' questions and assist with more serious addiction cases.

"We ask primary care providers to calculate the weekly number of drinks and to then ask their patients questions around alcohol abuse and dependency," explains Melnick. "Depending on where the clients fall in that continuum, the primary care provider will provide feedback, invite a response, offer psycho-educational material and follow up with that."

On the other side of the country is the BC/Yukon Collaborative Care Initiative (BCYCCI), launched in 2001 to improve the effectiveness and accessibility of primary health care for clients with concurrent disorders by enhancing co-operation among the health care providers who treat them.

The BCYCCI has implemented a system change process that works to improve links and working relationships among mental health, alcohol and drug and primary health care services in the Central Okanagan area of the Interior Health Region and in the Yukon Territory. While services in both areas focus on providing client-centred care in a collaborative model, the programs are unique to the different needs of the two areas.

"In Central Okanagan, key components of the model are the ongoing deployment of clinicians from addiction services into family practice settings," says Dr. Julian Somers, director of the Centre for Applied Research in Mental Health and Addiction, BC/Yukon. "Services are intervening with a much larger number of individuals when they're practising in that setting than they would when they're in their offices back at alcohol and drug services," he says.

In the Yukon, alcohol and drug services became the hub sites for the collaborative work because people would be brought in for withdrawal management or other kinds of acute services, but many of those clients had no other health care. To fill this need, a collaborative model was developed where general family practitioners visit the substance use treatment centres on an ongoing basis to work with clients, particularly those without a family physician.

Studies and collaborative care initiatives have found that most clients prefer to talk about their problem with their family doctor if he or she is interested or able to help them. "Partly, it's because walking through the door of an addiction clinic is like admitting to an addiction, which carries a lot of stigma, as opposed to just

ADDICTION CARE AT THE DOCTOR'S OFFICE

A 2004 U.S. Preventative Services Task Force reported that screening in primary care settings accurately identified individuals at risk for substance use issues and that brief behavioural counselling with follow-up produced a small to moderate reduction of 13 to 34 per cent in alcohol consumption that is sustained six- to 12 months or longer.

But one of the big challenges of providing care for people with substance use problems is that many family physicians are reluctant to treat or even ask about substance use because they feel ill prepared, lack the time and question whether the clients they refer to addiction services get the treatment they need in a timely manner.

Toolkits for substance use, such as one developed by the Canadian Collaboration Mental Health Initiative (CCMHI), can help primary care providers and other health professionals plan their own collaborative care initiatives. The toolkit is available at www.ccmhi.ca. Under "Our Products," select "Toolkits"; then under "For Health Providers and Planners," click on "Eight companion toolkits" and choose "Individuals with Substance Use Disorders."

The Addiction Shared Care Program at St. Joseph's Health Centre in Toronto has also developed an addiction toolkit that contains clinical protocols, screening instruments and other office tools for primary care physicians. It will soon be available at www.camh.net.

expressing a problem to the family doctor where there's no stigma," explains Kahan. "It's also easier to talk to a family doctor than it is to get into an addiction program. And there aren't the long assessments and having to confide in strangers."

Clients are also more likely to keep appointments and be more engaged throughout the process because they know their health care professionals are working together, says Little.

The ASC service is also seeing positive changes among physicians. "Community physicians who at one time were reluctant to address addiction issues at all are now very involved," says Little. "They're much more willing to acknowledge addiction within their own patients. They're asking the right questions, and when they flag an issue, they have more confidence and understanding dealing with the issue and aren't afraid to refer to us, knowing they'll get support."

This collaborative effort between primary care and addiction services is the wave of the future, says Kahan. "The tools that have been developed work," he says. "The Centre for Addiction and Mental Health here in Toronto has had a big role over the years in developing simple clinical protocols for treating withdrawal and for brief advice interventions. Now it's a matter of getting them to the people who can deliver them. With the revolution in primary care that has happened, especially in Ontario with family health teams, it's a good time to help primary care clinics get up to date on addiction." **Ä**

COLLABORATIVE CARE ONE-ON-ONE

A nursing perspective

BY LESLEY YOUNG

IF YOU'RE LUCKY ENOUGH TO GET AN OPPORTUNITY to work in a collaborative care model, jump at it, says registered nurse and shared care consultant Carol Rupcich. After co-piloting a consultation/service-based primary mental health care model nine years ago in Calgary, Alberta, she's never looked back.

Rupcich works on two collaborative care teams and links the programs whenever she can. In the Collaborative Mental Health Care (CMHC) program, she works with a team of four psychologists, five social workers and one nurse to support primary care providers in delivering mental health care to children up to age 6. In the Shared Mental Health Care (SMHC) program, Rupcich works with seven psychiatrists, three psychologists, a social worker, four nurses and an occupational therapist to enhance adult mental health services delivered in primary care settings. She attends appointments at physician's offices, usually alone, to meet with the physician and patient. "If team members have a question about something clinical that we're unsure of, we usually telephone one another for advice." The psychiatrists in the SMHC program also have

set times when they visit physicians.

An evaluation of the SMHC program, published in a 2004 issue of the journal *Families, Systems and Health*, showed the program to be a major success from the perspective of everyone involved – that an office-based shared mental health care model in a fee-for-service environment is a viable and effective mode of primary care service delivery. The evaluation also uncovered significant information about how the model works in practice. One key finding was that family physicians remain the central care provider in the service, augmented by mental health consultation. Recent evaluation data corroborates these findings.

Working in a collaborative care model offers Rupcich professional development opportunities she says she wouldn't get with any other job, as well as unique work environments and constant stimulation. "It is quite challenging but very satisfying," she says. "I really feel that I am part of the primary health care system." In a one-on-one interview with *CrossCurrents*, Rupcich talks about on-the-job challenges and rewards.

"Mutual respect is a job requirement."

For a collaborative team model to work, all members, including the physician and the mental health consultant, whether it's a social worker, nurse, occupational therapist, psychologist or psychiatrist, need to find common ground. Our goal can only be achieved when there is a mutual respect and recognition of everyone's skills. We're all focused on finding out what is happening with the client.

Family doctors are very misunderstood. They're generalists and they know a great deal about various areas, and for that reason, you need to be open to learning from each other. Some health professionals may not like the medical model and might have a hard time adapting to a collaborative care model. What I've discovered and come to respect about family physicians is how quickly they work, and how they are the gatekeepers to other services.

You need to be non-hierarchical in your approach. I'm there as a consultant to the physician. I don't go into a situation as the expert – I never think of the interview as mine. In fact, if a doctor introduces me to a patient as "our expert in psychiatry," I'll correct that, telling the patient that he or she is the expert, and that we each have different knowledge and information with which to find what works for the patient.

"Which brings us the next point: The linchpin of any successful team is understanding and managing the physician-patient dynamic."

The consultant needs to pay attention to the relationships that exist between the physician and the patient, the patient and the consultant and the physician and the consultant. Without a good working relationship, it just doesn't work. The physician is the patient in SMHC, but the patient is the linchpin that drives the process. One of the most surprising findings to come out of the evaluation of our shared care model was the degree to which patients are attached to their family physicians and how much trust they invest in them. Most patients said they would rather receive mental health help from their physician than get a referral elsewhere.

The trust that exists between the physician and the patient can be a healing component, so you must be careful not to rupture that relationship. I once consulted with a 26-year-old male with alcohol abuse whose GP had attended at his birth. As a consultant coming into the GP's practice you need the GP's input to enhance your understanding of what's happening to the patient and to make the process mutually supportive: As a consultant, you do your work through the GP's relationship with the patient, and the credibility the

GP has is transferred to you. Meanwhile, you have to build your own rapport with the patient. I've encountered situations where the physician doesn't like a patient. I had to speak with the physician about his feelings and handling the patient with more respect. It's as much about managing the consultation and relationship dynamic as it is about treating the patient. In some instances, it's like being a broker.

"If you don't get along with a GP, you try to address this issue and you try to make it work."

In the years I've been doing this, I can recall only one incident where the relationship between the consultant and the physician couldn't be fixed. Generally, physicians are very receptive to our help. They want to be in collaborative programs because they recognize the benefit of additional assistance for treating mental health in the primary care system. Physicians learn so much, and keep learning, that they don't want to leave the program. Graduating them is a real challenge.

"You have to be a generalist and a specialist."

As a consultant in a collaborative care model, you switch gears from generalist to specialist and back again. You need to work with individuals, couples and families, and to communicate well. I never know what's behind door number one in a physician's office. It could be a parent with a child or an adolescent problem, a couple with marital problems, someone elderly or suicidal. It's amazing what GPs handle in their practices. Depression and anxiety are frequently the initial complaint, but we see people with schizophrenia, borderline personality disorder and substance use problems. Here's an example of how broad care can be: In the SMHC program, we saw a 20-year-old with depression who came in with her mother. Unknown to the GP, the daughter used cocaine. We eventually ensured kinship guardianship for her and saw the entire family, including the estranged father, the daughter's own child and her sister.

"You have to be flexible in so many ways."

You need to adapt to primary care professional boundaries. Psychiatry has firm professional boundaries, particularly around issues like self-disclosure, which aren't always so cut and dried in family medicine. You also have to be able to tolerate uncertainty.

You must adapt to different professional cultures, too. The culture of family practice is characterized by brief contacts, whereas mental health tends to have longer contacts. Shared mental health care allows the GP to spend more time with the patient. You need to be bilingual, speaking the language of mental health and family medicine. It's also important to have a good working relationship with the team psychiatrist. If I need to consult with one, I do so over the phone or I set up a time. The psychiatrists also meet with the GPs regularly. If necessary, both the psychiatrist and the consultant meet with the GP, but that rarely happens and such meetings are not time- or cost-efficient.

"Peer support is your saving grace."

You have to stretch yourself clinically to address the range of patient problems you encounter. You need to be able to discuss with colleagues what's happening with your clinical practice. Because you work in a somewhat isolated environment, moving from doctor's office to doctor's office, you need peer support. We meet monthly to discuss cases and clinical concerns. We take turns presenting our cases to one another. In SMHC, we meet every three or four months with the entire team to keep in touch and hold monthly consultant meetings to deal with more complicated cases, but you can discuss a case with team members whenever necessary. We continually evaluate what's working and what's not, and we change accordingly. In the infant mental health program, we also meet regularly, since these cases tend to be very complicated and can involve going to court.

"Of course there are some barriers."

There are financial and policy constraints for some areas of the country that may prohibit collaborative care models. We could use more funds to hire more consultants because there's a wait list for our program. In Calgary's SMHC, an alternative payment plan enables the family physician to bill for the SMHC consultation services.

Obviously, some physicians don't buy into the collaborative model and don't want to participate in the interview process. Instead, they want to turn the patient's care over to you. Some GPs might not buy into the educational component of the model. That's not collaborative care. We're also concerned about the eventual shortage of GPs undermining a collaborative approach.

The job is very mobile. We have a central touchdown office, but you're really out most of the time, traveling to doctors' offices. Every case is different, as is every GP and their practice. A big challenge is that sometimes you can't find resources or there is a long wait list for the programs you need for patients. You need an arsenal of contacts and connections.

"You'll love the rewards."

I love what I do. I get to see how the mental health system works from the other side – the primary care side. I get the opportunity to try new things, such as doing brief therapy with GPs. I enjoy being forced to think quickly on my feet. Two heads can be better than one when looking at a patient's problem.

Today, I have a much broader repertoire of skills in assessment, referral resources and therapy for individuals, couples, families and groups. The ability to interface between primary health care and the mental health system is indispensable, especially given the goal of enabling more and better treatment of mental health issues in the primary care system. **A**

Taking care to the streets

Shared care teams reach out to people who are homeless

BY ANNE PTASZNIK

THE CHEERY, YELLOW WAITING room of the health care clinic at the Adelaide Resource Centre for Women, a city-run centre serving about 80 homeless women daily in downtown Toronto, has an eye chart, baskets of condoms, a folded-up wheelchair and a scale. A wall poster reminds women to get a Pap test. Women come here for health care and to get help with housing and life skills and to join social activities. There's no sign that this is also the office of a psychiatric outreach team.

The clinic is run by the Shared Care Clinical Outreach Service, which provides medical and mental health care for homeless people visiting shelters and drop-in centres at eight sites in the city. The service began in 1998 and is funded by the Ministry of Health and Long-Term Care, and run by the Centre for Addiction and Mental Health (CAMH) in partnership with St. Michael's Hospital and the University Health Network's Toronto Western Hospital.

The service works on a primary care support model through shared care teams. Each site has a full-time registered nurse and outreach worker; a salaried general practitioner visits one or twice a week, and a consulting psychiatrist visits regularly. In preparation for the doctor's visit, on-site team members engage and assess individuals who may need health care services.

The predictable hours of operation, visible location and familiar faces strengthen communication among clients and service providers. Kelly Yardy, an outreach worker with the service, explains that many women who come to the Adelaide centre don't think they have a mental illness. "Part of how we build trust is by not labelling this as a mental health clinic and by addressing women's physical health concerns."

The clinic is quiet today. It's "cheque day" for those on social assistance, so some women are shopping and taking care of other needs. The women here write their names on a list and wait to be seen. One woman has a cough and sits rubbing her shoulders. A blonde woman comes in and hands a urine sample to Gemma Cruz, the

team's registered nurse. Another woman with a visor and backpack, looking like she's heading out for a day in the sun, stops by to ask for calamine lotion and bug spray.

Chiara Tassone, manager of the shared care service, as well as a CAMH inpatient unit for people with schizophrenia, says, "It's usually through primary care that we develop a rapport, for example, if a nurse or case worker sees that somebody has a cut on her knee, they'll approach that person, and say, 'Hey, I notice you cut your knee,' and then tend to the wound, through that developing a relationship." It is that relationship, sometimes taking long months to develop, that eventually opens the door to dealing with the mental health issues.

Shaei*, who stops in to see Cruz, says she started coming to the clinic four years ago when she was staying at a nearby shelter and had no family doctor. When she developed more serious mental health problems, "The clinic was my only lifeline. I didn't have a hard time trusting them because they've always been good to me."

Dr. Kate Greenaway, a newly graduated family physician working with the Adelaide team since 2006, says, "If it's the first visit, I don't do anything except try to respond to medical issues and reinforce that we'll be here." Patients are only now beginning to tell her about their paranoid thoughts or fears about what might be going on. Greenaway has experience working with mental health issues but appreciates the back-up from the team's psychiatrist, Dr. Avery Krisman.

Krisman values that the team does not look to him to medicate symptoms but that they are interested in their clients as people and in his contribution to understanding them as people. Krisman works at making patients feel comfortable but acknowledges that sometimes his status as a psychiatrist is an "unbridgeable gap." He appreciates having other team members with whom

patients can connect and who can help obtain necessary supports like housing and income assistance.

Staff also accompany clients to appointments and provide them with clothing and blankets. They often need to be creative in meeting clients' needs, for example, taking them to buy new shoes if they fear there are homing devices in shoes provided to them.

The team may consult with the staff of various social agencies that offer programs like fabric arts and computer classes. But it is usually at the drop-in, downstairs from the clinic, where they begin connecting with clients. Oriana and Melissa, staff with the Fred Victor Centre Women's Day Program drop-in, call the shared care team when they

"It's usually through primary care that we develop a rapport." It is that relationship that eventually opens the door to dealing with mental health issues.

notice a client experiencing difficulty. As if to illustrate this, a staff member tells Yardy that she is concerned about a disoriented woman lying on the ground outside. Yardy knows the client and says she will check on her and that likely the woman will come upstairs and lie on the team's couch.

The service can sometimes help prevent hospitalization, although the benefit of Tassone also being the manager of an inpatient unit is that she can facilitate admission when needed. The teams have also worked to house clients successfully, even those who have been homeless for many years, but will continue to provide medical and psychiatric care for clients who remain on the street if clients choose to continue seeing them. "For those who are not bothering anybody and choose to live their lives in a certain way, we're not going to turn our backs on them just because they choose to live differently." A

*not her real name

Working together for kids

Child and youth collaborative care in action

BY TERRY ISOMURA, TRACY LINDBERG, ANN TURNER, ANDREA CHAPMAN AND MARTIN HOWARD

SINCE 2005, THE CHILD AND Youth Shared Mental Health Care Program in British Columbia has linked mental health professionals and family physicians. Supported by the Fraser Health Authority and the Ministry of Children and Family Development, the shared care (SC) program features two health teams comprising psychiatrists, mental health clinicians and a psychologist that operate out of four primary care sites. The teams take referrals from six multi-physician offices in Coquitlam and New Westminster. Clinicians attend each site one-half or one full day every week; psychiatrists attend each clinic once or twice per month.

Psychoeducation and early intervention are important program objectives. Referrals range from youth with no prior mental health issues to those with extensive histories. The teams provide assessment, medication consultation, short-term psychotherapy, follow-up and liaison with mental health resources.

Communication is key to the collaborative approach: “We communicate with family practice colleagues in the usual formal way, but our informal interactions are also valuable,” says Dr. Ann Turner, one of the program’s psychiatrists. “Questions can be asked and answered and ideas shared simply by a brief exchange between appointments.”

Dr. Andrea Chapman, another SC psychiatrist, agrees: “Since we are all in the same office, we can discuss the case and treatment recommendations with the physicians, who usually know the family and child well. This adds a real depth to our assessments.”

Stigma-busting is another benefit: “We have engaged clients who were reluctant to accept other mental health services because of stigma,” says Dr. Tracy Lindberg, the SC psychologist. “Parents and children appear to find it more comfortable and convenient to come to their doctor’s office.”

Drawing from experience in the clinics, the following case illustrates what collaborative care with youth might look like.

Sixteen-year-old Amanda* was referred to the SC program by her family physician

after her adoptive mother, Sharon,* consulted her about Amanda’s suspected drug use and declining school performance. The doctor scheduled a meeting for Amanda and Sharon with the SC clinician to take place in her office within five days of the referral. The clinician gave explained the program to Amanda and her mother and scheduled a multidisciplinary assessment with the SC psychiatrist and psychologist for two weeks later.

During the assessment, Amanda reported increasing family conflict and a decline in functioning. She had become involved with a group that used alcohol, marijuana and cocaine and had run away from home for one month. Sharon had persuaded Amanda to return home but Amanda had refused counselling. Sharon described Amanda’s increased irritability, lack of interest in school and disrespect for house rules. Amanda reported a low and irritable mood, decreased interest in activities, social withdrawal and disrupted sleep and appetite. She was self-critical and anxious. She also reported impulsive behaviour and difficulty with attention, concentration and school work.

At the end of the assessment, a case formulation and treatment recommendations were shared with Amanda and Sharon. The family doctor received a consultation report. She persuaded Amanda to start counselling.

In regular meetings with the psychiatrist and psychologist, Amanda and Sharon received psycho-education about mental illness and learned how substance use affects judgment, mood and behaviour. They also attended joint sessions to monitor symptoms and address family conflict. Amanda and the psychologist used a cognitive-behavioural approach to identify and change maladaptive behaviour patterns and to learn better strategies for managing mood.

Psychoeducational testing found that Amanda’s cognitive skills and attention abilities were intact, but that she struggled with a mathematics learning disorder. A report was sent to Amanda’s school, allowing her to receive coursework adaptations. The psychologist reviewed compensatory strategies with Amanda and her mother that could help

Amanda with school. The psychiatrist started Amanda on anti-depressant medication to address her depressive symptoms. Throughout counselling, Amanda’s doctor received informal updates and copies of all formal reports, and shared responsibility for following up on symptoms and medication issues.

Amanda reported improvement in her symptoms. Meetings with the SC team were tapered off as Amanda’s doctor took over medication management. However, over the next year, Amanda continued to display impulsivity and lack of regard for consequences, which affected her relationships and functioning. She had a substance use relapse and visited the emergency room several times. During this period, Amanda’s doctor consulted with the SC team to review diagnostic issues and coordinate treatment. The team gave her information and resources about counselling strategies to use with Amanda and ways to support Sharon. Amanda was referred to a local substance abuse program and returned briefly with her mother to psychotherapy with the SC psychologist to review strategies for managing her behaviour and mood.

Amanda terminated her substance use, disengaged from some of the detrimental factors in her social environment and established structure in school and at home that supported better functioning. Her mood issues stabilized. Amanda’s care is currently managed by her family physician. The SC team remains available for formal and informal consultations on medication issues, counselling strategies and local resources.

The benefits of collaborative care are clear. For Dr. Kathleen Ross, a family physician in Coquitlam, “This coordination has decreased the morbidity associated with mental illness in this age group, helped to relieve the uncertainties and stress facing families and improved the long-term outcome for our patients.”

*names have been changed

THE AUTHORS ARE MEMBERS OF THE CHILD AND YOUTH SHARED MENTAL HEALTH CARE PROGRAM IN BRITISH COLUMBIA.

Common questions about family health teams

BY ASTRID VAN DEN BROEK

In Ontario, they're touted as the solution to many of the painful issues facing the health care system – extensive wait times, family doctor shortages, lack of consistent care. This solution is family health teams (FHT), a concept introduced in 2005 by Ontario's liberal government, in which a range of health care providers – from dietitians to social workers to doctors – link up to serve a community. *CrossCurrents* interviewed Dr. Nick Kates, director of programs for Ontario's first and largest FHT, the Hamilton Family Health Team, and lead for the Quality Management Collaborative, the provincial agency set up to oversee the FHT initiative, to find out more about FHTs and their promise for the future.

What are family health teams?

FHTs are part of the government transformation of health care. They're a model that will hopefully develop a new paradigm for the way health care is delivered in Ontario. They are group practices involving a range of health professionals offering effective team health care with a strong emphasis on chronic disease management, health promotion, prevention and self-management support through 24/7 coverage.

Each FHT determines exactly which providers best meet their needs, but most have included family physicians and nurses or nurse practitioners. Many have included mental health workers, dietitians, pharmacists, health educators or individuals with specialized expertise in specific programs that they're interested in developing, such as an asthma educator or a children's health worker.

What are the benefits of family health teams?

Family health teams have the capacity to identify populations and manage individuals with chronic diseases more effectively. Instead of relying on a single provider to know all the resources and offer all the treatments – and that was almost invariably the family physician – you now have various people who bring different expertise like a

mental health worker or a dietitian. Other professionals may be able to assist with assessments or managing some of the problems seen routinely in primary care. For example, nurse practitioners can see cases that would otherwise be seen by the family physician, freeing up the family physician to deliver other kinds of care. And because of the extra resources, it's easier to link with community programs, and it's easier to develop programs within a single family health team because you're not relying on just one or two health individuals.

This means services aren't being duplicated, and at the same time, this set-up increases the number of individuals who can access primary health care. We're also going to see that older physicians who might have otherwise retired may find this to be a more satisfying way to practise and may thus practise a lot longer than they would otherwise.

What is the current state of the rollout of family health teams in Ontario?

All the FHTs – there are 150 funded in three waves – have now had their operating budgets and business plans approved and are in the process of setting up programs. Within our FHT, we've been operational for over a year. We're setting up a number of pilot programs within the FHT. Within the pilot programs we're looking at is a chronic disease management program for depression, which we're calling a program for the enhancement of care for individuals. This is based around identifying a population, being able to monitor them, not only during the acute phase of an episode, but after treatment has been completed. And as far as recruiting professionals to work within the FHT, this is a completely new style of practice for most practitioners working in primary care, so it involves some training and preparation for individuals as well.

What feedback have you received from clients about this new model?

In our program, patients report very high levels of satisfaction. They like getting mental health care in a family physician's office – it's

non-stigmatizing and it's accessible and usually must faster than a referral to a clinic. As far as formal evaluations, we intend to start them before the end of the year. We're already collecting relevant data toward an internal evaluation.

What have been the challenges to rolling out family health teams?

One difficulty has been with IT because a lot of the systems that have been used don't have registry capability and there's great variation between the systems. There are 19 different systems that have been approved to distribute products for registering clients in Ontario, so that's one area where there have been a lot of bumps.

The second challenge has been around team development. The family health team model is new to health professionals. We're recognizing that there's more to team development than funding and hiring a group of skilled health professionals. We need opportunities to meet as a team, not just around tasks, but to build the social aspect of the working relationship. There are also changes in the roles of individuals, particularly family physicians. They don't have to be doing everything they've been doing for the past 20 or 30 years because some of those responsibilities are now handled by other people on the team.

What is your vision for family health teams in the future?

I hope that family health teams will continue to expand, regardless of the outcome of the next provincial election. We need to evaluate what we're doing and look at what is and isn't working. We're also seeing more physicians wanting to join existing family health teams. If this model can demonstrate the kind of outcomes we anticipate, then more people – both care providers and consumers – will want to work in or be served by this model.

For more information about family health teams, visit www.health.gov.on.ca/transformation/fht/fht_mn.html

Strategies for addressing suicidality in adolescents

D*ialectical Behavior Therapy with Suicidal Adolescents* provides much-welcome support to clinicians who work with multi-problemated teens struggling with suicidal urges or non-suicidal self-injurious behaviour (self-harm). Broadening and building on the proven techniques of dialectical behaviour therapy (DBT), a psychosocial treatment developed specifically for treating a suicidal population, the authors articulate how DBT can be translated, tuned toward and extended to meet the needs of suicidal and self-harming adolescents and their families. In so doing, they provide an important resource to clinicians, as well as the families of teen clients facing these issues.

The book begins with an important grounding in the literature on suicidal behaviour among teens. The authors discuss the proximal and distal factors that contribute to teen suicide and self-harm and review the research to date on existing treatment options. Noting the practice-as-usual tendency of excluding from treatment trials those teens at highest risk for suicide, the authors propose DBT as a viable, desirable treatment option. They also support their view with some promising early research evidence of its effectiveness. The authors articulate the basic principles of DBT, its dialectical core, the bio-social model and how emotional dysregulation is often at the

core of distressed teens' urges to engage in problematic behaviour. They also explicate how transactional family patterns can inadvertently contribute to the problems these teens struggle with. From this established framework, they introduce an innovative element of the DBT treatment for suicidal adolescents – that DBT provide families with structured opportunities to engage in treatment with their teens. They describe how parents/families can participate in DBT treatment, and how, by understanding how behaviour is maintained and learning DBT skills, families can positively contribute to change in both the family and the adolescent.

The book then describes the structure and core strategies of DBT for suicidal adolescents. Many basic principles and strategies of DBT outlined in Marsha Linehan's original text, such as balancing acceptance with pushing for change, maintaining a focus on behavioural monitoring, analyzing factors connected to problematic behaviour, and understanding the importance of skill acquisition, will be familiar to those already literate in the DBT approach. However, this book goes beyond the original text, providing deeper understanding of particular dialectical dilemmas teenagers struggle with internally and with their families. The authors also offer practical coaching in how to build a strong therapeutic alliance with

this challenging population; of particular note, they provide a welcome new skills module, "Walking the Middle Path," which for the first time, provides clients and practitioners with a straightforward articulation of the fundamental dialectical principles at the heart of DBT.

Taking the reader step by step through implementing individual, family and group-based interventions, the authors guide the reader through every stage of treatment, from orientation to termination, succeeding in making their discussion of treatment issues highly accessible through case illustrations and sample dialogues. The appendices provide plentiful resources. These include helpful exercise formats for the DBT skills outlined in the text (30 mindfulness exercises, for example), lecture notes that both clinicians and clients will find useful and several reproducible handouts. This text is an invaluable resource for mental health providers working with this population. It will also be a valuable first-hand family manual for adolescents and their families.

Dialectical Behavior Therapy with Suicidal Adolescents. A.L. Miller, J.H. Rathus, M.M. Linehan. Guilford, New York, 2006, 354 pp., \$40US.

Dr. Alberta Pos is an assistant professor with the clinical psychology faculty at York University in Toronto.

downloaded Sheila Lacroix

Collaborative mental health care

Overview

The Ontario Division of CMHA, www.ontario.cmha.ca, is a good first stop for an overview of mental health reform and shared care initiatives. Under **Mental Health System**, see the section on **Health Care Reform** for key policy documents for reform at both the federal and Ontario provincial levels, provided in chronological order since the 1980s. Recurrent themes include community-based continuum of service, integration with other health and social services and shared service support. Under **Primary Care**, see links to major initiatives in both Ontario and Canada, including CCMHI (www.ccmhi.ca), covered extensively elsewhere in this issue of *CrossCurrents*, and Shared Mental Health Care (SMHC) in Canada (www.shared-care.ca).

Key Partners

SMHC's Collaborative Working Group was formed by the College of Family Physicians of Canada (CFPC) and the Canadian Psychiatric Association (CPA)

in 1997 to implement recommendations made in the first SMHC report, and continues to develop and promote professional training, evaluation tools, and protocols. Its work involves contributing to the development of the CCMHI Toolkits. The Collaborative Working Group also tracks projects and initiatives in shared care across Canada and hosts an annual conference. See the February 2007 issue of the *Canadian Journal of Psychiatry*, available free online at www.cpa-apc.org, for an example of a current initiative: Depression and Its Management in Primary Care. It includes a guest editorial by Dr. Roger Bland, active in the Working Group, followed by two reviews, one of which includes implications for practice. *Canadian Family Physician*, CFPC's monthly journal, available free at www.cfpc.ca, is another good resource for primary care support. For example, the March 2004 issue had two CME articles, *Treating Bipolar Disorder: Evidence-Based Guidelines for Family Medicine* followed by *Shared Mental Health Care: Model for Supporting and Mentoring Family Physicians*.

Is collaborative care moving forward?

Yes, but at a slower pace than some of us expected

DR. TYRONE TURNER

Collaborative care is now getting the attention it deserves. It is mentioned repeatedly in policy documents, planning briefs and professional position papers. It has moved beyond the pioneer paradigm of the psychiatrist-GP dyad and is now embraced by professions such as nursing, social work, occupational therapy and psychology. After all, it's such a good idea. Through shared care, psychiatric expertise can be made available to all who need it, on referral by that most available of all Canadian social benefits – the GP. Primary care physicians and nurse practitioners can attend to both arms of the Cartesian split, dealing with mind and body. They are more likely to speak the language of their patients, know their culture and their families. Shared care is a stigma-fighter when anxious, depressed or psychotic individuals, who would never attend a psychiatric clinic, can merge their mental health care with blood pressure and cholesterol checkups. Shared care psychiatrists can be freed up to provide their expertise to more people. In my own shared care practice, over the past 17 years, working collaboratively on average 1.5 days per week, I have attended to over 5,000 patients. Many of them would call me their psychiatrist, even though I may have seen them only two or three times. Contrast these numbers with the few hundred patients on the caseloads of conventional practices. As a method of opening access to mental health care to much larger populations, collaborative care cannot be beaten.

Why then, is collaborative care not yet standard practice? What stands in the way?

Lack of funding is often cited as a barrier. Shared care is best delivered by interdisciplinary teams, which requires staff and an infrastructure. Furthermore, the traditional fee-for-service method of paying psychiatrists and GPs discourages collaborative care, which involves extra time for telephone, e-mail, face-to-face meetings or even telemedicine. While government policy supports shared care, secure funding mechanisms are not yet in place.

Nevertheless, there is progress.

Ontario's primary care reform initiative now provides funding to engage collaborating psychiatrists (and internists and pediatricians). Many of the nation's pilot collaborative care programs have involved psychiatrists and GPs in alternatively funded practices (salaried, capitated or sessionalized), in which physicians have more time to engage in the clinical dialogue needed to make shared care work. To move beyond these generally more welcoming types of practices, we need to work harder at engaging the majority of GPs who continue to work on a traditional fee-for-service basis.

Another barrier is that collaborative care challenges the classical psychiatric model into which psychiatrists have been professionalized. One doctor and one patient talk together in a private office for serial 50-minute sessions, which continue until the illness stabilizes or psychotherapy is deemed completed. The health record is highly confidential and the psychiatrist does not customarily collaborate with the GP. Psychiatrists brought up in this model are often uncomfortable sharing care with other professionals. Can they be stimulated to change? This familiar model, reinforced by media, shapes public expectations, and sometimes patients want to be treated by specialists, not generalists. The traditional model also reinforces a deeply held need for confidentiality when sensitive personal information is processed. Can collaborative care ensure that privacy will be protected when care is delivered by teams of professionals in different locations?

At a broader level, are psychiatrists and GPs adequately convinced about the value of shared care? Until they are, how can we expect the public to buy in? The classic model of specialist referral still holds despite the low availability of psychiatrists and long wait times. Some GPs have even given up referring to individual psychiatrists, and now advise their patients to locate one on their own. Many GPs have not yet had shared care made available to them, and thus have no experience with positive outcomes or patient satisfaction. Even when shared care is available, some GPs do not refer, perhaps not

Editorials do not necessarily reflect the views of CAMH. We welcome submissions from our readers. For information, contact the Editor, *CrossCurrents*, 33 Russell St., Toronto, Ontario M5S 2S1, tel 416 595-6714, e-mail hema_zbogor@camh.net

being convinced of its effectiveness. Some are waiting for more evidence from outcome studies. Others need to know that patients would be satisfied with a shared care referral. Physicians feel professional gratification when their patients return and say, "Doctor, thank you for that referral."

Furthermore, it is not reasonable to expect all GPs to have the time, inclination or temperament to treat mentally ill individuals. Some physicians are more oriented toward birthing, pediatrics or seniors' care. During training, many were assigned to tertiary care mental hospitals or acute inpatient units but received little experience in outpatient psychiatry.

Many psychiatrists, while acknowledging that shared care sounds like a good idea, do not see it as a viable practice option. Some cite financial disincentives; others want the professional satisfaction of providing direct patient care, with a close doctor-patient relationship and clear lines of responsibility (and legal liability). Again, as with GPs, some are waiting for the evidence. For a few sceptics, collaborative care seems like a form of rationing, where scarce psychiatric expertise is spread too thinly to be effective. While the idea of population health can be valued intellectually, it can be hard to grasp its significance for individual practices.

Thus, it is clear that while the collaborative care model is moving forward, barriers persist. Commendably, the collaborative ideal is advancing along multiple fronts, which include funding incentives, research, patient satisfaction surveys and revamped educational curricula.

Overall however, it will be through the repeated experience of satisfied patients receiving effective treatment, with the knowledge that they are supported by mental health professionals, who in turn can access more intensive services, when needed. Nothing works like experience.

Tyrone Turner, MD, CCFP, FRCP(C), is chief of psychiatry and medical program director for Mental Health and Addictions at the St. Joseph's Health Centre in Toronto.

CANADA

5th National Conference on Tobacco or Health: "Smoke Free – A World of Difference"

October 1–3, Edmonton, Alberta
Contact: National Conference, Canadian Council for Tobacco Control, 192 Bank St., Ottawa, ON K2P 1W8
tel 613 567-3050
toll-free 1 800-267-5234
fax 613 567-2730
e-mail conference2007@cctc.ca
www.ncth.ca

Canadian Association for Suicide Prevention Conference: "Embracing Life, Choosing your Future"

October 5–8, Yellowknife, Northwest Territories
Contact: CASP 2007 Conference Coordinator, c/o Box 1320, Centre Square Tower 6, Department of Health and Social Services, Yellowknife, NT X1A 2L9
fax 867 873-0196
e-mail info@casp2007.ca
www.suicideprevention.ca

Canadian Society of Addiction Medicine 19th Annual Scientific Conference

October 11–13, Ottawa, Ontario
Contact: Alexis Martis, CSAM, 375 West 5th Ave., Ste. 201, Vancouver, BC V5Y 1J6
tel 604 484-3244
fax 604 874-4378
e-mail admin@csam.org
www.csam.org

4th Canadian Colloquium on Dementia

October 18–20, Vancouver, British Columbia
Contact: MedPlan Communications, 5524 Saint-Patrick, Ste. 200, Montreal, QC H4E 1A8
toll-free tel 1 888 726-8060, ext. 224
toll-free fax 1 888 726-8059
e-mail info@ccd2007.ca
www.ccd2007.ca

25th Anniversary National Conference: "Family Assessment and Intervention Training and Certification – Clinical Applications to Trauma, Child Abuse, and Violence Risk Assessment"

October 25–26, Saskatoon, Saskatchewan
Contact: Canadian Association of School Social Workers and Attendance Counsellors, c/o Kim Troesch, 30 Cory Place, Saskatoon, SK S7L 5G8
tel 306 683-8224
e-mail goulden-mcleodp@spds.sk.ca
www.casswac.ca

Second International Global Perspectives on Chronic Disease: Prevention and Management Conference

October 29–November 1, Calgary, Alberta
e-mail cdm.conference@calgaryhealthregion.ca
www.cdmcalgary.ca/en-ca/program.html

14th Canadian Conference on International Health: "Global Change and Health – Who Are the Vulnerable?"

November 4–7, Ottawa, Ontario
Contact: Canadian Conference on International Health, c/o Canadian Society for International Health, 1 Nicholas St., Ste. 1105, Ottawa, ON K1N 7B7
tel 613 241-5785, ext. 326
fax 613 241-3845
e-mail conference@csih.org
www.csih.org/en/ccih/index.asp

57th Annual Meeting of the Canadian Psychiatric Association

November 15–18, Montreal, Quebec
tel 613 234-2815
fax 613 234-9857
e-mail conference@cpa-apc.org
www.cpa-apc.org

Making Connections: A Canadian Cancer Research Conference Celebrating the National Cancer Institute of Canada's 60th Anniversary

November 15–17, Toronto, Ontario
Contact: NCIC 60th Anniversary Conference, National Cancer Institute of Canada, 10 Alcorn Ave., Ste. 200, Toronto, ON M4V 3B1
tel 613 235-8879
e-mail dunlopdr@rogers.com
www.ncic.cancer.ca

Canadian Centre on Substance Abuse National Issues of Substance Conference

November 25–28, Edmonton, Alberta
Contact: Zoë Stevens-Lavigne
tel 613 241-9333
e-mail ccsa@goldenplanners.ca, or Brooke Bryce, e-mail bbryce@ccsa.ca
www.issuesofsubstance.ca/ios

Early Years Conference 2008

January 31–February 2, 2008, Vancouver, British Columbia
www.interprofessional.ubc.ca/Early_Years.htm

39th American Society of Addiction Medicine 29th Annual Medical-Scientific Conference

April 10–13, Toronto, Ontario
tel 301 656-3920
e-mail smetc@asam.org
www.asam.org/CME_Activities_Home.html

UNITED STATES

National Conference on Tobacco or Health 2007

October 24–26, Minneapolis, Minnesota
Contact: 2007 National Conference on Tobacco or Health, 8737 Colesville Rd., Ste. 1100, Silver Spring, MD 20910
tel 301 960-2929
e-mail info@tobaccocontrolconference.org
www.tobaccocontrolconference.org/2007/conference/splash.cfm

The Male Survivor 2007 International Conference

October 25–28, New York, New York
Contact: MaleSurvivor, 5505 Connecticut Ave. N.W., Ste. 103, Washington, DC 20015-2601
e-mail MaleSurvivor@MaleSurvivor.org
www.malesurvivor.org/conferences.html

54th Annual Meeting of the Academy of Psychosomatic Medicine

November 14–18, Amelia Island, Florida
Contact: APM, 5272 River Rd., Ste. 630, Bethesda, MD 20816-1453
tel 301 718-6520
fax 301 656-0989
e-mail apm@apm.org
www.apm.org/ann-mtg/index.shtml

6th Annual Conference of the International Society for the Prevention of Tobacco Induced Diseases

November 2–4, Little Rock, Arkansas
e-mail contact@isptid2007.org
www.isptid2007.org

International Society for Traumatic Stress Studies Annual Meeting: "Preventing Trauma and Its Effects"

November 15–17, Baltimore, Maryland
Contact: Annual Meeting, International Society for Traumatic Stress Studies, 60 Revere Dr., Ste. 500, Northbrook, IL 60062-1591
fax 847 480-9282
e-mail drutherford@istss.org
www.istss.org/meetings

18th Annual Meeting and Symposium of the American Academy of Addiction Psychiatry

November 29–December 1, Coronado, California
Contact: American Academy of Addiction Psychiatry, 345 Blackstone Blvd., 2nd floor, RCH, Providence, RI 02906
tel 401 524-3076
fax 401 272-0922
e-mail cj@aaap.org
www.aaap.org/home.htm

National Association of Clinical Nurse Specialists Annual Conference

March 5–8, 2008, Atlanta, Georgia
Contact: NACNS, 2090 Linglestown Rd., Ste. 107, Harrisburg, PA 17110
tel 717 234-6799
fax 717 234-6798
e-mail nacnsorg@nacns.org
www.nacns.org

American Association for Geriatric Psychiatry Annual Meeting

March 14–17, 2008, Orlando, Florida
Contact: AAGP, Rachel Bieber, 7910 Woodmont Ave., Ste. 1050, Bethesda, MD 20814
tel 301 654-7850, ext. 111
e-mail meetinginfo@AAGPonline.org
www.aagpmeeting.org

ABROAD

9th Annual Meeting of the International Society of Addiction Medicine

October 22–28, Cairo, Egypt
e-mail nady.el-guebaly@calgaryhealthregion.ca
www.isamweb.com/pages/annualmeetingspresent.html

14th Biennial Winter Workshop on Schizophrenia and Bipolar Disorder

February 3–7, 2008, Montreux, Switzerland
Contact: Congress Secretariat, Khim Schenk, The Events Management Company, Route de l'Ancienne Scierie, 10, 1263 Crassier, Switzerland
tel 41 22 369 2436
fax 41 22 369 2446
e-mail wwwschiz@bluewin.ch
www.winterworkshop.org/lp/14WWreg/14WWreg?1=1

3rd World Congress on Women's Mental Health

March 16–20, Melbourne, Australia
Contact: Waldron Smith Management, 61 Danks St. W., Port Melbourne VIC 3207
tel 61 3 9645 6311
fax 61 3 9645 6322
e-mail iawmhcongress2008@wsm.com.au
www.iawmhcongress2008.com.au

16th World International Family Therapy Association Conference: "Global Family and Globalizations – Family Therapy in the 21st Century"

March 26–29, Porto, Portugal
Contact: Paragon Conventions, 18 Avenue Louis-Casaï, 5th floor, 1209 Geneva, Switzerland
tel 41 22 747 7930
fax 41 22 747 7900
e-mail ifta08@paragon-conventions.com
www.paragon-conventions.com/ifta2008

18th World Congress of the International Association for Child and Adolescent Psychiatry and Allied Professionals

tel 90 312 454 00 00
fax 90 312 454 00 24
e-mail iacapap2008@flaptour.com.tr
www.iacapap2008.org

World Psychiatric Association Thematic Conference on Depression and Relevant Psychiatric Conditions in Primary Care

June 19–21, Granada, Spain
tel 34 902 430 959
e-mail info@wpa2008granada.org
www.wpa2008granada.org

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