crosscurrents
AUTUMN 2010
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The Journal of Addiction and Mental Health

Chronic disease prevention and management

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Breaking down barriers to good physical health

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Hepatitis C, 15 years into recovery

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

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Cartier, Jan Swinburne, acrylic on unstretched canvas, 17" x 22"

Jan has been exhibiting for 30 years in Toronto and internationally. Her practice focuses on painting but includes sculptural installation and published written works. She is an alumnus of the Ontario College of Art and Design.

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In Every Issue

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

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note from the editor

For many years the poor physical health of people with serious mental illness and chronic addictions has been a significant concern. Poor physical health is rooted in poor housing and nutrition, high rates of smoking, and the effect of some psychiatric medication. But there is also evidence that patients with severe mental health and addiction issues who have existing co-morbid diseases and physical conditions are not adequately cared for. Inadequate access to primary care—and to specialized care requiring referral from primary care—is a big part of this problem.

This statement issued by the Centre for Addiction and Mental Health in a recent submission to the Ontario Human Rights Commission, which is developing a human rights mental health strategy for Ontario, reflects a startling reality around the world: people with mental health and substance use issues are more likely to die earlier and to experience chronic physical conditions and diseases including cardiovascular disease, obesity and diabetes.

The articles in this issue of *CrossCurrents* examine this stark reality and call for a more integrated, holistic approach to managing and preventing chronic disease.

As always, I invite you to send us comments and ideas so that we can continue to cover the issues that interest you.

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mad science

Paul, an octopus at the Sea Life Centre in Oberhausen, Germany, leapt to stardom during the 2010 soccer World Cup as an oracle that can predict the winners.

His career started soon after he was born in 2008, when he correctly chose the winner in four of six matches involving the German team. In this year's World Cup, he was correct in eight of eight matches—including the final.

During a prediction, Paul is presented with two boxes. Each contains food and is marked with the national flag of one of the teams in the upcoming match. Whichever box Paul eats from first is considered to be his choice for the winning team.

His prediction that Argentina would lose to Germany prompted an Argentine chef to post an octopus recipe on Facebook. When Paul predicted that Spain would beat Germany, German fans suggested that Paul should be cooked and eaten; the Spanish prime minister offered, albeit jokingly, official state protection.

But perhaps what is most interesting about Paul is what it says about our scientific literacy and our capacity for magical thinking.

From a scientific point of view this is straightforward. If Paul's choices were random, then choosing correctly for eight games in a row is similar to someone guessing a flip of a coin correctly eight times. It's rare, but possible. Of course it may be that the prediction method leads to bias. Being colourblind, octopuses are attracted by brighter colours and contrasts, so Paul may be more likely to choose particular flags.

But most people haven't considered the science. They have been thinking magically. The marketing gurus at Sea Life who thought up the stunt are exploiting how people think. We all know that octopuses have no idea of countries, soccer or world events. No one would seriously believe that the Sea Life test taps a well of natural knowledge that could predict the future. Yet most people wonder how these predictions could happen and whether there is something more to it. For many, scientific answers of luck and chance do not satisfy.

Is it a problem that scientific answers do not satisfy and that people are looking for more? At one level, yes, but science is not about having all the answers; it is about increasing our understanding of the world so we can predict what happens and change what we don't want to happen. We need to better understand the capacity for hope and the need to believe in something greater than ourselves—hence our belief in psychic octopuses. It is also the type of hope that, against the odds, propels humanity forward and allows individuals with long-term problems to take steps toward recovery. Knowing how to understand and building on that essential human quality may be a challenge that scientists want to investigate. Because if Paul were asked to pick a winner between scientific thinking and magical thinking, I'm not sure who he would choose.

Kwame McKenzie, MD, MRCPSYCH (UK)
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Honouring Aboriginal grandmothers to promote safety and healing

Amanda Dale

Guided by the benevolent spirit of her recently departed grandmother, Billie Allen has taken on a research project that is both groundbreaking and heartbreaking: exploring the meaning of abuse to elder Aboriginal women, and exploring their solutions. "Really," she tells the audience at the recent Aboriginal Health Forum in Toronto, "I am just a helper to the grandmothers."

Allen, a health research and policy officer at the Native Women's Association of Canada (NWAC), is midway through completing the Grandmother Spirit Project on the morning I speak with her at the forum, which showcased new health research and program development by, for and about Aboriginal Canadians. The 22-month national qualitative research project hopes to improve understanding and increase awareness of abuse committed against older Aboriginal women.

Based in aboriginal/indigenous approaches to research, the project is guided by the participants, and thereby aims to bring forward the voices and visions of older Aboriginal women to improve safety and well-being for this generation and generations to come. Ever mindful of a colonial history that has included the use of research to measure, classify and objectify aboriginal ways, Allen has taken a very different approach.

"My role is to take what the grandmothers have to share and raise it up," she says. "Not to tell people what to do. To do research in the aboriginal way, you have to know what went before and what you are giving back. It is about reciprocity and relationship." She is careful to point out that it is not about displaying problems without self-generated solutions. This is not research for research's sake.

"I worry about words taking on a life of their own," she says. "Speaking about something gives it spirit. Repetition gives words and deeds new life. Speaking about Aboriginal communities mistreating grandmothers is not something that I want to bring more power and life to." This is why Allen can't presage her results, except to say that it is certain they will come with solutions—solutions that come from the wisdom of the grandmothers themselves.

Speaking about elder abuse is not easy for any culture. A 2008 Environics survey estimated that between 4 and 10 per cent of older adults in Canada experience some kind of abuse, but reliable research for incidents has been a relatively recent addition to the statistical library. According to the National Network for the Prevention of Elder Abuse, the first Canadian comprehensive research on the subject was in 1989.

The growing body of research shows that the risk of experiencing elder abuse increases with age, social isolation, reduced cognitive capacity, disability, dependency and living with someone with alcohol, drug or gambling problems. Ageism, a history of domestic violence and intergenerational dynamics are also associated with increased risk.

> "We need to ask, 'How did colonization affect our grandmothers differently?'"

Allen's research is delving deeper. She uses the metaphor of the coyote, an animal spirit known for its trickery and cunning, to explain the unreliability of mainstream research to represent and assist Aboriginal communities. "We need to ask, 'How did colonization affect our grandmothers differently?' We need to look at structural or institutional abuse differently. For instance, what happens to a grandmother when she is pulled from her community and put into a seniors' home? This institutional setting echoes her residential school experience," Allen explains.

On most reserves, it is impossible to get supportive devices to keep women independent in their homes. And the forms of abuse they endure within their families and communities reflect the despair and poverty that characterize too much of Aboriginal experience in Canada—prescription theft, being robbed of their residential school settlement cheques, over-drugging while relatives take over their homes.

Without culturally and historically attuned research and community development models, Allen argues, terrible trauma can be repeated at later stages of life, potentially compounding what good intentions had intended to heal. She cites a procedural rule in which older adults in remote communities lose their subsidy for heat and electricity if they invite a grandchild to live with them. Such disincentives push grandmothers into further isolation and vulnerability and remove the benefit of their wisdom from the development of the new generation. On or off reserve, Allen tells me, it is extremely hard to find care for older adults that is based in Aboriginal culture.

But appropriate care is crucial for healing to happen. According to the philosophy that guides health research at NWAC, "health is everything. Every aspect of our life (social, economic, environmental) and our self (mental, emotional, spiritual, physical) must be healthy and strong in order for healing to occur. Maintaining good health involves maintaining connections between the individual, the family, the community, the nation and the land."

It is Allen's belief that women—and grandmothers in particular—have a critical role in forming these connections.

Using the Grandmother Spirit Project as a place from which to honour the goals of self-determination and decolonization and to benefit the community through storytelling research methods, policy recommendations and community development, Allen is at the forefront of crystallizing indigenous research methods while creating contemporary accountability to grandmothers within Aboriginal communities.

"Grandmothers have solutions to the problems of our youth," Allen insists, referring to the drug use, truancy and loss of cultural values identified in others studies presented at the Aboriginal Health Forum. "Women have lost their revered place in our culture. We need to help them get to where they can make their contribution and regain their respect."

myth busters

Breaking through the shame of male sexual victimization

Helen Buttery

New York psychologist Dr. Richard Gartner treats men who have been sexually abused. Author of *Beyond Betrayal: Taking Charge of Your Life after Boyhood Sexual Abuse*, he says myths still abound about male sexual victimization. In this column, Gartner sets the record straight about these misnomers.

Myth: Males cannot be victims of sexual abuse.
Fact: Although a lot has been written about the shifting of the "macho image"—the idea that boys are strong and therefore not vulnerable to victimization—most boys still grow up with that traditional idea. It's part of differentiating themselves from girls. Men give lip service to evolving gender ideas; for example, I've heard many men say, "It's okay for men to cry, but not me." I don't think there's a man in our culture who never falls into those stereotypical traps about what it means to be a man, even if he recognizes it. The reality is that boys are smaller and weaker than their perpetrators. Often boys chosen by abusers are already marginalized, making them vulnerable. For example, one or both parents have substance use problems or the parents are divorced. These young boys may already be troubled and are looking for a connection to a male mentor for what is missing in their own lives. Unfortunately, the predator's radar is up for someone like that. Often abusers are in a position of power and trust, for instance, a teacher or club leader.

Myth: Homosexual men are most likely to sexually abuse boys.
Fact: In one study of approximately 3,000 incarcerated pedophiles, not one of them identified as gay. This study suggests that pedophiles are not homosexual—being attracted to adult men. If we define homosexuality as being attracted to other men (as opposed to male children or adolescents), there are virtually no homosexual pedophiles. Sexual abuse is not about sex; it's about power. Boys are less threatening than women, yet they resemble women—hairless, smaller and not as physically powerful as men. Often pedophiles see children as their peers.

Myth: Sexual abuse of boys by women doesn't happen.
Fact: It is mostly men who abuse boys, but the number of women who abuse is higher than we may think. A recent study showed that 60 per cent of boys were abused by men, 29 per cent by women and 11 per cent by both. Abuse by women doesn't usually involve physical threats; it's more covert. When a women initiates sex with a boy, he may consider it a "sexual initiation" and deny that it was abusive. His friends will think he's lucky. Often, men are in their 30s and early 40s before they acknowledge the sex as traumatic. One man I saw in my practice had been abused as a freshman in college. His parents were divorced. He was vulnerable and looking for maternal nurturing. A female professor invited him over to teach her yoga. She propositioned him and he feared losing his new-found maternal connection. He thought, "If I say yes, I'll maintain my relationship and have sex—that's not a bad thing." But it was. When the relationship ended, this young man dropped out of school. Now, at age 42, he has never had another relationship with a woman.

Myth: Abused boys will go on to become abusers.
Fact: This is one of the most damaging myths. Yes, a disproportionate number of perpetrators were themselves abused. However, more than 80 per cent of sexually abused boys do not become adult perpetrators. It's important to put it in perspective because this stigma creates fear and further traumatizes male victims. They are afraid to disclose because people will suspect they are pedophiles. One of my clients who told his family he was abused was denied access to his grandchildren. Many abused men internalize this myth and walk around fearful that they will abuse or be accused of abusing. Sometimes men seek treatment because they have become fathers and are afraid to diaper their children. They may also seek help because their child reaches the age they were when they were abused and they are paralyzed with fear—they are afraid of themselves.

Myth: Boys who are sexually abused by a man will become homosexual.
Fact: Boys are developing their sexual identify as growing young men. Whatever their sexual identity—homosexual or heterosexual—abuse will make them question their sexuality. Corroborating this myth is another myth: if a boy becomes aroused during the abuse, he must have enjoyed it and therefore he must be homosexual. Any 14-year-old boy will become physically aroused by this kind of contact, even if the experience is traumatic or painful. Pedophiles play on this insecurity, saying, "You enjoyed it." Blaming the victim is a common strategy abusers use. It may be easier for a child to accept that "he asked for it," rather than thinking that the world is a scary and unpredictable place. And if he does disclose, he may fear that everyone will think he's a "fag." Even today, there is no worse insult on the playground than being called a "fag." What's most important is for parents to teach their children that they are allowed to tell them anything, that they will not be blamed or punished. Opening this line of communication is so important.

From treatment refusals to stories and hope

Barbara Russell

When a person first experiences a serious health problem, new decisions have to be made by the person, their family and health care workers. The inescapability of decisions helps explain why the health ethics community, with complementary attention by the legal and regulatory communities, devotes so much time to the concept of autonomy, the nature of professionals' fiduciary responsibilities and the criteria for a valid consent process.

In terms of decisions about addiction and mental illness, a paradigmatic case for the past 30 years or so has been psychiatric medications. The first generation of antipsychotic drugs was designed to provide more immediate benefits to more people than had been possible. Because these medications were seen as breakthroughs, many professionals were baffled when individuals declined them or did not take them as prescribed. This bafflement, which often grew into frustration, generated much discussion about treatment refusal and noncompliance. But for the people taking them, these medications often caused unremitting, negative side-effects, so researchers sought alternatives.

The second generation antipsychotics —"the atypicals"—have helped some people, but for others, they contribute to physical consequences such as cardiovascular problems or diabetes. Making treatment decisions can constitute true dilemmas for both clients and their health care providers. "Should I continue taking this medication or not?" is matched by "Am I helping my client more by prescribing or by not prescribing this medication?"

Yet there is another way to think about illness. Arthur Frank, a University of Calgary sociology professor, contends that illness signals a need for stories, because stories help "repair the damage illness does to the ill person's sense of where she is in life, and where she may be going." Moreover "the call for stories is literal and immediate," because there are always family members, employers, professionals or government agencies to deal with. In his book *The Wounded Storyteller*, Frank considers three stories common to illness and health care settings. The first is the restitution story, which fits well with non-chronic illnesses: "I was ill for a time; I got medical help; and now I'm back to normal."

The other two types of stories align better with chronic health concerns. First is the chaos story, wherein illness challenges or even disconnects the person from what he has always taken for granted, believed in and found meaningful. Here, the challenge for other people is to not temper his story or back away from him. Second is the quest story, in which revised meanings, self-concepts and goals develop from persevering, re-imagining and re-committing, while still understanding how contingent our daily lives are.

Implicit in the quest storyteller's work is hope. Four recent studies about hope will help return us to the treatment–no treatment dilemma common to chronic illnesses. Delmar and colleagues, in a 2005 issue of the *Scandinavian Journal of Caring Sciences,* found that among people with chronic illness, hope and a "spirit of life" are essential to living in harmony with the illness. Beanlands and colleagues studied two groups of people with chronic illness—one with schizophrenia and the other with chronic kidney disease. The study, published in 2006 in the *Canadian Journal of Nursing Research*, found that both groups avoided being "engulfed" by their illness by "getting on" with their lives and being their "best selves."

Kim and colleagues argued that hope is a dynamic, multi-factorial process. The chronically ill people in their study, published in 2006 in the *International Journal of Nursing Studies*, referred to internal and external sources of action combined with present and future expectations. For instance, someone is currently hopeful because of what she can do now, but at another time, she is hopeful because of what other people will do in the near future. In their research on the impact of hope, published in 2009 in *Psychiatric Research,* Hasson-Ohayon and colleagues coined the phrase "usable insight" and concluded that increasing hope can improve both a person's insightfulness and their quality of life.

In terms of chronic illness and treatment dilemmas, it is important to factor in what preserves hope. Doing so will help prevent a quest story from eroding into a chaos story. Furthermore, ethics-informed decisions about treatment—to start, continue or stop —require a context, namely the person and their story. Clinicians should recommend interventions based not only on scientific and clinical evidence, but also on their clients' unfolding journeys.

But with this said, Lester and Gask in a 2006 issue of the *British Journal of Psychiatry* question the wisdom of using the language of chronic illness. They found that people with mental health issues favoured the recovery approach's characterization of illness. The description of recovery presented by Onken and colleagues in the *Psychiatric Rehabilitation Journal* in 2007 includes "dialogical action—telling one's narrative, uncovering the strengths and assets embedded within it, untangling and externalizing the negative dominant discourses," which "results in a transformative re-authoring of one's experiences, triggering new meanings and personal and political growth."

The points about telling and dominant discourses help illuminate ethically salient aspects in some treatment dilemmas. For instance, people considering or receiving treatment often must fight against other people, no matter how well intended, speaking for them, as well as against reliance on the majority's presumptions and priorities. Our willingness to deepen and, at times, reframe individual and collective understandings of human illness can help preserve or regain meaningfulness, interpersonal connectedness and communal solidarity.

Do you have a comment or ethics question for ethicist Barbara Russell?

Visit the Ask the Ethicist blog at www.camhcrosscurrents.net to read more postings and to have your say.

Mark de la Hey

Dissociation common among people with substance use disorders

Researchers at the University of Hamburg in Germany have found high rates of dissociation in people with substance use problems, notably among those with both alcohol and drug dependence. However, these associations appear to be the result of the underlying characteristics of individuals with substance use problems, rather than the substance use itself. The study involved 459 individuals, 182 of whom were alcohol dependent, 154 were drug dependent, and 123 were dependent on both alcohol and drugs. Participants completed questionnaires to confirm alcohol and drug dependence and measure rates of childhood trauma, post-traumatic stress disorder (PTSD) and dissociation. The results showed high rates of traumatic childhood events in all three groups. Higher levels of dissociation were found in individuals with drug dependence and in those with both drug and alcohol dependence compared with those who were alcohol dependent alone. Female participants with either drug dependence or both drug and alcohol dependence were most likely to meet criteria for a dissociative disorder. A low proportion of men in the study and of women with alcohol dependence alone met these criteria. However, when childhood trauma, PTSD, age and gender were taken into account, the influence of any type of substance use problem was not significant. Rather, it was the severity of childhood traumatic experiences, especially emotional abuse, that was most strongly associated with dissociation. Higher rates of dissociation were also evident among younger participants. The authors conclude that screening for dissociation should focus not just on identifying substance use problems, but should also consider female gender, younger age and especially a history of childhood trauma.

Drug and Alcohol Dependence, June 1, 2010, v. 109 (1–3): 84–89. Ingo Schäfer et al., Center for Interdisciplinary Addiction Research, University of Hamburg, Hamburg, Germany.

Near-win situations may encourage problem gamblers to gamble more

Among regular gamblers, a near-win stimulates parts of the brain associated with reward, which may lead them to gamble even more, according to research from the University of Nottingham in England. Researchers recruited 20 regular gamblers whose gambling ranged from recreational playing to probable pathological gambling. Functional MRI scans were performed on participants while they played a slot machine simulation. Two slot machine reels were presented on a computer screen and participants were asked to choose an icon from the left reel. The right reel was then spun and if it stopped on the selected icon the participant was given a small monetary reward. Participants exhibited significant responses in the ventral striatum region of the brain after both wins and after near-misses, in which the slot machine reel stopped one position above or below the selected icon. There was also a positive relationship between gambling severity and dopamine response in the midbrain to near-miss outcomes—the more severe an individual's gambling was the greater the response. There was no such relationship in response to win outcomes. These results suggest that near-misses enhance dopamine transmission in problem gamblers, which could explain why near-misses drive them to gamble more. The researchers state that this points to neurobiological similarities between problem gambling and drug addiction, which also involves enhanced dopamine transmission. The responses to near-win outcomes may help to explain the cognitive distortions that lead problem gamblers to overestimate their chances of winning in the future. The researchers suggest that in future, drugs which reduce dopamine transmission may be useful in reducing these cognitive distortions.

Journal of Neuroscience, May 5, 2010, v. 30 (18): 6180–6187. Henry W. Chase and Luke Clark, School of Psychology, University of Nottingham, Nottingham, United Kingdom.

Young smokers often unaware of emerging signs of addiction

Youth who smoke occasionally exhibit clear symptoms of nicotine dependence, but often don't recognize those symptoms as precursors of addiction, concludes a study from the University of Massachusetts Medical School in Worcester. Researchers looked at data on 370 adolescents from a four-year study of nicotine dependence. Sixty-two per cent of the youth, aged 11 to 13 when the study began, smoked at least once a month, with 25 per cent smoking daily. Thirty-three per cent reported symptoms of dependence, such as cravings, withdrawal symptoms, feelings of addiction or difficulty controlling cigarette use. The more frequently participants smoked, the more dependence symptoms they reported. Forty per cent of those who smoked cigarettes at least once a month escalated to daily smoking, and the presence of any dependence symptom increased the risk that the participant would progress to daily smoking. Participants typically experienced cravings and symptoms of nicotine withdrawal before they began smoking daily. Feelings of addiction and difficulty controlling tobacco use emerged after the onset of daily smoking. The authors suggest that this pattern indicates that non-daily smoking results in nicotine dependence, which leads to increased smoking frequency. This in turn leads to additional symptoms of dependence, creating a positive feedback loop that leads to further increases in smoking frequency. Young people tend not to realize that cravings and withdrawal are symptoms of addiction, leading the authors to recommend research to determine whether educating young people to recognize early symptoms of dependence could lead to more successful smoking cessation efforts.

Pediatrics, June 2010, v. 125 (6): 1127–1133. Chyke A. Doubeni et al., Department of Family Medicine and Community Health, University of Massachusetts Medical School, Worcester.

Thrill of risky behaviour trumps concern over consequences among adolescents

New research from University College London indicates that adolescents' tendency to engage in risky behaviour is due not to difficulty estimating negative consequences of their behaviour, but to the fact that the thrill adolescents experience in risky situations outweighs their concern about negative consequences. Researchers recruited 89 male participants: 20 pre-adolescents aged 9–11, 26 young adolescents aged 12–15, 26 mid-adolescents aged 15–18, and 17 adults aged 25–35. Participants played one of two "wheel of fortune" games on a computer and indicated their emotional responses after each trial. The researchers found that the ability to weigh expected value (the value of potential outcomes weighted by the probability of their occurrence) increased with age. Older participants showed a preference for gambles with a higher expected value. On the other hand, a preference for risky gambles (gambles with greater variance in outcome) peaked at age 14 and declined thereafter. Compared with pre-adolescents, young adolescents showed a significant increase in expressions of relief or regret when shown that the outcome would have been worse or better had they chosen to play the other game on the screen. These emotions decreased gradually through mid-adolescence and adulthood. The researchers suggest that adolescents' preference for risky gambles appears to have been largely driven by their strong enjoyment at winning in "lucky escape" situations, where the outcome could have been much worse had they chosen the other wheel. While these results shed light on the reasons for adolescent risk taking, the authors caution that risk-taking in real life situations is likely to have various underlying causes.

Cognitive Development, April–June 2010, v. 25 (2): 183–196. Stephanie Burnett et al., University College London Institute of Cognitive Neuroscience, London, United Kingdom.

Telephone therapy may effectively treat depression

Telephone psychotherapy can be almost as effective in treating depression as face-to-face psychotherapy, according to research from Brigham Young University in Provo, Utah. The six-month study followed 30 adults seeking treatment for depression at an outpatient mental health clinic. Treatment involved cognitive-behavioural therapy delivered over the phone in eight weekly half-hour sessions, followed by two monthly half-hour booster sessions. All participants completed the three-month follow-up assessment, and 87 per cent completed the six-month follow-up. All participants completed at least one telephone session, while 90 per cent completed at least four and 77 per cent completed at least eight. At the six-month follow-up, 69 per cent of participants said they were "very satisfied" with the treatment. Forty-two per cent were considered recovered after six months, compared with 50 per cent of participants in a recent study of in-person cognitive-behavioural therapy. The cost of each session of telephone therapy was approximately $40, compared with a recent estimate of $96 for traditional office counselling. Participants in this study indicated that they appreciated the privacy and flexibility of telephone counselling. The study's authors note that telephone therapy has the advantage of avoiding some of the barriers associated with traditional office psychotherapy, such as stigma, travel, waiting time and costs.

Behavior Therapy, June 2010, v. 41: 229–236. Steve Tutty et al., Brigham Young University, Provo, Utah.

Injectable heroin effective treatment for heroin addiction

Injectable heroin can be more effective than methadone in treating heroin addiction, according to a new study from King's College London. The study involved 127 individuals with chronic heroin addiction who were being treated with oral methadone but who continued regularly to inject with street heroin. Participants were assigned to receive injectable heroin, injectable methadone or optimized oral methadone. After six months, 88 per cent of those given injectable heroin remained in treatment, compared with 81 per cent of those given injectable methadone and 69 per cent of those on oral methadone. The primary outcome objective was a result of at least 50 per cent negative urine samples for street heroin during the last three months of the study. This outcome was achieved by 72 per cent of those on injectable heroin, compared with 39 per cent of those on injectable methadone and 27 per cent of those on oral methadone. Abstinence from street heroin during the final month of the study was achieved by 37 per cent of those on injectable heroin, 18 per cent of those on injectable methadone and eight per cent of those on oral methadone. The authors note that although the costs of supervised injectable treatment are relatively high, the gains from reduced heroin use are significant.

Lancet, May 29, 2010, v. 375 (9729): 1885–1895. John Strang et al., National Addiction Centre, King's College London, London, United Kingdom.

High rates of PTSD and depression found among Iraq veterans

Research from the Walter Reed Army Institute of Research in Silver Spring, Maryland, indicates that U.S. soldiers returning from combat in Iraq have high rates of post-traumatic stress disorder (PTSD) and depression. The study involved 13,226 soldiers from four Active Component and two National Guard brigade combat teams. Researchers collected anonymous mental health surveys from the soldiers three and 12 months after deployment from Iraq. After three months, rates of PTSD with serious functional impairment were eight per cent among Active Component soldiers and seven per cent among National Guard soldiers. At 12 months, rates had risen to nine per cent and 12 per cent respectively. Rates for depression with serious functional impairment at three months were eight per cent for Active Component soldiers and five per cent for National Guard soldiers. At 12 months, these rates had risen to nine per cent for Active Component and seven per cent for National Guard soldiers. The fact that rates of PTSD and depression increased between the three-month and 12-month surveys led the authors to conclude that the 12 to 18 months typically given to Active Component soldiers between deployments may not be sufficient to allow them to recover.

Archives of General Psychiatry, June 2010, v. 67 (6): 614–623. Jeffrey L. Thomas et al., Department of Military Psychiatry, Walter Reed Army Institute of Research, Silver Spring, Maryland.

Mind the body

Breaking down barriers to good physical health

By Dr. Steve Kisely and Leslie Anne Campbell

Physical and mental illnesses are closely related. Mental health problems can increase the risk of developing diabetes, heart disease and stroke. Depression, for example, is not only a serious chronic illness; it is also a major risk factor for heart disease and cancer. At the same time, strong evidence indicates that mental health is important in coping with stressors and maintaining good physical health and healthy lifestyle practices.

These inter-relationships can have fatal consequences. Mortality risk is more than 70 per cent higher in people with mental illness than the general population, even after adjusting for demographics such as socio-economic status. Excess risk of mortality from chronic physical disorders, including cardiovascular disease, cancer and chronic lung disease, is 10 times that of suicide, yet it receives far less attention. A meta-analysis of mortality in schizophrenia by Saha and colleagues, published in the *Archives of General Psychiatry* in 2007, identified 36 studies drawn from 19 different countries. It found increases for all causes of death apart from cerebrovascular disease. Unexpectedly, the review also found that the differential mortality gap associated with schizophrenia was increasing. These data suggest that people with mental illness have not shared in the improved health of the general community.

Although lifestyle factors such as obesity and alcohol or tobacco use are often suggested as an explanation for increased mortality among individuals with psychosis, they are unlikely to be the sole explanation. Hamer and colleagues in the *Archives of Internal Medicine* in 2008 found that all-cause mortality remained high, even after adjusting for behavioural risk factors such as smoking, physical activity and body mass index. In the case of cancer, our paper published in 2008 in the *Canadian Journal of Psychiatry* found that mortality rates for some cancers were 65 per cent higher for people with mental illness than for the general population, even though incidence rates were similar. It is unlikely that lifestyle explains this finding, as otherwise, incidence should better reflect the increased mortality.

Prescribed medication can also predispose to physical illness through mechanisms such as weight gain. The largest group of medications associated with weight gain are those used for psychiatric conditions and include the most commonly used antipsychotic agents and mood stabilizers and several anthidepressants.

Another explanation for increased mortality might be that physical illnesses go unrecognized among people with severe mental illness. Reasons might include the tendency for people with psychosis to be less likely to report a medical complaint and to have more difficulty interpreting physical symptoms or distinguishing them from symptoms of their mental illness. These individuals may also be less able to problem-solve and care for themselves.

A 2007 article in *Family Practice* by Roberts and colleagues reported that even when physical health problems are diagnosed, people with mental illness are less likely to receive adequate treatment for their physical health problems. This is despite the fact that physician consultation rates are higher among people with severe mental illness. For instance, Hippisley-Cox, among others, reported that people with mental illness are less likely to have a physical examination or to be assessed and treated for hyperlipidemia (abnormally high level of lipids, especially cholesterol). They are also less likely

Fast facts about physical health and mental illness

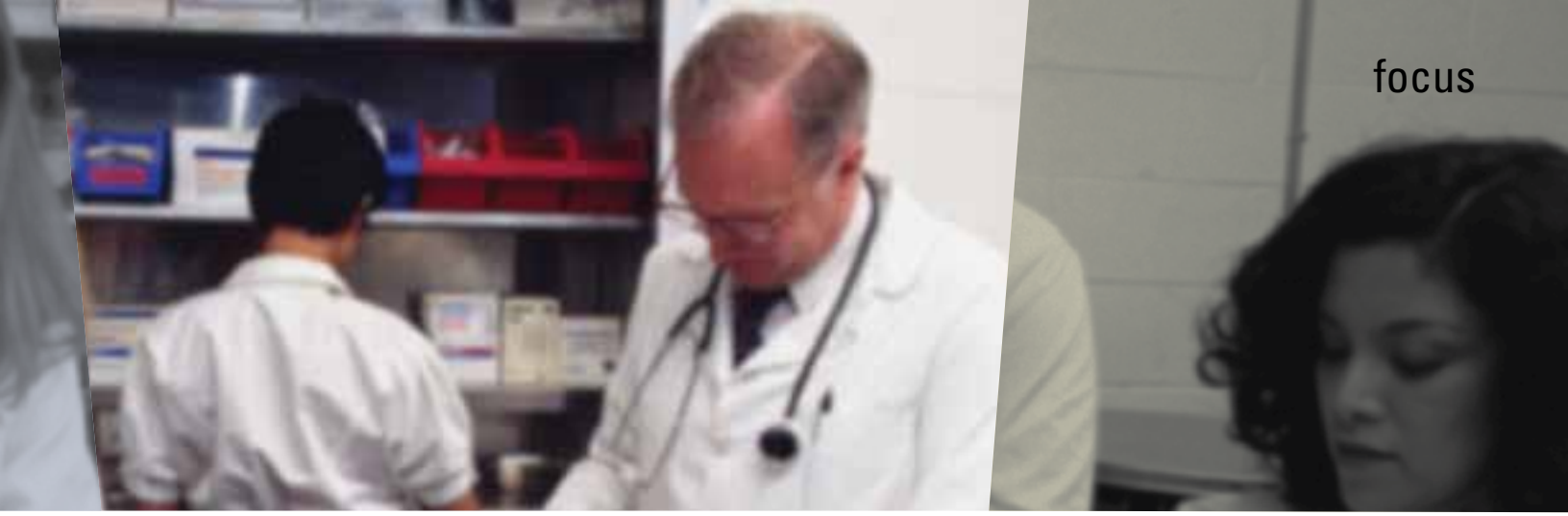
Compared to the general population, people with severe mental illness are:

- 2.5 times more likely to die from cardiovascular disease
- more than twice as often overweight or obese
- more likely to develop type 2 diabetes
- less physically active
- more likely to smoke, and smoke heavily
- 3.5 times more likely to have liver disease and cirrhosis

Source: Activate: Mind and Body

Risk factors for the development of depression in physical illness

- past history of psychiatric disorder
- illnesses or treatments affecting central nervous system
- chronic painful, disabling or disfiguring illness hindering self-care
- life-threatening illness
- major and unpleasant treatments
- lack of social support
- sense of loss associated with serious medical illness



Data suggest that people with mental illness have not shared in the improved health of the general community.

to be screened for cancer. Our preliminary data suggest that delays in initial presentation lead to more advanced cancer at diagnosis.

Management of physical health in secondary health services may be no better. Of particular concern is that people with severe mental illness such as schizophrenia are less likely to receive common medical or surgical interventions. In the *Canadian Medical Association Journal* in 2007, we found that people with mental illness and circulatory disease were less likely to receive specialist interventions such as cardiac catheterisations and coronary artery bypass grafting than the general population, despite their significantly higher mortality rates. Last year, we reported in the *British Journal of Psychiatry* that people with mental illness were also less likely to receive appropriate medications on discharge following heart attack.

All these data suggest that even when people with psychiatric conditions have their comorbid physical illness detected by the health system, they are not afforded the same level of active treatment as the general community. This may reflect practical difficulties in engaging these individuals in complex health systems, including a lack of co-ordination between mental health services and the general health sector. Shander, writing in JAMA 10 years ago, suggested that physicians are reluctant to offer some procedures because of the ensuing psychological stress, concerns about capacity or adherence with post-operative care or the presence of contra-indications such as smoking. Daumit and colleagues, in a 2005 paper in the *Archives of General Psychiatry*, also suggested that people with mental illness may be at higher risk of developing complications following medical or surgical interventions or have poorer outcomes post-operatively.

These explanations are less applicable to the prescription of medications known to reduce morbidity and mortality. Contra-indications to specialized interventions, such as smoking or problems with informed consent, are less relevant to the prescription of vascular drugs such as ACE inhibitors, beta blockers or statins. The concern is, therefore, that appropriate treatments are not offered because of the stigma of mental disorders in general medical settings. For instance, Goodwin's 1979 article in JAMA suggested that some primary care physicians may see people with severe mental illness as being disruptive to their practices or may feel uncomfortable treating them. In a 2009 BMC *Family Practice* article, Fleury and colleagues reported that lack of expertise also contributed to the reluctance of general practitioners to take on patients with serious mental illness. With a shift toward community care of people with serious mental illness comes the need for improved education of primary care practitioners.

Dr. Steve Kisely is director of Health LinQ at the University of Queensland in Australia and an adjunct professor in the Department of Psychiatry and the Department of Community Health and Epidemiology at Dalhousie University in Halifax, Nova Scotia. **Leslie Anne Campbell** is a lecturer in these departments and a research co-ordinator with Capital Health in Halifax.

Chronic disease management in Ontario

Improving chronic disease prevention and management (CDPM) is a priority in Ontario's health care agenda. The **Canadian Mental Health Association–Ontario division**, in partnership with other organizations, is working to define the place of mental illness and mental health within the CDPM framework. To read about policy and research related to CDPM, visit CMHA Ontario's website at www.ontario.cmha.ca. Under Policy and Research, choose "CMHA Public Policy," then "Chronic Disease Prevention and Management."

The **Ontario Chronic Disease Prevention Alliance** has developed messages for use by individuals, groups and organizations to promote action on chronic disease prevention. The messages address five chronic disease risk factors: high-risk alcohol consumption, physical inactivity, poor mental health, tobacco use exposure and unhealthy eating. www.ocdpa.on.ca/rpt_evidence_messages.gk

Weighing in on metabolic monitoring

Unique clinic integrates twin priorities of body and mind

By Patricia Nicholson

Type 2 diabetes is three times as common in people with schizophrenia compared to the general population. The metabolic syndrome—a characterization of risk for developing diabetes and heart disease—is also prevalent in this population. Because many second-generation antipsychotics increase risk for weight gain, hypertension and diabetes, medications are a big contributor to this problem.

"Medication is one part of it, but it is not that simple," says psychiatrist Dr. Tony Cohn, head of the Mental Health and Metabolism Clinic at the Centre for Addiction and Mental Health (CAMH) in Toronto. "It may have to do with lifestyle, for example, high smoking rates, diets heavy in simple carbohydrates and low activity levels. Social determinants including poverty and access to education are also powerful factors." Cohn adds that a cellular or genetic overlap between schizophrenia and diabetes may also exist.

What is clearly understood is that people with serious mental illness die on average 25 years earlier than members of the general population, mostly from metabolic problems like diabetes and heart disease. It's this sobering statistic that motivated Cohn and his colleagues to develop the metabolism clinic.

The clinic was the first in Canada to focus on treating weight gain, obesity and diabetes in clients with serious mental illness. In addition to providing ongoing health monitoring, the multidisciplinary clinic offers diet and lifestyle interventions specifically designed for this population.

All of the symptoms associated with the metabolic syndrome —abdominal obesity, high triglycerides, low HDL, hypertension and high fasting glucose—are prevalent in people with schizophrenia. Metabolic monitoring is crucial for these clients, but standard approaches may not work well.

"It's a bit of a systems challenge how to do this," says Cohn. "Everybody around the world struggles with how to implement it. Historically, we've tended to separate physical health care and mental health care, and it's only been in the last 10 years or so that we've focused on the need to integrate them."

Part of the challenge is reflected in debates about who is responsible for monitoring: some psychiatrists view it as part of a GP's job, while GPs may think that the psychiatrist who prescribed the medication should monitor its side-effects. In a multidisciplinary practice, some staff may view it as the nurse's job, while others view it as the dietitian's. "It tends to fall into the cracks," says Cohn. "That's why we developed our metabolic tool—to try to do it more systematically."

The clinic's electronic Metabolic Health Monitor tool was originally developed as a paper form. Its first on-screen incarnation was as an Excel spreadsheet. "Various calculations need to be done for a metabolic assessment—like a Framingham risk assessment, target lipid values, body mass index—the sort of things that computers can do quickly," says Cohn.

The current Metabolic Health Monitor tool, which is linked into CAMH's electronic records system, recently won an award from the Information Technology Association of Canada.

The tool tracks relevant information such as how long the client has been monitored, how long since their last assessment, their age, sex, waist circumference, blood pressure and lab test results. Worrisome data, such as high blood pressure or a significant weight change, are automatically highlighted in red, while information that may be cause for concern but does not yet require urgent attention is highlighted in yellow.

"This tool helps us keep the information well organized for reflection later," says Cohn. "It's also useful for us to collect information on the whole population and learn about specific factors. For example, we've seen that if people smoke, they have about double the rate of diabetes. That has been shown in the general population, but because people with serious mental illness have high smoking rates, it's important to focus on the combined lifestyle risks of smoking and obesity together in this population."

The monitor incorporates data from all aspects of the clinic's multidisciplinary practice, which includes a registered nurse, a dietitian and a recreation therapist.

Registered nurse Elizabeth Budd explains that while the clinic focuses on metabolic issues, it looks at all contributing factors. "We evaluate mental health care, but with an integrated, holistic approach," says Budd. "We evaluate risks that clients are exposed to, not necessarily as a result of medication, but because of their illness, medication, lifestyle and social environment."

The Mental Health and Metabolism Clinic addresses the complex health needs of people with mental illness. l-r: Recreation therapist Natasha Bakiewicz, psychiatrist Dr. Tony Cohn and registered nurse Elizabeth Budd.

Clinic dietitian Ruth Hsueh explains that in terms of managing weight loss, clients with mental illness face the same challenges as the general population, but often face more barriers. "The illness itself can make it very hard for people to get motivated, and motivation is everything," she says. "Medications can make them more tired, so managing weight is harder than for the rest of the population. They need more support."

The structured clinical assessment includes food frequency questionnaires and physical activity scales. That lifestyle information becomes part of the client's metabolic assessment record, accessible to team members. The information is then sent back to the referring doctor, along with recommendations, which may include reviewing medications or switching to a medication less likely to cause weight gain, as well as recommendations concerning diet, activity and smoking.

Cohn began working in the area of metabolic issues in people with serious mental illness more than 10 years ago. He soon realized that further expertise in nutritional science would be an asset, so he returned to school to do a master's degree in that area.

Combining expertise in metabolism with psychiatry is still not common, but Cohn views it as emerging specialty. "Often the dilemma is that people need the medication to maintain good mental health and to treat psychosis, but the medication can also cause side-effects related to weight gain and diabetes," he says, noting that on some commonly used antipsychotics, 90 per cent of clients gain more than 10 per cent of their body weight.

"Ironically, our best medications have the most problems metabolically," says Cohn. "We can switch people to other medications, but we may then run the risk of people decompensating from a mental health perspective and becoming more psychotic. This is probably the biggest dilemma when you have to weigh issues around mental stability versus physical health."

The clinic already has more than 2,000 patients in its Metabolic Health Monitor, and gets as many as 18 new referrals per week. But Cohn recognizes the potential to expand the tool beyond the clinic. "Such a system could be bigger, province-wide," he says. "This way you can monitor a population and identify and track the really high-risk people and also do preventive work."

This vision is becoming a reality as the clinic plans to extend its workshops and webinars for clinicians beyond Toronto and pilot the training with rural and remote communities via the Ontario Telemedicine Network. Health care professionals are enthusiastic, but the clinic's most important responses come from its clients: "We get very good feedback from patients and families," says Cohn.

B.C. metabolic mental health program is kids' stuff

The link between antipsychotic medications and metabolic side-effects is well known. So it wasn't surprising when a British Columbia psychiatric unit identified high rates of insulin resistance—a precursor to diabetes—in patients on these medications.

Except the patients were in a pediatric unit—the average age was 12.

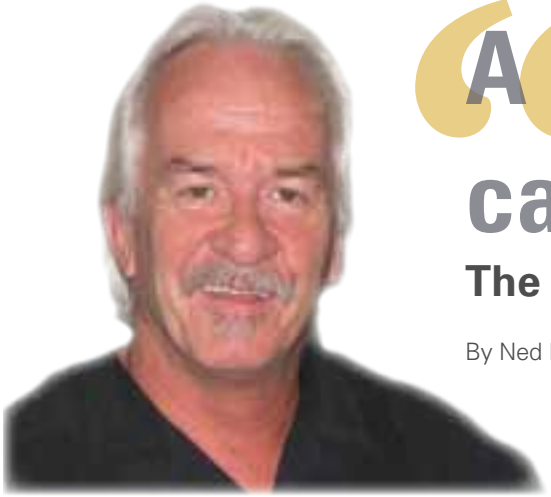
"This is alarming," says psychiatrist Dr. Jana Davidson, founder of the Provincial Mental Health Metabolic Program at B.C. Children's Hospital, a clinic launched in April that specializes in children and youth who have both mental illness and metabolic or endocrine problems. The clinic's mandate includes monitoring and mitigating metabolic side-effects of antipsychotic medications, as well as producing toolkits for families and professionals.

The program serves all of B.C. and was launched in response to research which found that metabolic problems—including metabolic syndrome, diabetes and hypertension—were distressingly high in children and youth on antipsychotic medication.

"These medications can be incredibly effective for treating early-onset mental health problems," says Davidson, adding that antipsychotics often make it possible for children to remain in school and with their families and friends. However, the long-term impact of the metabolic side-effects in pediatric patients is not known.

The clinic treats patients with mental illness who are experiencing metabolic or endocrine disturbances, as well as endocrinology and metabolic patients who develop mental illness.

"These medications can be very helpful, but we also know they have side-effects and consequences to watch out for," Davidson says. "We hope to make a significant impact in B.C. minimizing those adverse effects."



A ghost from my past came back to bite me

The shame of hepatitis C, 15 years into recovery

By Ned Morgan

In 2008, Don Crocock was in his fifteenth year of recovery from cocaine and alcohol addiction. Five years earlier, his success had earned him a Courage to Come Back Award from the Centre for Addiction and Mental Health. He had recently transitioned into a second career as an addiction worker in Ontario's Niagara region. All signs pointed to a bright future that placed Crocock's past firmly behind him. But that autumn, he began feeling symptoms of chronic fatigue. After his family doctor ran some blood tests, he was called back to the office. As soon as Crocock sat down, his doctor said, "You've got hepatitis C."

The news hit Crocock hard. "You could've knocked me over with a feather," he recalls. "It was the last thing I expected—that a ghost from my past would come back to bite me." Crocock suspects he contracted the hepatitis C virus (HCV) in the mid-eighties, when he experimented with injection drug use. "IV use was something I tried less than 10 times," he says. "That's significant—it emphasizes the fact that it only has to be once."

Hepatitis C and injection drug use resources

CATIE's Hepatitis C website – Knowing Helps
www.hepcinfo.ca

Hepatitis C Advocacy Network
www.hepcnetwork.org

Hepatitis C Support Group/HCV Advocate
www.hcvadvocate.org

Hepatitis C University
www.hcvu.org

National CIHR Research Training Program in Hepatitis C
www.ncrtp-hepc.ca

Resources for Hepatitis C and Injection Drug Use: A Needs Assessment
www.phac-aspc.gc.ca

HCV, spread by blood-to-blood-contact, can lead to chronic liver disease, including cirrhosis and liver cancer. According to the Public Health Agency of Canada, about 243,000 Canadians are infected with HCV, which can be asymptomatic for many years after infection. Health Canada reports that 70 to 80 per cent of HCV transmission is due to injection drug use. Added to the fact that it is a relatively newly discovered disease (it was isolated in 1989), HCV's association with injection drug use carries with it misperceptions that contribute to stigma.

According to HCV researcher Gail Butt, writing in a 2008 issue of the *Western Journal of Nursing Research*, the stigma of HCV "leads some people with the disease to experience disregard for personal well-being, shame, feelings of uncleanliness, lowered self-esteem, demoralization, social isolation, loss of income, decreased quality of life, and declines in health."

Crocock felt that burden. As he drove home from the doctor's office that day, a wave of panic hit him, accompanied by embarrassment. As he struggled with the new diagnosis, shame became a constant theme. His former addictions were suddenly front and centre again. "I worked so long and so hard to undo the damage from my past," says Crocock. "I advocated, I volunteered—and for what? It seemed like I just got blindsided."

The diagnosis did nothing to shake his recovery, but it did stir up his difficult past and feelings he thought he had overcome. "Not even in the wildest depths of my imagination would I ever think about picking up [substances] again," says Crocock. "But my past is my past. The HCV diagnosis brought out all these feelings—feeling dirty, feeling shameful."

His family's supportive reaction to the news eased the stigma burden, and his friends also rallied around him—with one exception. "I told one person, and a week later he called me, saying, 'Hey, should we go get tested? You stayed at our house 10 years ago.' I said, 'No. You'll be fine … maybe you should've Googled it.'"

As soon as Crocock entered treatment (an intensive 48-week bout that he completed this past spring), he broke the news to his manager at work, who proved exceptionally understanding. Initially, however, Crocock hid his condition from other co-workers at the withdrawal management service and men's recovery home where he works. "All I said was 'I'm going through a tough time, I'm getting treatment for something and it's not cancer, okay?' I just didn't want to talk about it." But Crocock did break the news when he returned

to work full-time with 28 weeks still remaining in his treatment. "When I came back to work, I was more comfortable in my own skin."

Crocock's interaction with his clients underwent a shift after he entered treatment. Some of the side-effects drew comments from clients about his hair and weight loss. After he allowed the news of his diagnosis to get out, however, therapeutic discussions with clients followed. "I have very open relationships with my clients," says Crocock. "And they're very caring. They're always asking how I'm doing. Now some of them are coming to me for more information and direction because some of them are HCV-positive."

Crocock is quick to add that his HCV status does not mean he is more qualified than other addiction professionals. "They don't have to have hepatitis—they just need to be sensitive to it," he says. "Some people in the addiction field don't know enough. I know I didn't. Somebody taking the initiative can do clients collectively a world of good by increasing the knowledge of addiction workers dealing with people with HCV." (Crocock is careful to add that his knowledge of the matter is "anecdotal" and that he has "no proof that we are underserving this clientele.)

According to Crocock, this lack of knowledge is compounded because HCV gets little media attention. One reason for this, he says, may be that it is never listed as a cause of death. (It's often listed instead as liver failure, liver cancer or cirrhosis.) Another reason is that HCV is not a "sexy issue," says Crocock. "It's a dirty, backroom issue. It's up to us in the field to address this stigma. Withdrawal management workers, front-line staff in intensive treatment and in recovery homes can do more internal training; we can provide information and dedicate energy."

Crocock sees his story as emblematic of more than one person's struggle with hepatitis. "This isn't just about me anymore," he says. "I learned a long time ago that you can get all puffed up and yell and scream and you're not going to get anywhere. With maturity comes a refocusing on a means to an end. I achieve this by using myself as an example."

Don Crocock can offer peer support for addiction workers living with hepatitis C. He can be reached at dcrocock@cogeco.ca

Creating a safe space for clients with hepatitis C

Stigma and Hepatitis C: A Fact Sheet for Health Care Providers, published by the B.C. Centre for Disease Control, provides these tips, identified by people with HCV, for establishing a safe environment:

- Use standard infection control precautions with everyone so no one will feel pressured to disclose their status to protect others.
- Avoid questions about how HCV was acquired so people won't fear being treated badly because of associations with drug use.
- Follow policies of confidentiality.
- Acknowledge active drug users' expectations about problems obtaining pain relief to open communication about appropriate dosing.
- Establish a trust relationship by using precise, non-judgmental language about substance use, such as "injecting" (rather than "intravenous") and "drug use" (instead of "drug abuse"), and by avoiding terms that may be offensive, misleading or discriminatory, such as "addict," "addiction" or "drug abuser."
- Consider information needs related to HCV as involving transmission risks, the social, psychological and physical effects of drug use and the effectiveness of and access to treatment.

Health-related consequences of alcohol

Globally, alcohol is estimated to account for almost 4% of deaths and 5% of disability-adjusted life years. Alcohol has been linked with more than 60 diseases and chronic conditions:

- cancers, e.g., esophagus, mouth, colon, liver, breast
- neuropsychiatric conditions, e.g., Wernicke-Korsakoff syndrome
- cardiovascular conditions, e.g., high blood pressure, heart disease, stroke
- diabetes
- gastrointestinal conditions, e.g., liver cirrhosis
- maternal and perinatal conditions, e.g., fetal alcohol syndrome
- acute toxic effects, e.g., alcohol poisoning

Source: Jurgen Rehm et al., "Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders," *Lancet,* 2009.

fit in and out

Community partnerships promote wellness through exercise

By Anne Ptasznik

Community partnerships challenge clients of Search Community Mental Health Services to "Search for Fitness."

Michael Aucoin, a community crisis worker, greets me warmly at Gerstein on Bloor, a short-term residence for people with mental illness involved in the justice system or who are homeless. Aucoin has invited me to meet the participants and a worker from the Fresh (Finding Recovery through Exercise, Skills and Hope) program. But first, he offers me a nutritious dinner of home-made lasagna, salad and corn bread, an important component of Fresh's wellness approach.

One participant, Violet*, has just started going to the gym. "I wish I could go every day because I see people around; it makes me feel comfortable, and it motivates me," she says. "It doesn't leave me depressed." Violet credits her comfort level to Fresh worker Cathy, who showed her how to lift weights properly without exacerbating a recent injury.

Exercise has been shown to help manage and even prevent chronic health conditions, particularly important for people with mental illness because they are at higher risk for conditions like diabetes and heart disease. A recent Cochrane review by University of Toronto researchers also showed that exercise may reduce depression and anxiety in people with schizophrenia.

But despite the known benefits, community agencies often lack the resources to develop programs for consumers, who frequently face social and financial barriers to physical activity. That need led to Minding Our Bodies, an initiative of the Canadian Mental Health Association (CMHA) – Ontario division, in partnership with the YMCA and the York University Faculty of Health. Funded by the Ministry of Health Promotion Communities in Action Fund, the two-year project culminated in the development of a toolkit to help community mental health organizations develop evidence-based, sustainable physical activity programs.

Gerstein and two other pilot sites, CMHA-Thunder Bay and the Haldimand-Norfolk Resource Centre, received financial support to develop and deliver a physical activity program. Search Community Mental Health Services, Community Resource Connections of Toronto and the Sunnybrook Health Sciences Centre inpatient psychiatry unit were also invited to test the toolkit and access the project's resources, but did not receive funding.

With the funds, Gerstein hired three Fresh peer workers for 10 hours per week to do group and one-one-one activities. A week-long training in first aid, crisis intervention and overall wellness was held in space provided by the local YMCA, with which Gerstein has also negotiated a corporate membership that allows six people to use the facility at one time.

Fresh worker Cathy lets participants choose the activities, for example, hockey, basketball or even pool. "It could even be as simple as going to the mall or walking around the block or to the park," she says. "Trying to find a place to live and sort out your life is one big stress," she says. Going to the gym, she believes, helps to relieve that stress.

Henri, who has been both a Fresh participant and a peer worker, agrees: "Part of mental health is physical health," he says. For Henri, exercise is self-motivating, builds self-esteem and provides discipline. He moved on from the Fresh position to other employment and was accepted into college to become a community worker.

Such success isn't rare. "I can immediately think of three clients for whom the program has significantly changed their lives," says Aucoin. "For the first time in a long time people were physically healthy and that changed their outlook and created optimism. They're eating and sleeping better; they're not as isolated."

One challenge, however, is sustainability. Since the pilot project wrapped up, Gerstein has been picking up the cost for the Fresh worker, but will need to apply for funding to continue. Minding Our Bodies project manager Kendal Bradley says that when limited staffing is a problem, community agencies can bring in volunteers, apply for grants and develop partnerships.

Search Community Mental Health

Services in Strathroy is one example of such a partnership. Activity team leader Paul Lattimer says that as an unfunded site, the agency created its Search for Fitness program within its existing budget. The program involved two groups of about 10 participants, who joined a fitness program that included group activities like aerobics (for which Middlesex Community Living provided staff) and individual activities, including Wii Active. Lattimer also negotiated a bulk membership from the local YMCA and free use of the outdoor town pool from the local recreation department. Being in a rural area with few amenities close by, the program recruited volunteer drivers to take people to London for aqua fit classes.

Lattimer received a $500 grant from an online printing company to subsidize incentives. Program participants received free running shoes for joining and then various other incentives like t-shirts and duffle bags as they reached various targets of participation.

Even though staff time was diverted from other programming, Lattimer considers the pilot a huge success. "People definitely got more fit and physically active," he says. "It also gets people socially active, from which friendships develop."

But there have been challenges. Lattimer says that some women were hoping to lose more weight. While the local diabetes education centre provided a nutritional class twice a month, participants were not given a strict diet to follow. Lattimer says it would have been difficult to monitor people's eating at home, and due to lower incomes, their diets tended toward cheaper, processed foods.

This challenge prompted many groups to request more support with nutrition. The next project, Minding Our Bodies Eating Well for Mental Health, will help mental health agencies deliver healthy eating and food security programs. The project team is also launching a set of tools that organizations can use to evaluate the mental and physical health benefits of physical activity. "Many of the benefits coming out of these types of programs aren't just about physical activity and physical health," says Bradley. "It's also about mental and social health."

For more information about Minding Our Bodies, visit www.mindingourbodies.ca

*All Fresh participant and worker names have been changed.

Social inclusion and physical activity

The Canadian Parks and Recreation Association, along with other national, provincial and territorial associations, has developed a national policy on affordable access to recreation.

In Ontario, Howie Drayton, chair of the Task Group on Access to Recreation for Low-Income Families, has seen the difference that involvement in recreational activities makes for people with mental illness. Currently director of recreation for the Town of Ajax, Drayton was at one time in charge of the Region of York's domiciliary hostels, which mostly provided housing for people with schizophrenia. "When I toured these buildings I was astounded at the way people were being warehoused and sitting around the television all day," he says. He developed a program in which home operators who took residents to the library, pool or a movie, or who facilitated other recreational or social activities were eligible for extra funding. About 80% of operators took up the opportunity, and incidence reports of mental health crises and violence decreased.

Drayton says the task group's policy framework, Affordable Access to Recreation for Ontarians, is the first time the recreation sector has developed a policy approach to user fees and used research to make the case for investing in recreation as a social and community service. The task group recognized that eliminating all user fees was not possible because the capital and operational costs would put an enormous burden on the tax base. Rather, the group advocates that communities identify a core set of recreation programs that will be universally available for free and subsidized access for other programs for people who cannot afford user fees. The importance of corporate support such as Canadian Tire's Jumpstart, which provides affordable recreation in local communities, was also recognized.

For more information, visit www.prontario.org. In the Public Policy section, select "Affordable Access to Recreation."

Want to know how one psychiatric inpatient unit is using Wii to overcome barriers to exercise virtually?

Access this story at **www.camhcrosscurrents.net** to find out.

Mending HEARTS

Are we failing cardiac patients with depression?

By Avril Roberts

It wasn't until his participation in a study about cardiac patients and depression ended that Warren Moquin discovered that he had been depressed for some time, possibly dating back years before his series of heart attacks. "The changes were subtle enough that I did not recognize it," says Moquin. "I just thought it was a natural part of aging."

On the advice of the researchers, Moquin sought help—seeing a psychiatrist and taking antidepressant medication—albeit reluctantly. "This idea that you're crazy—nobody wants to admit to that," says Moquin. But it was during the study that Moquin had begun to make a connection between his inner rage and previous episodes of chest constriction. "I realized that depression may have contributed to that," he recalls.

Looking back five years later, Moquin views the researchers' intervention as a lifesaver. "Without them identifying the problem and without their offer of help, I can't say how long I would have lasted. I might not be here today."

Mood problems such as depression and anxiety are surprisingly common in people with chronic health conditions. Canadian research has found that about 15 per cent of people hospitalized for cardiac problems experience major depression, which itself increases the risk of cardiac morbidity and mortality. Another 15 to 20 per cent have depressive symptoms. Research also shows that depression may actually increase the risk of heart disease in physically healthy people, particularly women.

Yet despite mounting evidence of a link between depression and heart disease, depression remains underdiagnosed in cardiac patients and is not effectively treated —if at all.

Researchers and clinicians cite various reasons for this oversight. It can be difficult to diagnose depression with co-morbid conditions, says Dr. François Lespérance, professor of psychiatry in the Faculty of Medicine at the University of Montreal. "Sleep problems and fatigue could be due to heart disease, and concentration difficulties may be due to vascular disease of the brain," says Lespérance. "There could be several factors that blur the identification of symptoms and attribute them to the physical condition rather than depression."

People may not seek help for depressive symptoms that they mistakenly attribute to heart disease. Some may be reluctant to take medication for depression in addition to their heart medications. Others lack access to proper professional care. "Patients with heart disease are seen by cardiologists or family doctors," says Lespérance. "Access to psychiatrists who can advise patients or physicians to prescribe antidepressants may not be readily available."

The obvious answer seems to be routine screening for depression. The American Heart Association issued a scientific advisory in 2008, recommending routine screening for depression in cardiac patients. General practitioners in the United Kingdom are required to screen heart disease (and diabetes) patients for depression. However, there is no similar requirement or call for screening in Canada.

"Based on international guidelines, we do recommend that cardiac patients be screened," says Dr. Brian Baker, a spokesperson for the Heart and Stroke Foundation (HSF), but he acknowledges that the HSF has not issued a position statement about this. In fact, in the larger cardiology and psychiatric communities, the issue of screening generates much debate.

Baker, a psychiatrist whose practice focuses on people with cardiovascular disorders, says the complexity of treatment for depression in heart disease is a major problem. The older tricyclic antidepressants can be toxic to the heart. Two selective serotonin reuptake inhibitors (SSRIs)—sertraline (Zoloft) and citalopram (Celexa)—have been tested in cardiac patients and proven safe and effective, mainly for people with previous or recurrent moderate to severe depression. They seem to be less effective for first-time depression in people with heart disease and for people with mild to moderate depression.

As for psychotherapy, Baker cites a major study of cognitive-behavioural therapy with cardiac patients, which found that although there was some improvement in mood, CBT didn't make any difference to survival.

For Dr. Brett Thombs, assistant professor of psychiatry at the Faculty of Medicine at McGill University, the problem with routine screening is basic. "It's a question of evidence. There has never been a randomized controlled trial to establish whether or not there is a benefit," he says. "As with any other intervention, we need a large, pragmatic, randomized controlled trial to show that the group that is screened has better mental health outcomes than the group that isn't screened. Then we need to assess how big the benefits are compared to how much it will cost and what would be the potential harms to patients."

Thombs suggests that cardiac patients with depression would be better served by good clinical interviewing and good clinical care from well-trained front-line health care providers. "Speaking with patients about how well they are doing and difficulties they are having with the things they need to do to take care of their disease will lead the conversation to depression where it is appropriate," he says. Thombs also sees a need to educate patients "so they know what depression is, how to recognize it and destigmatize it."

Lespérance echoes some of Baker's and Thombs' concerns: "You don't screen if you don't have the resources to properly evaluate patients and treat them," he says. Lespérance favours an interdisciplinary care approach that addresses depression in the broader context of cardiovascular risk management, such as medication compliance and proper exercise and nutrition. "Screening for depression in cardiac patients could be perceived negatively, but if you include the management of emotion, including anxiety and depression, in a more comprehensive cardiac rehabilitation program, then patients will see themselves as being treated more globally."

Fast facts about sad hearts

- Unmanaged stress can lead to high blood pressure, arterial damage, irregular heart rhythms, faster blood clotting and weaker immune systems.
- During recovery from cardiac surgery, depression can intensify pain, worsen fatigue and sluggishness, or cause a person to withdraw into social isolation.
- Patients with heart failure and depression have an increased risk of being readmitted to hospital.
- Patients with heart disease and depression have worse medication adherence than patients with heart disease who do not have depression.
- Negative lifestyle habits associated with depression—e.g., smoking, lack of social support—interfere with treatment for heart disease.

Source: Cleveland Clinic

Self-management: Getting to the heart of the matter

In chronic illness, day-to-day care responsibilities fall most heavily on patients and their families. Guided or supported self-management is a promising approach to care that partners patients with their health care providers.

Dr. Dan Bilsker, a psychologist and consultant with the Centre for Applied Research in Mental Health and Addiction in Vancouver, British Columbia, is a strong proponent of supported self-management. Co-author of the self-care workbook *Positive Coping with Health Conditions*, Bilsker trains family physicians to deliver supported self-management to adult patients with mild to moderate depression and chronic physical illness. "Research shows that if you give someone a self-management tool, it can be meaningful, but if you add support, you double the impact," says Bilsker. Self-management is also affordable and easy to disseminate, and it is an effective use of existing networks of community and medical support.

The Bounce Back: Reclaim Your Health program, led by the Canadian Mental Health Association–B.C. division (CMHA-BC), showcases British Columbia as one of the first jurisdictions in the world to take an integrated approach to addressing chronic health conditions that are accompanied by mental health issues, using a self-management approach.

Targeting people with mild to moderate depression and chronic illness, Bounce Back provides psychoeducation and guided self-help through two interventions: a DVD provides practical tips on managing mood, healthy living, building confidence and problem solving; patients also have access to one-on-one telephone coaching by community-based coaches trained and supervised by psychologists. The coaches guide participants through a workbook based on cognitive-behavioural therapy.

"Many people who are depressed do not feel very motivated or organized," says Lynn Spence, associate executive director and director of provincial programs at CMHA-BC. "Coaching helps people identify what might be getting in the way of making changes and supports them to develop plans to introduce new behaviours into their lives to better manage their mood."

Access to the program is via physicians' offices throughout B.C. Other health care professionals such as nurse practitioners and mental health clinicians can make referrals, but they must be endorsed by a family doctor. Spence says it makes sense to place the family doctor at the heart of the service delivery system because "the first place people go with issues of depression is primary care." It also serves as a safeguard in case a person needs more help with depression than Bounce Back can provide in the typical three to five sessions over four to eight weeks.

Since Bounce Back launched two years ago, 38,000 DVDs have been distributed to physicians' offices, and there have been more than 7,000 referrals. Feedback has been positive: "The more tools we have, the better we can respond," said one doctor. "It is very difficult for patients to get mental health services, so Bounce Back is a critical option."

For more information about Bounce Back, visit www.cmha.bc.ca/bounceback

Psychiatric hospitals as obesogenic environments

By Lesley Young

In 2009, the World Council Research Fund released a report suggesting that hospitals and other public health institutions play a leading role in modeling healthy dietary behavioural change. Yet hospitals may provide conditions that are not conducive to good physical health. Dr. Guy Faulkner is an associate professor in the Faculty of Physical Education and Health at the University of Toronto. He is the lead author of a landmark study published in *Psychiatric Services* in April 2009, which examined environmental factors that may contribute to obesity in one Canadian psychiatric hospital. *CrossCurrents* interviewed him about obesogenic environments and how psychiatric hospitals can promote good physical health in a population already at risk for many chronic conditions.

What is an obesogenic environment?

An obesogenic or obesity-promoting environment is a setting that by its nature restricts physical activity and encourages excessive food consumption. According to Boyd Swinburn, director of the World Health Organization Collaborating Centre for Obesity Prevention, an obesogenic environment is "the sum of the influences that the surroundings, opportunities or conditions of life have on promoting obesity in individuals or populations."

Are psychiatric hospitals obesogenic?

The environments in which psychiatric services are provided are probably not the primary factor contributing to obesity in this population, but they may make a bad problem worse. In our study, we found factors in the inpatient setting that led toward increased calorie consumption, such as overeating from easy access to high-calorie snacks and beverages, and skipping breakfast (known to increase snacking later). We also found reduced energy expenditure, such as not having access to stairs or exercise facilities. These factors play an important role, over and above medication side-effects, in the increasing rates of obesity.

Does addressing environmental factors reduce individual accountability for obesity?

We can't overlook individual responsibility in any setting. The psychiatric environment is one micro-setting in the larger society we live in, and both are obesogenic. We need to tackle obesity from an individual as well as an environmental angle. It is more challenging for people with mental illness to cope with obesity because they may have cognitive issues that interfere with the ability to make healthy choices. We need to look at how to make the setting as healthy as possible so that people are more likely to make healthy choices. Doing so doesn't just impact the patient; it impacts the staff positively as well.

What are common obesogenic elements in psychiatric hospitals?

Our study identified many obesogenic factors, mostly related to food consumption—vending machines filled with poor food choices, lack of drinking water as an alternative to soda and buffet-style food delivery (which encourages excessive consumption). These elements are likely to exist at most inpatient facilities. And while these problems could be overcome, mental health settings face particular challenges, such as respecting patient autonomy, for example, when it comes to making sure patients eat breakfast, which has been shown to help reduce obesity risk. Staff in our study said they were reluctant to force patients to get up in the morning to eat. In terms of lack of physical activity, one factor was that stairways were closed for safety reasons, so patients were forced to take elevators.

How can psychiatric hospitals reduce obesogenic factors and promote good physical health?

Reducing obesogenic elements requires creative thinking. For example, the hospital in our study is starting a stair-climbing intervention, where patients are encouraged and reminded through posted signs to use the staircases that are accessible. In terms of food, tray services can replace buffet-style meals. The hospital in our study made this change, with participants losing an average of six pounds over six months. One of the biggest challenges for patients identified in the study involved economic considerations. We know from the general population that if you have less money, you are less likely to buy healthy food because it often costs more. So the question is: how can we make subsidized fruit and vegetables (and even physical activity options) accessible to psychiatric inpatients?

Do psychiatric inpatients think their environment is physically unhealthy?

In a follow-up study to this one, we asked patients for their perspective on obesogenic elements. The findings are not yet published, but I can say that patients were receptive to healthier changes, such as reducing the volume of food (which currently makes it hard to control cravings). They also welcome interpersonal interventions that encourage them to be more healthful through an individualized approach.

What is the key to creating a physically healthy environment in psychiatric hospitals?

Collaboration. All solutions need to be developed in partnership with staff and through patient and advocacy groups. That being said, change needs to follow a top-down approach—it needs to be supported at the senior management level—that looks at what is in this particular setting that may cause people to overeat or be physically inactive. It's important to remember that there is no magic solution for obesity. We need to look broadly and systemically.

What is your workplace doing to improve the physical health of clients and inpatients?

Visit our discussion forum at **www.camhcrosscurrents.net** and tell us.

Prohibition scrapbook weaves a colourful morality tale

When *The Rumrunners: A Prohibition Scrapbook* was first published in 1980, it was a surprise bestseller, selling more than 40,000 copies. It is easy to see why: the topic is colourful and the book stylish, with a treasure-trove of photos and anecdotes.

But *Rumrunners* is more than just a coffee table book. It is also a morality tale about the folly and unintended consequences of prohibition. The story is all too familiar. A country imposes prohibition, and it is the border towns that both prosper and suffer. In this case, the two towns were Windsor, Ont., and Detroit, Mich., separated only by a river. For 10 rollicking years, enterprising Canadians smuggled liquor out of Windsor into Detroit. They packed liquor in speedboats, in jalopies they then drove over the ice, in planes and trains, in hearses and submarines. They packed liquor in their underwear, in baskets of eggs and inside "booze bricks." They were ingenious, brazen and successful, and thanks to their efforts, Windsor and its environs have the dubious distinction of having supplied four-fifths of all the bootleg liquor that entered America during the Prohibition era.

The great enabler in this story was the Canadian government. Until Prime Minister Mackenzie King put an end to exports of alcohol in 1930, Ottawa was collecting upwards of $28 million a year off the trade. Small wonder that officials did little to stop it, or that so many of them took their cut in the form of bribes and cases of liquor and beer.

Gervais calls his book a "scrapbook" because it is put together from a wide range of sources—interviews, newspaper articles, recordings and, above all, photos. As fun as the photos are, it is the book's forays into oral history that stand out. Some of Gervais's informants insisted on anonymity, still fearful that their criminal pasts might catch up with them. Others, however, seemed glad of the notoriety. Milton "Whitey" Benoit was one of these, agreeing to be interviewed in his two-room flat in Windsor. Another, Blaise Diesbourg, struck a particularly jaunty pose when photographed, and rattled on about the day he met Al Capone. Charles Johnson, who was a constable at the time, also talked excitedly about Capone. He "seemed like a very nice fellow, very gentlemanlike."

Perhaps the most remarkable part of the story is how little violence there was. Most of the murders and massacres Gervais describes took place on the American side of the border, and as brutal as these were, they had little of the sadism one finds among today's drug cartels. There was no one quite in a league with "El Teo" (his trademark is to boil rivals in barrels of lye). Or with Beltrán Leyva (his trademark—until he was gunned down—was to decapitate his victims after torturing them).

Gervais has a good eye for colourful detail, but this same talent often stands in the way of properly weighing the facts. To read his description of the temperance movement is to come away with the impression that Carry Nation's was the face of the U.S. temperance movement and that H.L. Mencken's characterization of it was essentially correct. The reality was that the movement had more than its share of Yale graduates, and that fanatics like Carry Nation were an embarrassment to its middle-class base. And Gervais is simply wrong when he says that the movement has been neglected by historians. On the contrary. There are, if anything, far too many studies on the subject, and each year brings still more.

But few of these are quite so entertaining as Gervais's. If you are looking for a good escape or simply for a glimpse into Canada's wild past, look no further.

The Rumrunners: A Prohibition Scrapbook. Marty Gervais. Biblioasis, Emeryville, Ontario, 2009, 175 pp., $22.95 paper.

Jessica Warner teaches with the Institute for the History and Philosophy of Science and Technology at the University of Toronto.

books in brief

Black Dogs and Blue Words: Depression and Gender in the Age of Self-Care
Kimberly K. Emmons. Rutgers University Press, Piscataway, New Jersey, 2010.

Black Dogs and Blue Words examines how women with depression are identified, constrained and constructed by physicians, drug companies, the media and women's own discourses.

The Evolution of Childhood: Relationships, Emotion, Mind
Melvin Konner. Harvard University Press, Cambridge, Massachusetts, 2010.

Anthropologist and physician Melvin Konner tells the complex story of how universal characteristics of our growth from infancy to adolescence became rooted in genetically inherited characteristics of the human brain.

Hysterical Men: The Hidden History of Male Nervous Illness
Mark S. Micale. Harvard University Press, Cambridge, Massachusetts, 2008.

Western masculinity has established itself as the voice of reason, knowledge and sanity in the face of testimony to the contrary. *Hysterical Men* challenges this vision of the stable, secure male by examining the central role played by modern science and medicine in constructing and sustaining it.

Where is the recovery in chronic disease management?

Raymond Cheng

The power of language in health care is an understated one. For those of us who pass our days as stakeholders, whether on the front lines, during policy discussions or in meeting rooms, jargon is the lifeblood of rhetorical discourse. But do we ever consider its effect on those people who use services and programs?

Take the term "chronic disease management", for example, for a little deconstructing. I think I know what this means from my perch as a policy wonk. On the surface, it has to do with presenting a model of care that involves teamwork among professionals in a clinical or community setting to help service users cope with a health issue. Ideally, it would help stabilize or improve their quality of life. Sounds great, right?

But to most people, "chronic disease management" sounds as unpalatable as that cough mixture that boasts in commercials about how awful it tastes. "Chronic" connotes "a problem you'll have until you die." "Disease" means "you're ill and will always be." "Management" states in no uncertain terms that "someone else is going to do it for you; please lie back and enjoy the show." Do these three words reflect the values and ethical expectations of our health care system?

Personally, I think these words are empowering only to cloak the medical model when it comes to asserting for a share of health care dollars. "Chronic disease management" may unwittingly entrench the power of spending money on illness. Omitted by implication are the values of promoting wellness and self-care. There appears to be little room for a dialogue that considers whether pre-empting the conditions to which the individual's health is susceptible (e.g., the social determinants of health—good food, proper housing, social supports) is a direct causal factor in turning on the switch on the disease and setting off the need to partake of chronic disease management. Most importantly, in such a setting, one feels very much alone in combating the health problem without the overt presence of peers to confide in or with whom to share first-hand experiences and insights about making healthier choices.

In the case of mental illness and addiction, the concept of chronic disease management is particularly complex. Coming as I do from a consumer/survivor perspective, I bridle at the idea that individuals with a mental health diagnosis have a chronic disease that needs to be managed.

Certainly, as part of a recovery-based focus on living with mental health or addiction problems, it is necessary to take care of one's physical health. Diabetes, obesity and other issues that reduce life expectancy are an unfortunate reality for people with mental illness and addiction. Proactive monitoring and proper care are indisputably good strategies to help people work towards their life goals.

However, as someone who has seen recovery in action from all walks of life, as someone who has seen it take many forms, across different time spans, with different languages, cultures and racialized populations, I like to think that I am more open-minded than most about the ebb and flow of the mental health diagnosis in each individual. Focusing on the chronic disease model of care and committing to funding the "sick" without an exit strategy, and more importantly, not asking individuals what they want, may not be the optimal way to go.

When it comes to mental health, taking preventative measures to reduce symptoms, time in emergency rooms and hospitalizations is a sound and practical approach to maintaining wellness. WRAP (Wellness Recovery Action Plan), Pathways to Recovery and PACE (Personal Assistance in Community Existence) are programs being taught to individual consumer/survivors.

But it is within the dynamics of a group or a one-to-one relationship that personal self-initiative, teamwork and cost-effectiveness come together as a proven best practice—that of peer support.

Peer support has the rich potential to complement and be integrated into the chronic disease model. The idea of the sole courageous mental health consumer working in isolation outside of formal care to overcome a label through self-discovery is an earnest vision that is best aligned with group activities that build on collective strengths—experiential knowledge, problem solving and non-judgmental feedback in a safe and confidential environment, where hugs are valued over OHIP cards (Ontario's government-run health plan).

The Ontario Peer Development Initiative, a provincial umbrella of more than 60 consumer/survivor initiatives, peer support groups, patient councils and alternative businesses, has been funded by the Ontario Trillium Foundation to create the Peer Support Core Essentials Training program—created by peers, for peers. This project has distilled the very best wisdom of almost two decades into a manual that will create certified trainers. The same potential lies untapped for people with substance use issues as well.

Now, more than ever, is the right time for practitioners of the chronic disease model to work with practitioners of the recovery and peer support model. As someone with lived experience, away from my desk and computer keyboard, I only wish for the best sustained quality of life. It can best come from a mutual collaboration and respect for both models.

"Be well" is a wise greeting that a colleague of mine appends to her e-mails as a salutation. I hope that one day the mental health and addictions system integrates this message into its way of doing business.

Raymond Cheng is an advocacy and policy co-ordinator at the Ontario Peer Development Initiative.

Would you like to have your say in this debate?

Share your thoughts on our Last Word blog at www.camhcrosscurrents.net

CANADA

Health and Wellbeing in Children, Youth and Adults with Developmental Disabilities Conference
September 29–October 1
Vancouver, British Columbia
Contact: UBC Interprofessional Continuing Education, 2194 Health Sciences Mall, Rm. 105, Vancouver, BC V6T 1Z3
tel 604 822-7524
e-mail ipad@interchange.ubc.ca
www.interprofessional.ubc.ca/Developmental_Disabilities.html

Centre for Addiction and Mental Health Women's Mental Health Conference
October 1, Toronto, Ontario
Contact: Adrienne Amato, Centre for Addiction and Mental Health, 455 Spadina Ave., Ste. 300, Toronto, ON M5S 2S1
tel 416 535-8501, ext. 7600
e-mail adrienne_amato@camh.net

Creative Expression, Communication and Dementia 5th International Conference
October 1–2, Penticton, British Columbia
Contact: Society for the Arts in Dementia Care, 125 West 2nd St., Ste. 100, North Vancouver, BC V7M 1C5
tel 604 986-6408
e-mail Info@CECD-Society.org
www.cecd-society.org

Canadian Society of Addiction Medicine 2010 Annual Conference
October 19–23, Charlottetown, Prince Edward Island
Contact: CSAM, 47 Tuscany Ridge Terrace N.W., Calgary, AB T3L 3A5
tel 403 813-7217
fax 403 944-2056
e-mail admin@csam.org
www.csam.org

Thriving in 2010 and Beyond
October 22–24, London, Ontario
Contact: Thriving in 2010 and Beyond c/o Canadian Mental Health Association London-Middlesex Branch, 648 Huron St., London, ON N5Y 4J8
tel 519 434-9191
e-mail info@thrivingin2010.ca
www.thrivingin2010.ca

British Columbia Association of Social Workers Fall Conference
November 5–6, Vancouver, British Columbia
Contact: BCASW, 402 – 1755 West Broadway, Vancouver BC V6J 4S5
tel 604 730-9111
toll-free 1 800 665-4747
e-mail bcasw@bcasw.org
www.bcasw.org

2nd Conference on Positive Aging
November 26–27, Vancouver, British Columbia
Contact: UBC Interprofessional Continuing Education, 2194 Health Sciences Mall, Rm. 105, Vancouver, BC V6T 1Z3
tel 604 822-7524
e-mail ipad@interchange.ubc.ca
www.interprofessional.ubc.ca/Positive_Aging_2010.html

Canadian Association on Gerontology 39th Annual Meeting
December 2–4, Montreal, Quebec
Contact: CAG, 222 College St., Ste. 106, Toronto, ON M5T 3J1
tel 416 978-7977
fax 416 978-4771
e-mail contact@cagacg.ca
www.cagacg.ca/conferences/400_e.php

Society for Research on Nicotine and Tobacco Conference
February 16–21, 2011, Toronto, Ontario
Contact: SRNT, 2424 American Lane, Madison, WI 53704 USA
tel 608 443-2462, ext. 145
fax 608 443-2474
e-mail info@srnt.org
www.srnt.org/conferences/future/index.cfm

4th International Conference on Fetal Alcohol Spectrum Disorder
March 2–5, Vancouver, British Columbia
Contact: UBC Interprofessional Continuing Education, 2194 Health Sciences Mall, Rm. 105, Vancouver, BC V6T 1Z3
tel 604 822-0054
toll-free 877 328-7744
e-mail ipad@interchange.ubc.ca
www.interprofessional.ubc.ca/FASD.htm

UNITED STATES

American Psychiatric Nurses Association 24th Annual Conference
October 13–16, Louisville, Kentucky
Contact: APNA, 1555 Wilson Blvd., Ste. 530, Arlington, VA 22209
tel 703 243-2443
fax 703 243-3390
e-mail lnguyen@apna.org
www.apna.org

American Psychiatric Association 62nd Institute on Psychiatric Services
October 14–17, Boston, Massachusetts
Contact: APA, 1000 Wilson Blvd., Ste. 1825, Arlington, VA 22209-3901
tel 703 907-7300
e-mail: apa@psych.org
www.psych.org/ips

Association for the Treatment of Sexual Abusers 29th Annual Research and Treatment Conference
October 20–23, Phoenix, Arizona
Contact: ATSA, 4900 S.W. Griffith Dr., Ste. 274, Beaverton, OR 97005
tel 503 643-1023
fax 503 643-5084
e-mail atsa@atsa.com
www.atsa.com/conf.html

American Association for the Treatment of Opioid Dependence National Conference
October 23–27 Chicago, Illinois
Contact: 225 Varick St., 4th flr.
New York, NY 10014
tel 212 566-5555
fax 212 36604647
e-mail info@aatod.org
www.AATOD.org

American Academy of Child & Adolescent Psychiatry 57th Annual Meeting
October 26–31, New York, New York
Contact: AACAP, 3615 Wisconsin Ave., N.W., Washington, DC 20016-3007
tel 202 966-7300
fax 202 966-2891
e-mail ntejada@aacap.org
www.aacap.org/cs/AnnualMeeting/2010

International Nurses Society on Addictions National Educational Conference
October 27–30, Old Greenwich, Connecticut
Contact: International Nurses Society on Addictions, P.O. Box 14846, Lenexa, KS 66285-4846
e-mail intnsa@intnsa.org
www.intnsa.org/events.php

Addictions 2010: The New Frontier in Addiction Treatment – Evidence-Based Policy and Practice
October 28–31, Arlington, Virginia
e-mail a.hill@elsevier.com
www.addictions-conference.elsevier.com

National Federation of Families for Children's Mental Health 22nd Annual Conference
November 5–7, Atlanta, Georgia
Contact: National Federation of Families for Children's Mental Health, 9605 Medical Center Dr., Ste. 280, Rockville, MD 20850
tel 240/403-1901
fax 240 403-1909
e-mail ffcmh@ffcmh.org
www.ffcmh.org

6th World Conference on the Promotion of Mental Health and Prevention of Mental and Behavioral Disorders
November 17–19, Washington, DC
tel 617 618-2262
e-mail aoneill@edc.org
http://wmhconf2010.hhd.org

Association for Behavioral and Cognitive Therapies 44th Annual Convention
November 18–21, San Francisco, California
tel 212 647-1890
e-mail convention@abct.org
www.abct.org

21st American Academy of Addiction Psychiatry Meeting
December 2–5, Boca Raton, Florida
Contact: AAAP, 400 Massasoit Ave., Ste. 307, 2nd flr., East Providence, RI 02914
tel 401 524-3076
fax 401 272-0922
e-mail annualmeeting@aaap.org
www2.aaap.org/meetings-and-events/annual-meeting

15th Annual Society for Social Work and Research Conference
January 12–16, 2011, Tampa, Florida
Contact: SSWR, 11240 Waples Mill Rd., Ste. 200, Fairfax, VA 22030
tel 703 352-7797
fax 703 359-7562
e-mail info@sswr.org
www.sswr.org/conferences.php

American Group Psychotherapy Association Annual Meeting
February 28–March 5, New York, New York
Contact: AGPA, 25 East 21st St., 6th flr., New York, NY 10010
tel 212 477-2677
e-mail info@agpa.org
www.agpa.org/mtgs/

American Association for Geriatric Psychiatry 24th Annual Meeting
March 18–21, San Antonio, Texas
Contact: AAGP, 7910 Woodmont Ave., Ste. 1050, Bethesda, MD 20814-3004
tel 301 654-7850
e-mail meetinginfo@AAGPonline.org
www.aagpmeeting.org

ABROAD

4th International Conference of Schizophrenia
October 22–24, Chennai, India
Contact: Dr. Thara / Dr. R. Padmavati, Schizophrenia Research Foundation, #R/7A North Main Rd., Anna Nagar (West Extn.), Chennai 600 101 India
e-mail info@icons-scarf.org
www.icons-scarf.org

20th World Congress of Social Psychiatry
October 23–27, Marrakech, Morocco
e-mail masri@atlasvoyages.co.ma

2nd International Conference on Violence in the Health Sector
October 27–29, Amsterdam, The Netherlands
Contact: Oud Consultancy, Hakfort 621, 1102 LA Amsterdam, The Netherlands
e-mail conference.management@freeler.nl
www.oudconsultancy.nl

53rd International ICAA Conference on Dependencies
November 7–12, Cancun, Mexico
e-mail icaa2010@icaa.ch
www.icaa.ch/mexico2010.html

4th World Congress on Women's Mental Health
March 16–19, 2011, Madrid, Spain
Contact: TILESA OPC, Londres, 17, 28028, Madrid, Spain
tel 34 91 361 2600
e-mail info@iawmh2011.com
www.iawmh2011.com

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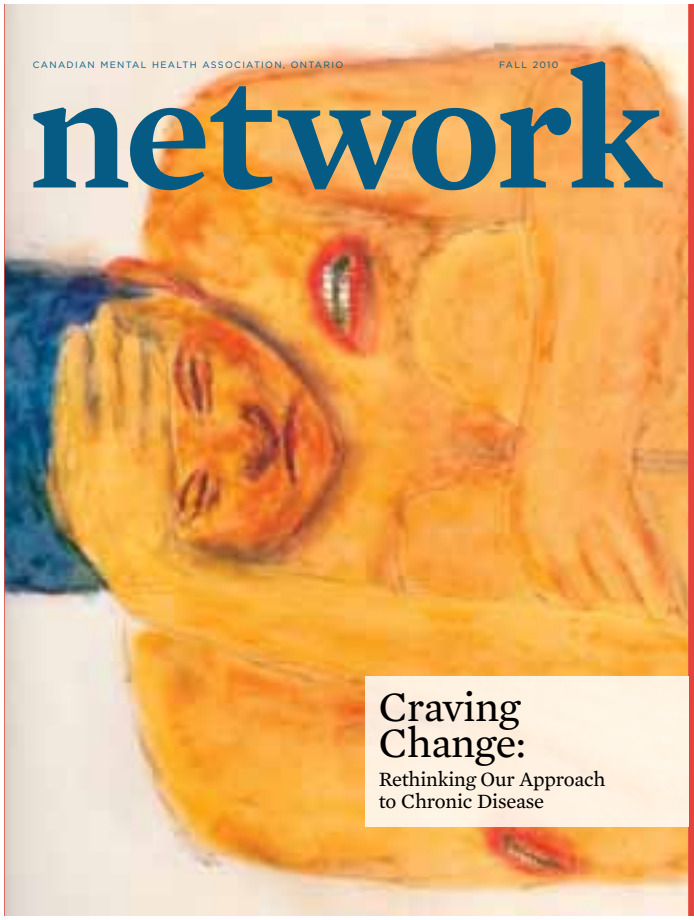

To read more about chronic disease and mental health, see CMHA Ontario's Network magazine Fall 2010 issue.

www.ontario.cmha.ca/network

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