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International: \$36.95 CDN (approx. \$25.00 US). Prices include shipping and handling, and all taxes.



33 Russell Street
Toronto, Ontario
Canada M5S 2S1

Publications Mail Agreement Number /
Envoi de publications – convention de vente n°
40005034



crosscurrents

AUTUMN 2005
VOL 9 NO 1

The Journal of Addiction and Mental Health

In Our Own Voices

ON DELUSIONS

One man's torment and euphoria

A SIBLING'S STORY

Brothers and sisters need support too

PSYCHO, PATIENT, PERSON

Perspectives on being labelled mentally ill

BEYOND THERAPEUTIC MODELS

Do therapists know what clients *really* want?

When caring hurts

Compassion fatigue strikes addiction workers

Triple whammy

Services needed for traumatic brain injury and concurrent disorders



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VOL 9 NO 1

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Snow Owl, Rai Wasilczyk, oil on canvas, 14” x 18”

Rai is a self-taught artist who took up oil painting as a hobby after leaving the Navy more than 27 years ago. His art is on display through the Being Scene exhibit at the Centre for Addiction and Mental Health in Toronto.



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

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or 416 595-6059 in Toronto

Issued four times a year.

Annual subscriptions are \$16.00 in Ontario (\$8.03 for Ontario students, seniors, patients, clients, consumers and family members), \$26.70 in Canada and \$36.95 in the U.S. and internationally (includes shipping and handling and taxes).

Published by the Education and Publishing Department
CENTRE FOR ADDICTION AND MENTAL HEALTH
A PAPHO/WHO Collaborating Centre
Affiliated with the University of Toronto

Autumn 2005
Vol. 9, No. 1
ISSN: 1481-3122

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#3170

CANADA

Canadian Association for Suicide Prevention Annual Conference: “Out of the Darkness – Shining the Light Toward a National Suicide Prevention Strategy”
October 16–19, Ottawa, Ontario
Contact: D.R. Dunlop & Associates, 128 Powell Ave., Ottawa, ON K1S 2A3
tel 613 235-8879
e-mail casp2005@drdunlopandassociates.com
www.suicideprevention.ca

52nd Joint Annual Meeting of the American Academy of Child and Adolescent Psychiatry / Canadian Academy of Child and Adolescent Psychiatry
October 18–23, Toronto, Ontario
Contact: AACAP, 3615 Wisconsin Ave., NW, Washington, D.C., 20016-3007 USA
tel 202 966-7300
e-mail meetings@aacap.org
www.aacap.org/meeting/annual/2005

Canadian Rural Health Research Society Conference: “Rural and Northern Health Research – Bridging the Distance”
October 27–29, Quebec City, Quebec
Contact: CRHRS Secretariat, 103 Hospital Dr., P.O. Box 120 R.U.H. Saskatoon, SK S7N 0W8
tel 306 966-7888
fax 306 966-8378
e-mail crhrs-scrsr.usask.ca
<http://crhrs-scrsr.usask.ca/quebec2005/info/>

5th Canadian HIV/AIDS Skills Building Symposium
October 27–30, Montreal, Quebec
Contact: The Skills Team, Canadian AIDS Society, 309 Cooper St., 4th flr., Ottawa, ON K2P 0G5
tel 613 230-3580
toll-free 877 998-9991
fax 613 563-4998
e-mail skills2005@cdnaids.ca
www.hivaid-skills.ca

26th Annual Canadian Group Psychotherapy Association Conference: “Building Bridges – Collaboration Coast-to-Coast”
November 2–5, Vancouver, British Columbia
toll-free 800 422 1382
www.cdngppsy.ch/eventnews.html

21st Annual Meeting of the International Society for Traumatic Stress Studies: “Dissemination – Transforming Lives Through Transforming Care”
November 2–5, Toronto, Ontario
Contact: ISTSS, 60 Revere Dr., Ste. 500, Northbrook, IL 60062 USA
tel 847 480-9028
fax 847 480-9282
e-mail istss@istss.org
www.istss.org/meetings/index.htm

55th Annual Meeting of the Canadian Psychiatric Association
November 3–6, Vancouver, British Columbia
Contact: CPA, 141 Laurier Ave. W., Ste. 701, Ottawa, ON K1P 5J3
tel 613 234-2815, ext. 242
fax 613 234-9857
e-mail conference@cpa-apc.org
www.cpa-apc.org

Women Healing Conference
November 4–5, Toronto, Ontario
Contact: Hazelden Foundation, P.O. Box 11, Center City, Minnesota 55012 USA
fax 651 213-4344
e-mail pbroat@hazelden.org
www.hazelden.org/womenhealing

46th Annual Meeting of the Psychonomic Society
November 10–13, Toronto, Ontario
Contact: The Psychonomic Society, 1710 Fortview Rd., Austin, Texas, 78704 USA
tel 512 462-2442
fax 512 462-1101
e-mail cinnamon@psychonomic.org
www.psychonomic.org/meet.htm

Canadian Centre on Substance Abuse National Conference: “Issues of Substance”
November 13–16, Toronto, Ontario
Contact: Enid Harrison, Canadian Centre on Substance Abuse, 75 Albert St., Ste. 300, Ottawa, ON K1P 5E7
tel 613 235-4048, ext. 237
fax 613 235-8101
e-mail eharrison@ccsa.ca
www.ccsa.ca/index.asp

Annual Convention of the American Counseling Association: “Culture-Centered and Diversity Counseling Empowers All Families”
March 30–April 3, 2006, Montreal, Quebec
Contact: ACA, 5999 Stevenson Ave., Alexandria, VA 22304-3302 USA
tel 703 823-6862
e-mail rhayes@counseling.org
www.counseling.org/AM/Template.cfm?Section=CONVENTION

UNITED STATES

24th Annual Conference of the Association for the Treatment of Sexual Abusers
November 2–5, New Orleans, Louisiana
Contact: ATSA, 4900 SW 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

International Drug Policy Reform Conference: “Building a Movement for Reason, Compassion and Justice”
November 10–12, Long Beach, California
Contact: Drug Policy Alliance, 70 West 36th St., 16th flr, New York, NY 10018
tel 212 613-8034
fax 212 613-8021
e-mail psantiago@drugpolicy.org
www.drugpolicy.org/events/dpa2005

American Academy of Nursing 32nd Annual Meeting and Conference: “Shaping Healthier Behaviors and Environments”
November 10–12, Scottsdale, Arizona
Contact: AAN – Registration, 555 East Wells St., Ste. 1100, Milwaukee, WI 53202
tel 414 287-0289
fax 414 276-3349
e-mail conferences@aanet.org
www.aanet.org

39th Annual Association for Advancement of Behavior Therapy Conference
November 17–20, Washington, DC
Contact: ABTC, 305 7th Ave., 16th fl., New York, NY 10001
tel 212 647-1890
fax 212 647-1865
e-mail mebrown@aabt.org
www.aabt.org

SouthEast Conference on Addictive Disorders 2005
November 30–December 1, Atlanta, Georgia
Contact: National Association of Addiction Treatment Providers, 313 W. Liberty St., Ste. 129, Lancaster, PA 17603-2748
tel 717 392-8480
fax 717 392-8481
e-mail rhunsicker@naatp.org
www.naatp.org/secad/index.php

16th Annual Meeting of the American Academy of Addiction Psychiatry
December 8–11, Scottsdale, Arizona
Contact: AAAP, 1010 Vermont Ave, NW, Suite 710, Washington, DC 20005
tel 202 393-4484
fax 202 393-4419
e-mail info@aaap.org
www.aaap.org/meetings/2005am/2005info.html

34th Annual Meeting of the International Neuropsychological Association
February 1–4, 2006, Boston, Massachusetts
Contact: INS, 700 Ackerman Rd., Ste. 625, Columbus, Ohio 43202
tel 614 263-4200
fax 614 263-4366
e-mail ins@osu.edu
www.the-ins.org/meetings/detail/index.cfm?id=17

Society of Behavioral Medicine Annual Meeting
March 22–25, San Francisco, California
Society of Behavioral Medicine, 15000 Commerce Parkway, Ste. C, Mt. Laurel, NJ 08054
tel 856 439-1297
fax 856 439-0525
e-mail info@sbm.org
www.sbm.org/annualmeeting/index.html

ABROAD

4th European Congress on Violence in Clinical Psychiatry
October 20–21, Vienna, Austria
Contact: Oud Consultancy & Conference Management, Hakfort 621, 1102 LA Amsterdam, The Netherlands
tel 31 20 409 0368
fax 31 20 409 0550
e-mail conference.management@freeler.nl
www.oudconsultancy.nl/violence/index.html

48th International Conference of the International Council on Alcohol and Addictions: “Science, Politics and the Practitioners”
October 23–28, Budapest, Hungary
Contact: ICAA Budapest Office, H-1111 Budapest, Karinty F. út 32
tel 36 70 452 0022
e-mail budapestoffice@icaa.hu
www.icaa.ch

9th International Symposium on Smoking Cessation
November 2–5, Rio de Janeiro, Brazil
Contact: C&M Conferences and Meetings, Rua Marques 3 sl. 101, Humaitá, Rio de Janeiro 22260-240 Brazil
tel 21 2539 1351
fax 21 2539 1214
www.cmeventos.com.br/index_eng.html

5th International Forum on Mood and Anxiety Disorders
November 9–11, Vienna, Austria
Contact: Organizing Secretariat, PubliCreations, 27, Bd d'Italie 98000 Monte-Carlo, Monaco
tel 377 9797 3555
fax 377 9797 3550
e-mail ifmad@publiccreations.com
www.aim-internationalgroup.com/2005/ifmad

International Society for the Prevention of Child Abuse and Neglect Asian Regional Conference
November 16–18, Singapore
Contact: Singapore Children' Society, Research & Outreach Department, Block 107 Yishun Ring Road, No 01-233, Singapore 760107
tel 65 6853 7382
fax 65 6853 7381
e-mail enquiries@ispcansingapore.com
www.ispcan.org/events.htm

European Federation of Neuropsychiatry Annual Congress
November 16–18, Munich, Germany
EFNP, 9a Magdala Rd, Nottingham, NG3 5DE UK
tel 44 115 969 2016
fax 44 115 969 2017
e-mail info@efnp.org
www.efnp.org

Society for the Study of Addiction Annual Symposium
November 17–18, York, United Kingdom
Contact: SSA, 4 Windsor Walk, London, SE5 8AF UK
tel 44 20 7848 0841
fax 44 20 7703 5787
e-mail membership@addiction-ssa.org
www-users.york.ac.uk/~sjp22/addiction/ssa_10.htm

14th European Congress of Psychiatry
March 4–8, 2006, Nice, France
Contact: AEP2006, 17 Rue du Cendrier, P.O. Box 1726, CH-1211 Geneva 1, Switzerland
tel 41 22 908 0488
fax 41 22 732 2850
e-mail aep2006@kenes.com
www.kenes.com/aep2006

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note from the editor

Patient/client-centred care has become an espoused rule for 21st-century health care. But this philosophy is sometimes honoured more in rhetoric than in practice. Patient/client-centred care is not simply providing care that the service provider thinks is good for the client. It means empowering the client and sharing power in the care relationship. According to the International Alliance of Patients' Organizations, patient/client-centred care encompasses cultural sensitivity, making services user-friendly, helping clients navigate the system, involving family members in care, being flexible with treatment options and empowering clients to be active participants in care. This issue of *CrossCurrents* presents the voices of clients, patients and consumers, as well as their family members, so that service providers can learn from their unique perspectives and ultimately build strong partnerships with clients.

The diversity of individual experiences of the mental health and addiction system is represented by an array of thought-provoking stories in this issue. Bob Ramsay and Howard Fluxgold each discuss the role

of social support – Ramsay from the perspective of an individual who struggled with addiction, and Fluxgold from the perspective of a family member. An anonymous story poignantly portrays the experience of a sibling – a family member whose experience is often overlooked when a brother or sister develops mental health or substance use issues.

Michael Armstrong eloquently describes the psychotic delusions he has experienced intermittently over the last three decades, and the impact they have had on him. I reflect on my brief experience in crisis care, based on the health records I accessed from my stay.

Patient/client-centred care means listening to what clients want, including respecting their perspectives on the language used to describe and address them. This issue includes a collage of three perspectives on terms like “consumer/survivor.” Next, Caroline Fei-Yeng Kwok draws from her personal experience to provide recommendations for culturally competent care. Kate Kitchen discusses research that examines what clients want from therapy. Finally, the Q&A column describes a client-driven



project that addresses the needs of people with severe mental health issues in terms of developing and maintaining intimate relationships.

Enjoy reading these diverse perspectives. We'd also like to hear from you. Let us know how we are doing. Or write a letter to the editor expressing your thoughts on our stories.

Hema Zbogar
tel 416 595-6714
hema_zbogar@camh.net

a view from CAMH

One hundred years ago, a young man named Clifford Beers decided to recount for public consumption his harrowing experience of both psychiatric illness and psychiatric treatment. His gripping book, *A Mind That Found Itself*, was published in 1908 and chronicled the descent into madness of a well-educated young man of social advantage. Beers described not only his symptoms and how they overtook his mood, thought and behaviour, but also the experience of hospitalization and treatment. He witnessed both compassion and inhumanity in his care through three institutions.

Beers sent his manuscript to Professor William James of Harvard University, one of the leading psychologists of his era. James wrote Beers a letter, stating, “It is the best written ‘case’ that I have seen; and you no doubt have put your finger on the weak spots of our treatment of the insane, and suggested the right line of remedy ... You were doubtless a pretty

intolerable character when the maniacal condition came on and you were bossing the universe ... but you were certainly wrongly treated nevertheless ... your report is full of instructiveness for doctors and attendants alike.”

Beers went on to found the National Committee for Mental Hygiene, dedicated to prevention and early detection of mental disorder, eradication of stigma, sensitization of physicians to the interplay of physical and mental health, and more. The committee's agenda appears as timely today as when the committee was founded in 1909.

There have been many other first-person accounts of illness and treatment before and since, from philosopher John Stuart Mill's description of his painful depression in 1826 to novelist William Styron's recent memoir of depression entitled *Darkness Visible*.

Pat Capponi's *Upstairs at the Crazy House* and Julia Nunes and Scott Simmie's *Beyond Crazy: Journeys through Mental Illness* reflect the views of both ordinary and celebrated Canadians who have experienced mental illness. These are important works for us as mental health and addiction professionals to read, even if they are uncomfortable for us at times in their descriptions of the experience of treatment.

Empathy is the foundation of the therapeutic alliance. Understanding the experiences, perspectives and perceptions of those people we try to help is an essential building block of empathy. This issue of *CrossCurrents* is dedicated to that goal.

Dr. David Goldbloom
SENIOR MEDICAL ADVISOR, EDUCATION AND PUBLIC AFFAIRS
CENTRE FOR ADDICTION AND MENTAL HEALTH
PROFESSOR OF PSYCHIATRY
UNIVERSITY OF TORONTO

Training partnership sets global health example

The mental health and addiction training experience of a Canadian-Chilean partnership between the Office of International Health (OIH) at the Centre for Addiction and Mental Health (CAMH) in Toronto and the Municipality of Puente Alto, Chile, is setting an example for both Chile and the world.

The backdrop for the collaboration is a process of health reform based on a family health care model that this southernmost country in South America urgently needs. Health care providers are faced with staggering challenges; Chile has one of the highest prevalence rates of mental health issues in primary care. The capital city, Santiago, has the highest global prevalence of serious psychiatric disorders among 15 international cities, at 52 per cent.

In 2002, Puente Alto began to implement the new model by focusing on mental health and substance use as important issues for

Training in progress in Puente Alto, Chile.



Akwatu Khenti

PROMOTING A WORLD VIEW OF MENTAL HEALTH AND ADDICTION

The Office of International Health (OIH) at the Centre for Addiction and Mental Health (CAMH) in Toronto has numerous projects under its belt. Here are two key initiatives:

MEXICO

Two years ago, work began on a project with the National Institute of Psychiatry in Mexico. It involved an exchange program between members of CAMH's Aboriginal Services and members of an indigenous community in Mexico, as well as health professionals serving the community. The project involves exchanging mental health knowledge and skills, as well as cultural traditions in the areas of addiction and mental health.

BRAZIL

Last year, CAMH partnered with Brazil to field-test a manual on youth, drugs and mental health in three very different areas of Brazil. "It will serve as a capacity-building program for treating young people with addiction and mental health issues. It's being tested for the whole of Brazil, which will make it an invaluable tool," says Akwatu Khenti, director of the OIH.

individuals, families and communities, as well as the health system. By 2004, a group of clinicians in the municipality decided to move forward to improve service organization, delivery and capacity-building to meet mental health and addiction needs. Forging a strong partnership between the Corporación Municipal de Educación, Salud y Atención a Menores de Puente Alto (Municipal Corporation of Puente Alto) and CAMH was an important step.

"CAMH's Office of International Health was committed to developing training," says Dr. Jaime Sapag, former municipal health co-ordinator and a family physician who was instrumental in the joint venture. "We decided to design a training program for the Chilean reality. Not only were mental health and addiction problems prevalent, but the infrastructure in place to deal with them was barely there."

That idea turned into a week-long program in July 2004 based on the training needs of about 40 primary care health professionals from six primary care centres in the municipality. "Not only were many mental health needs hugely under-met, but there were also many stigma issues for people with addiction and mental health problems," says Akwatu Khenti, director of the OIH. "The training was based on practical problems practitioners face in their everyday world and involved visits to their places of work to see what working conditions were like, so we wouldn't develop unrealistic solutions."

The power of the training lay in its impact on morale, as well as in the enhanced competencies that emerged. "Participants really appreciated the training – the humanistic orientation," says Dr. Consuelo Garcia-Andrade, a researcher from Mexico who is evaluating the program.

"I had always referred addiction clients to others because I didn't know how to work with them," says a psychologist who participated in the training. "Now I have learned protocols for working with addiction clients. I don't know how this could happen in five days, but it has. Perhaps it comes from the strong relationship between the Canadian team and the participants."

The training has also made significant headway in challenging stigma. "Training is needed for professionals outside the mental health and addiction field because they may work with people with addiction and mental health issues," says a nutritionist who attended the training. "I feel a positive change in my attitude that will affect how I work."

The training has been a catalyst for institutional action. A mental health co-ordinator for the region of Puente Alto was named and has begun to co-ordinate facilitators at the six regional health centres to study how mental health and addiction issues were dealt with. A mental health and addiction assessment for the region has also been completed. "We needed to know exactly what is happening at the population level," says Sapag. The federal ministry of health is interested in expanding the pilot across the country, and other countries have expressed interest in implementing a similar initiative. "The entire process was just very powerful," says Sapag.

AKWATU KHENTI

New study examines risk factors for child sexual offences

ANDREA ZOE ASTER

What's the tipping point? In the past decade, the Internet has become an anonymous smorgasbord of child pornography for those who would feed such proclivities. The crucial issue is whether consumption of child porn triggers actual sexual abuse – a debate that has heated up since Toronto software developer Michael Briere, who kidnapped, raped and murdered a 10-year-old girl two years ago, confessed to police that Internet images of pedophilia pushed him over the edge.

"If someone has already committed a sexual offence, we have tools to assess him. But what about the child pornography offender who hasn't committed a sexual assault? What's his future risk?"

Groundbreaking research challenges Briere's plea that there is a link between child-porn possession and sex crimes against children. "A history of viewing child porn is not itself a strong indicator of who is going to sexually abuse children," says Dr. Michael Seto, a clinical psychologist with the Law and Mental Health Program at the Centre for Addiction and Mental Health and an associate professor in psychiatry and criminology at the University of Toronto. Seto's study is researching yet-unmined police data that documents child-porn offences in an attempt to discover exactly what distinguishes individuals who view Internet child porn who go on to commit offences against children.

In a recent study, published in the April issue of *Sexual Abuse*, involving a sample of Ontario sex offenders, Seto and colleague Angela Eke found that of 201 child-porn offenders, 17 per cent committed some sort of crime again within a three-year period, and four per cent committed a sexual offence. The main point was that child-porn offenders with a prior criminal record were significantly more likely to reoffend in some way.

"The conclusion was that a past criminal history matters," says Seto. "Does a person have a history of antisocial or criminal behaviour? That's a much stronger predictor [than child-porn possession] of who would reoffend," says Seto.

It's somewhat comforting that in a climate of unreined access to Internet porn, mere possession is not the strongest predictor of future deviance. Indeed, the greater availability of child porn since the early 1990s does not correlate with an increase in sexual crimes with children, says Dr. Martin Lalumière, an associate professor in psychology at the University of Lethbridge in Alberta, who researches sex crimes. "In fact, there has been a significant decrease in sex crimes in North America overall," says Lalumière.

"That's not to suggest that child porn satisfies fantasy, thus making it less likely that people will act out – that hypothesis has not yet been supported by the data. But it is still good advice to make sure that those who have been convicted of child-porn possession stay away from it."

So the question remains: What is different about the four percent of child-porn offenders in Seto and Eke's study who do act out?

One thing is for certain: If there are commonalities among pedophiles, they currently elude police. Of the two-dozen arrests the Toronto Police Service has made this year, the demographics are all over the map. Suspects range in age from 18 to 82, an officer said in a recent article in *Macleans*. "They are people who live in housing projects and in Forest Hill mansions."

Still, there is a more methodical approach, and Seto and Eke are hot on the trail with a new study, designed to produce a useful tool to evaluate the future threat a child-porn offender may pose, in an area where no such tool currently exists, says Eke, manager of the Research Unit for the Behavioural Sciences Section of the Ontario Provincial Police. Ultimately, it is hoped that the study's findings will lead to development of a much-needed risk-assessment tool that will help to predict the shift from child-porn

viewing to sex crimes against children.

The limitation of the initial study was that Seto and Eke had access only to limited data from Ontario's sex offender registry, including name, address and criminal history, says Seto. Now, funded by the Ontario Mental Health Foundation, the team is pouring over close to 400 complete files of Ontario's child-porn offenders, with the cooperation of the OPP and Toronto, Peel and York regional police.

"What's unique about this research is that the police have searched the offenders' homes and computers, so we have access to the porn content," says Seto. "Are the offenders viewing images of 13- and 14-year-old girls? A lot of men might find those images attractive, but it's a different story if there are images of three-year-olds and other deviant content like violence."

By developing a checklist of risk factors, the team aims to determine whether child care workers, clinicians, police and the courts need to be worried about risk of sexual offences against children. "This information about risk can be helpful in prioritizing cases for investigation, making decisions about bail and sentencing and treatment," says Seto.

It's too early in the study to determine what factors increase the risk of future offences, says Seto. Risk-factor data collected includes such factors as age, previous criminal charges, employment history, living arrangements and, of course, the nature of the content in the offender's porn collection. "We can't say for sure, but the factors I think will turn out to matter most are a risk-taking lifestyle, substance abuse and an impulsive, antisocial character," says Seto. The team expects to complete the study by next year.

"We're trying to fill an existing gap," says Seto. "The literature on sex offender risk-assessment has only grown over the last 10 years and we're aiming to extend that into the realm of child-porn offenders."

"If someone has already committed a sexual offence, we have tools to assess him," says Eke. "But what about the child pornography offender who hasn't committed a sexual assault? What's his future risk? That's what we're aiming to find out."

HELEN BUTTERY

Leigh MacEwan knew something was wrong. “My soul felt weary,” she recalls of the time in the early 1990s when she worked as an addiction counsellor at Lakeside Centre, part of the Northern Regional Recovery Continuum in Sudbury, Ontario, which treats women with substance use problems.

Fast-forward to 2005. MacEwan, an assistant professor at Laurentian University’s School of Social Work in Sudbury, is getting ready to defend her PhD thesis at the University of Sussex in Brighton, U.K. Her topic? Compassion fatigue. Almost 15 years ago it plagued her soul – and, as she has discovered through talking with more than 500 social workers in Ontario, it is affecting many workers in the addiction field.

Making an early appearance in 1992, the term “compassion fatigue” described

nurses worn down from dealing daily with hospital emergencies. Since then, its meaning has been fine-tuned and the phenomenon goes by many names. “Compassion fatigue is synonymous with secondary traumatic stress and vicarious trauma, but it’s the more user-friendly term,” explains Dr. Charles Figley, director of Florida State University’s Traumatology Institute. In his groundbreaking book *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*, Figley defined compassion fatigue as “the natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by a significant other – the stress from helping or wanting to help a traumatized or suffering person.”

When MacEwan starting searching for what was ailing her, she didn’t know what to

call her problem – or even if it had a name. She came across Figley’s work describing the parallel effect on trauma workers and mental health workers from listening to the ordeals of clients – what Figley describes as “bearing the suffering of clients.” The symptoms of compassion fatigue share a striking resemblance to posttraumatic stress disorder (PTSD) symptoms. For instance, someone with PTSD might have recurring dreams of the event, and a person experiencing compassion fatigue might have disturbing dreams about a client’s event. But nothing in the literature looked at whether, or how, addiction workers experienced compassion fatigue.

MacEwan links this neglect to a lack of recognition of the connection between addiction and stories of violence. “Workers in a shelter know they’re going to listen to stories of violence and see women with black eyes,” says MacEwan. “But when you sign up for addiction treatment, you go in with the idea that you’re going to be working strictly with addiction. You don’t realize that when the anaesthetic of drugs and alcohol wears off, these painful stories come out.” These are stories of sexual abuse, including child sexual abuse and rape; physical violence and emotional violence.

The heavy burden of hearing terrible stories of substance abuse and violence may be compounded by the personal experiences of addiction workers. Some are themselves in recovery from substance use or have family members who have struggled. In these cases, empathy for clients often comes from the worker’s intimate understanding of the issues. But it’s a double-edged sword. What makes these workers good at what they do also makes them vulnerable to compassion fatigue. “When you put those two things together, there’s a much higher probability that addiction workers will develop compassion fatigue,” says Figley.

MacEwan decided to explore this uncharted territory, delving into the experiences of addiction workers who listen daily to stories of violence and trauma. Her research brought her full circle to her former workplace, Lakeside Centre, where her study

involved intense interviews with 12 staff members. MacEwan’s study posed five questions: What are addiction workers’ experiences of listening to clients’ stories of violence? What are the effects on addiction workers of listening to stories of violence? How do addiction workers cope with listening to clients’ stories of violence? What are the benefits of doing addiction work? What strategies do addiction workers recommend to maintain their health and well-being?

MacEwan’s study has found that the symptoms Lakeside staff described came close to and, for the most part, replicated those experienced by other workers exposed to trauma through their work. For instance, staff described intrusive imagery, difficulty sleeping and taking their work home with them.

Through the study, Kathryn Irwin-Seguin, executive director of the Northern Regional Recovery Continuum and a participant in MacEwan’s research, recognized her own symptoms from her 15 years of working on the front line of addiction treatment. “When I got home at night, I wasn’t as present for my family,” she recalls. “I started reacting to what I thought was petty complaining from my family, thinking, ‘Gee, if you heard what I heard today you’d be thankful for what you had.’”

This type of day-in, day-out exposure to stories of violence and trauma differs from what trauma workers deal with on the scene of a large-scale traumatic event, such as the tsunami in Asia. Workers at a catastrophe scene are away from home, in an environment they will soon leave. “There’s a tendency to just work and work and not take breaks because when you do, you feel guilty,” says Figley. “But it’s interesting that there’s a natural tendency to take care of yourself once you return from the field.” For addiction workers, there is no returning from the field.

“Every time you think you’ve heard the worst story, you hear something else,” says Irwin-Seguin. “After a while, you hit a saturation point.”

To deal with this constant onslaught, Lakeside Centre staff now have formal

and informal strategies for coping with the stressors that may cause compassion fatigue. MacEwan’s study participants spoke of spiritual, mental, physical and emotional resources they use to cope. The centre has now also established a wellness committee. Staff meet monthly for three hours for retreats and fun days. Some sessions discuss coping strategies; others are designed to de-stress staff through normalizing experiences, such as interior designer visits, painting class and golf lessons.

Since staff participated in MacEwan’s

research, they are more willing to use the Employment Assistance Program and reach out for help. “In the past, the attitude was ‘Suck it up, you should be able to handle this or you’re not in the right field,’” says Irwin-Seguin. Instead of recognizing compassion fatigue as an occupational hazard, workers often blamed themselves, thinking they were incompetent.

Fortunately, that attitude is shifting. “Compassion fatigue is not inevitable, but compassion stress is,” says Irwin-Seguin. “Stress is a demand – a demand for attention.”

SELF CARE AT WORK INVENTORY

The below inventory is adapted from a 2003 Green Cross Foundation workshop conducted by Kathy Regan Figley called “You too! Introduction to professionals who care enough (about others) to ignore their own needs.” The foundation trains and dispatches trauma specialists around the world.

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Do I take a lunch break every day and do something unrelated to work? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do I work reasonable hours? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do I schedule breathing room every day so I can step back, and reevaluate my priorities? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is my office free of clutter? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do I have adequate lighting and clean air? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do I delegate work to free my time and empower others? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do my family/friends honour my work time? If no, have I asked them? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do I have blocks of uninterrupted time without distractions and interruptions? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do I have a “Do not disturb” sign? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have I scheduled specific times for returning phone calls and checking e-mail? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have I stopped taking on more than I can handle? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do I drink enough water when I am at work? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do I have comfortable shoes/slippers at my office? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do I schedule time off from work (sick leave and/or vacation time) to take care of myself? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do I have someone to talk with about my professional life? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do I have creature comforts that make my office pleasant? (music and other sounds, aroma, artwork) |
| <input type="checkbox"/> | <input type="checkbox"/> | Do I say “yes” to commitments that I later regret? |

Fewer than 10 “yes” answers and more than eight “no” answers indicate violation of standards of self-care.

COMPASSION FATIGUE VERSUS BURNOUT

COMPASSION FATIGUE	BURNOUT
<ul style="list-style-type: none">• Related to worker’s interaction with client’s traumatic material• Faster onset, occurs with little warning, faster recovery rate• Characterized by physical emotional, cognitive, spiritual, mental symptoms	<ul style="list-style-type: none">• Related to work environment• Gradual process that gets progressively worse• Characterized by physical, emotional, mental exhaustion

Source: Moira Ferguson, Kathryn Irwin-Seguin, Leigh MacEwan and Vivian Munroe, Compassion Fatigue and Relational Spirituality: A Participatory Action Research Project with Northern Ontario Addiction Counsellors, presented at the 2005 Annual Addictions Conference, Addictions Ontario.

COMPASSION SATISFACTION: IT’S GOOD FOR YOU

Unlike compassion fatigue, which describes the negative costs of caring, compassion satisfaction, a term developed by psychologist Dr. Beth Hudnall Stamm at Idaho State University, describes the positive costs of caring and the pleasure derived from this work. Leigh MacEwan, a social worker conducting research on compassion fatigue among addiction workers, found that despite the toll of their work, staff at Lakeside Centre, an addiction treatment centre for women in Sudbury, Ontario, had tremendous resiliency stemming from job satisfaction and feeling privileged to be able to make a difference. Stamm developed the Professional Quality of Life scale to measure compassion fatigue, compassion satisfaction and burnout. Download the scale for free at www.isu.edu/~bhstamm.

Pain medication addiction more likely among young people

Young people are more likely than older people to want to rapidly increase their dosage of opioid-based medications such as morphine, methadone and oxycodone, thus raising risk of abuse, according to research from the University of California, San Francisco. Researchers examined the medical records of 206 individuals who had been treated at a pain management centre for two years for non-cancer –related pain. Records of clients under age 50 were compared with those 60 or older. The study found that older clients, regardless of gender or type of pain, increased opioid use significantly less over two years than younger clients. The average peak dose for clients under age 50 was more than twice that of older clients – often more than half a gram per day of morphine or other drugs. Older clients also experienced long-term pain relief with opiate-based drugs, but younger clients did not. The authors indicate that younger clients may be better candidates for newer non-steroidal anti-inflammatories and poorer candidates for opioids, whereas older clients may benefit more from opioids.

Anesthesia and Analgesia, June 2005, v. 100: 1740–1745. Chante Buntin-Mushock et al., Department of Anesthesia and Perioperative Care and Department of Neurology, University of California, San Francisco.

Excessive Internet use linked with psychiatric disorders

Young people who use the Internet excessively experience more psychiatric symptoms than those who access it less often, according to researchers at Korea's Dong-A University College and Harvard Medical School in Boston, Massachusetts. Participants were 328 male and female Korean students aged 15–19. They completed four questionnaires: Internet use patterns during the previous month, the Internet Addiction Test, the Symptom Checklist-90-R and the Sixteen Personality Factor Questionnaire. Participants were separated into four groups based on average Internet use: non-users, minimal users (0.8 hours per day), moderate users (1.5 hours per day) and excessive users (2.3 hours per day). Sixteen students were classified as excessive users, logging on an average of 19 hours per week. Fifty-nine students reported no Internet use. There were significantly more males than females in the moderate and excessive groups. Excessive users experienced more hostility, obsessive-compulsiveness, paranoia, depression, irritability, impulsiveness, anxiety, phobias, somatization and psychoticism than moderate and minimal Internet users. Excessive users also appeared to have a distinctive personality profile compared with other users and non-users. The authors indicate various study limitations, including small sample size and use of questionnaires rather than interviews. They suggest that excessive Internet users “may use the Internet to counteract psychological distress rooted in their personality.”

Canadian Journal of Psychiatry, June 2005, v. 50: 407–414. Chang-Kook Yang et al., Department of Psychiatry, Dong-A University College of Medicine, Busan, Korea.

Medication adherence linked to good therapeutic relationships

Good relationships with clinicians during admission to acute treatment may improve attitudes toward and adherence to anti-psychotic medication, according to UK researchers. The study examined various factors that may influence medication compliance, including psychiatric symptoms and lack of insight, as well as factors related to the therapeutic relationship, including the client's perception of the degree of coercion during admission to hospital and the attitudes of inpatient staff. The study involved 228 clients in eight inpatient acute care wards in Wales and England who were diagnosed with schizophrenia or schizoaffective disorder. It was found that good insight, lack of coercion during admission, a positive relationship with the medication prescriber, involvement in treatment decisions and medications with fewer side-effects increased medication adherence. The researchers mention limitations to the study, including the focus on the acute phase of treatment, indicating that different stages of illness and different social contexts may yield different results. They propose measures for client-centred care, including involving clients in treatment decisions, respecting clients' health beliefs and adjusting treatment to minimize negative side-effects.

Archives of General Psychiatry, June 2005, v. 62: 717–724. Jennifer C. Day et al., Pharmacy Department, Mersey Care NHS Trust, Merseyside, United Kingdom.

Friendships help us live longer

Strong friendships may lead to longer life, according to researchers at Flinders University in Adelaide, Australia. Researchers used data from the Australian Longitudinal Study of Ageing, which assesses how economic, social, behavioural and environmental factors affect people over age 70. Beginning in 1992, researchers monitored 1,477 people living in the community and residential care facilities. Participants were asked how much personal and phone contact they have with their spouses, children, other relatives, friends and confidants. They were monitored every year for the first four years and then every three years. The study found that participants over age 70 with a strong network of friends were 22 per cent less likely to die compared to those with the weakest network. A smaller positive effect was found for confidants. Networks with children and other relatives had little effect on survival. The correlation held after controlling for socio-economic status, health and lifestyle. The researchers suggest that friends may discourage risky behaviours, while lifting mood, self-esteem and coping ability.

Journal of Epidemiology and Community Health, June 2005, v. 59: 574–579. Lynne C. Giles et al., Department of Rehabilitation and Aged Care, Flinders University, Adelaide, Australia.

Antipsychotic drugs show quick effect

Antipsychotic medications begin to reduce psychosis within the first 24 hours of treatment, suggests research from the Centre for Addiction and Mental Health and University of Toronto. In this multi-centre double-blind study, 311 individuals with schizophrenia were randomly assigned to either a placebo group or a group that received the antipsychotics olanzapine or halperidol. Participants were monitored for changes in their behaviour at baseline and two hours and 24 hours after the drugs were administered, using the Positive and Negative Syndrome Scale and the Clinical Global Impressions rating scale. Analysis of clinical data showed that change in psychosis (which included conceptual disorganization, hallucinatory behaviour and unusual thought content) appeared within 24 hours for both drugs and showed greater change than the placebo group. The authors indicate that this result is contrary to the prevailing assumption that it takes at least two weeks for antipsychotics to affect symptoms. They suggest that this finding has important clinical implications because it raises the possibility that physicians may be able to look for effects earlier, and thereby develop more efficient strategies for the medical management of psychosis.

American Journal of Psychiatry, May 2005, v. 162: 939–946. Shitij Kapur et al., Centre for Addiction and Mental Health, Toronto, Ontario.

Successful anti-stigma campaigns target violence stereotype

Campaigns aimed at reducing stigma and discrimination toward people with schizophrenia would be most effective if they addressed perceptions of unpredictability and dangerousness, according to researchers at the University of Leipzig in Germany. A fictional case scenario was presented to 5,025 people, describing an individual who met DSM-III-R criteria for schizophrenia or major depressive disorder. Participants were asked to describe the problem presented. Responses were grouped into four categories: correct psychiatric diagnosis, other psychiatric illness, personal problem or other. Participants then indicated whether the individual was unpredictable or dangerous, whether lack of willpower was responsible for the illness and what the prognosis would be given optimal treatment. They were also asked whether they had personal experience with mental illness. Finally, participants were given a list of social relationships such as tenant or in-law and indicated whether they would accept the individual from the case scenario in such roles.

The study found that regardless of familiarity with mental illness, mental illness labels increased the likelihood that participants would consider the individual unpredictable and dangerous. Perceived unpredictability and dangerousness increased negative responses to accepting the individual in a social role. Labelling the problem as a mental illness lowered the tendency to attribute the disorder to lack of willpower. The authors caution that the findings may be limited by the study's focus on schizophrenia. They conclude that anti-stigma campaigns should address stereotypes of unpredictability and dangerousness because these are most likely to affect people's willingness to engage in social relationships with individuals with schizophrenia.

Social Psychiatry and Psychiatric Evaluation, May 2005, v. 40: 391–395. Matthias C. Angermeyer and Herbert Matschinger, Department of Psychiatry, University of Leipzig, Leipzig, Germany.

Gambling and substance use issues share personality traits

Rebelliousness, anger and risk-taking are personality traits shared by compulsive gamblers and people with substance use issues, according to researchers at the University of Missouri-Columbia. Researchers performed personality assessments on 939 18-year-old males and females in New Zealand and administered structured interview-based diagnoses of past-year problem gambling and alcohol, cannabis and nicotine problems at age 21. They examined the association between problem gambling and each of the three substance use problems. They then compared 10 basic personality traits of individuals in each disorder group to individuals who did not develop gambling or substance use problems. The study found similar personality profiles for people with a gambling problem and those with substance use problems. Those with problem gambling in the past year were three times more likely to have a substance use problem. Those with gambling problems were more likely to score higher on personality measures of negative emotions, including nervousness, anger and feeling victimized, and impulsive or risk-taking behaviour. The authors indicate that the findings may help to explain the relationship between problem gambling and other addictions and may lead to better treatments.

Archives of General Psychiatry, July 2005, v. 62: 769–775. Wendy S. Slutske et al., University of Missouri-Columbia, Columbia, Missouri.



Alcohol use during pregnancy ups infant infection risk

Children born to mothers who drink during pregnancy are more likely to contract infections as newborns, according to a study at Emory University in Atlanta, Georgia. Researchers examined data from 872 women who delivered single infants at 36 weeks or more of gestation. Following delivery, mothers were asked about alcohol and tobacco use in the three months prior to conception, and during the first, second and third trimester. Information about gender, gestational age and size was also collected. Fifty-one infants were diagnosed with newborn infections. Mothers who reported alcohol use, excessive drinking (seven or more drinks per week) or smoking during pregnancy were more likely to have a newborn diagnosed with an infection than were mothers who reported abstaining. After controlling for low maternal income, smoking and low

birth weight, excessive alcohol use, especially during the second trimester, increased the risk of newborn infection more than three-fold. The authors recommend further research to determine whether drinking during the second trimester is particularly damaging. Maternal smoking at any time point before and during pregnancy also increased infection risk. The authors call for further research on the effects of maternal alcohol consumption on developing organ systems, as well as on the combined effects of alcohol consumption and smoking on the newborn.

Alcoholism: Clinical and Experimental Research, June 2005, v. 29: 1035–1043. Theresa W. Gauthier et al., Children's Center Division of Neonatal-Perinatal Medicine, Emory University, Atlanta, Georgia.



The triple whammy of acquired brain injury and concurrent disorders

CINDY MCGLYNN

Karl* is an artistic man who loves the Beatles and vintage clothing. He also has a substance use problem and a mood disorder, and has had three brain injuries. The first two, from beatings, left him with memory and concentration problems. As a result of the injuries, he is unable to keep food in his stomach, which reduces the effectiveness of the medications he needs for his other symptoms. Recently hit by a bus, Karl now feels even more confused. He was a heavy drinker before his injury, but the alcohol dependence and mood disorder surfaced post-injury. Unfortunately, like many people with the triple whammy of substance use and mental health issues and acquired brain injury (ABI), Karl finds himself turned away from services.

Traditionally, mental health issues, substance use problems and ABI are treated by different systems of care. Substance use programs screen out individuals with brain injury, and mental health and addiction programs are ill prepared to deal with clients with ABI. Increasingly, mental health and addiction intake workers are screening for ABI (see Partners sidebar), but even if it is detected, there are virtually no services designed to treat

all three issues. “We create services for people in the majority, not the minority,” says Jean Budden, a social worker with the G.F. Strong Rehab Centre in Vancouver, British Columbia. “These are the people out on the fringes; they represent the minority, but they desperately need treatment.” Not surprisingly, people like Karl fall through the cracks.

The desperate need for treatment is reflected in research. A 2005 article in the *Archives of General Psychiatry* found that alcohol use problems frequently occur in people with acquired brain injury and that previous alcohol use problems increase the risk of developing mood disorders after ABI, which in turn increases the risk of alcohol relapse. At the Ohio Valley Center for Brain Injury Prevention and Rehabilitation, a leader in the field, approximately half of clients in the program have a history of alcohol use problems.

It is difficult to say how many people live with this triple whammy because there is virtually no research. Dr. Shree Bhalerao, director of medical psychiatry at St. Michael's Hospital in Toronto, sees many such cases. “It's not unusual, especially here in the inner-city,” says Bhalerao. “Most head

injuries happen to males in their 20s to 30s from motor vehicle accidents and alcohol use. A typical profile is a patient with severe mental illness who may be homeless and living on the street with limited resources. Then they suffer an acquired brain injury.”

Integrating all three issues is complicated. In the early 2000s, a Toronto-based group set out to develop ways to integrate treatment of all three issues, but realized that the wide range of mental health issues and symptoms make the establishment of assessment guidelines and treatment protocols for the triple diagnosis extremely difficult.

Yet the need for integrated services remains. At a recent concurrent disorders conference in Vancouver, Budden and colleague Rick Lawrie, an alcohol and drug intervention coordinator, tackled the issue head on. They described the symptoms of brain injury to concurrent disorders workers and discussed the unique needs of people with this triple diagnosis. “The information was brand new to most audience members,” says Budden. “Mostly frontline workers expressing frustration at not being able to help clients who likely had an acquired brain injury and a concurrent disorder.”

From a treatment perspective, the problem is multi-dimensional and can lead to misunderstanding of symptomatic behaviours. It may be difficult to distinguish between mental health, substance use and ABI-related symptoms because many overlap (see Symptoms sidebar). The memory problems, emotional outbursts and difficulty initiating tasks that are common to brain injury may also indicate mental health issues. “People with ABI frequently have difficulty initiating activities,” says Dennis James, deputy clinical director of the Addictions Program at the Centre for Addiction and Mental Health (CAMH) in Toronto. “This, combined with memory impairment, means that people may miss appointments or not do their “homework,” which can be seen as low motivation. But in fact, they really do want to address their problems.”

Usually the only route available is to treat the problems separately, but this too proves difficult. People with ABI who appear unmotivated and have poor impulse control often get kicked out of traditional substance use rehabilitation programs because the cause of the behaviours isn't correctly identified. “It's hard to get these people to a

place that can help them,” says Bhalerao. “They have to almost be in perfect condition when they're accepted at a rehab unit, and that just doesn't happen with these people.”

Treatment for ABI also takes time – up to three times longer than treating addiction or mental health issues alone, according to Lawrie. Budden says this slow progress can be frustrating for frontline workers with long waiting lists. “With brain injury you do things much more slowly,” says Budden. “There's a cycle of getting better, slipping back and getting better again. To get someone with a brain injury through this cycle usually takes five years.”

Although there are no established, widespread strategies to help frontline workers deal more effectively with people with ABI and concurrent disorders, health care workers should learn about all three areas. The crucial starting point, says Lawrie, is for frontline workers in all three fields to screen for triple diagnosis. When ABI and concurrent disorders are detected, workers can follow practical guidelines to help treatment, according to Marty Wolfe, program director of the Traumatic Brain Injury Network at Ohio State University Hospital in Columbus.

“Part of what we usually see is a reduced attention span,” says Wolfe. “Keep information as simple as possible and make eye contact to make sure individuals stay with you.”

Wolfe also advises repeating information and encouraging clients to write things down. Provide feedback in a direct but kind manner. And follow up or assist clients in the community where possible – people with ABI often have difficulty applying learned information to real-life settings and may have a short fuse if they get confused, for example, about accessing services from a different agency (see Practical tips sidebar for more strategies).

Wolfe also recommends that workers listen to their instincts. Sometimes recognizing the triple diagnosis begins by realizing that a client's symptoms simply don't make sense. “I've done workshops with large groups where participants say, ‘This patient didn't seem to be a typical user, or a typical person with personality disorder,’” explains Wolfe. “After learning about ABI and concurrent disorder, they say, ‘Suddenly this patient makes sense.’”

*not his real name

SYMPTOMS THAT BRAIN INJURY AND MENTAL ILLNESS MAY HAVE IN COMMON

- memory problems
- unpredictable behaviour
- being very emotional
- concrete thinking
- seemingly low motivation
- impaired capacity for insight
- substance abuse
- social isolation
- failing to acknowledge having a problem

Source: Rick Lawrie, G.F. Strong Rehab Centre, Vancouver, British Columbia

SYMPTOMS THAT BRAIN INJURY AND SUBSTANCE ABUSE MAY HAVE IN COMMON

- short-term memory loss
- impaired thinking
- difficulty with balance and coordination
- impulsivity
- mood disturbances (diminished emotional control)
- personality changes
- diminished judgement
- fatigue
- depression
- sleep problems
- decreased frustration tolerance

Source: *Brain Injury and Substance Abuse: The Cross-Training Advantage*

PRACTICAL TIPS FOR BRAIN INJURY AND ADDICTION WORKERS

Through a grant from the Ontario Neurotrauma Foundation, a group of ABI and addiction workers developed *Brain Injury and Substance Abuse: The Cross-Training Advantage*, a video and training package that raises awareness between the addiction and ABI fields and provides frameworks for care. The manual can be downloaded for free from the ABI Network at www.abinetwork.ca/downloads/bisa_manual.pdf. Here are practical tips taken from the guide for workers in both fields.

ABI workers should:

- Educate ABI clients and family about the risks of using substances.
- Involve family and social networks in supporting the client to address the issue.

- Take a history of client's past and current substance use. Be specific – ask, “What's the most you've used? The least?”
- Ask what effect substance use is having on client's life (social, family, job, legal).
- Assess stressors and risk factors that might cause client to begin using (eg., isolation, boredom, depression, job loss).
- Help clients find meaningful substance-free activities.
- Establish ongoing contact with addiction professionals to exchange information and ensure client gets appropriate treatment.

Addiction workers should:

- Screen for ABI, which includes asking about crashes, blows to the head, falls, fights periods of unconsciousness and hospitalizations.

- Adapt substance abuse treatment for people with ABI:
 - slow down and simplify language
 - provide extra time for clients to complete tasks
 - repeat information and use short, simple phrasing
 - encourage clients to take notes
 - anticipate off-topic remarks
 - keep instructions brief and clear
 - encourage feedback– ask “Do you understand?”
 - Give rest periods and reduce distractions
- Consult with ABI specialists about how to tailor treatment to the client's learning style and remain in contact throughout to monitor progress and make changes.

PARTNERS FOR INTERGRATED TREATMENT

An 18-month Toronto-based pilot project is examining ways to integrate substance use treatment with ABI rehabilitation. The pilot is a partnership between Community Head Injury Resource Services of Toronto, the Acquired Brain Injury Network and the Addictions Program at the Centre for Addiction and Mental Health (CAMH). The goals are to develop greater capacity for the participating agencies to work with people with a concurrent brain injury and substance use problem, and to develop strategies to build greater system capacity. Plans include modifying harm reduction, motivational interviewing and relapse prevention resources from CAMH for use with and by people with cognitive impairments, and conducting outcome studies based on the use of the adapted resources. For more information, contact Carolyn Lemsky at CHIRS at 416 240-8000.

HEMA ZBOGAR



BY BOB RAMSAY

The bigger your community, the better your chances

LIKE MANY RECOVERING ADDICTS AND ALCOHOLICS, I like to predict who will stay clean and sober, and who won't. I'd been to a treatment centre where a lot of patients came back every six months for a "tune-up." At these reunions, we'd all be surprised at how poorly we had predicted which of us would be in recovery, which would have relapsed, and which had disappeared entirely.

It took me a while to figure out what most of the "strong recovery" patients had in common. It wasn't their willpower (it never is with addiction). Or their education. Or their job. It was their community. Or rather, the number of people who were ready to help them. And that community, like every community, began at home.

What I saw at these reunions has been reconfirmed time and again in my 14 years of recovery: If your family, friends and co-workers – especially your family – are there to help you, you stand a much better chance of getting and staying clean and sober.

An unemployed teenager who is prepared to enlist her family, schoolmates and family friends into a network that will watch out for her (this includes not only preventing relapse but intervening if one happens) stands a much better chance of getting well than ... well, than an alcoholic family physician from a small town who has to drive 60 miles to the nearest Alcoholics Anonymous meeting, whose "secret" must remain tightly held because he's the town doctor, and whose family treats his alcoholism as a character flaw, not a disease.

I learned this lesson the hard way. After I first went into treatment for 30 days, I was determined that no one back home should know. I conjured up a story that I had gone out West for a month to clear my head and refocus my priorities. I was determined to get well entirely on my own; I didn't need anybody. Of course, that strategy didn't work. Before long, I was back in treatment – this time for four months – and I quickly learned that in my secrets lay my sickness.

So before I came home this time, I told my family and a few friends what was going on. I was terrified they'd leave me. But as I've learned from helping others with substance use problems, they never do. Never. Not once has anyone acted out the worst fear someone with an addiction has by saying, "You awful person. Get out of my life."

In between treatments, I met the woman who is now my wife. It's coincidental that she happens to be a physician, because although her role in my getting and staying well has been profound, it hasn't been medical. Jean was divorced like me and the mother of three teenagers who weren't exactly thrilled that mom was going out with a

drug addict. Despite their very legitimate fear, they did come to AA meetings with me and have supported me enormously since.

In fact, going to someone who's been a friend for years and saying, "Look, I've had a serious drug problem this past year, but I'm getting better and I'd like to ask for your help," you just don't know how important that is to the person with the addiction.

But creating this community of supporters isn't all sweetness and light. One of the characteristics of the disease of addiction is relapse. It doesn't always happen. But sometimes enough that your community can be of enormous help when it does happen. Too many addicts fall off the wagon, and consumed with shame, they hide. Now all alone, they continue their downward spiral all the faster, until ...

But let's look at a different scenario. You're an addict. You relapse. You call your spouse. Or your best friend. Or your boss. You say, "Look, I relapsed and I'm going to need help to get back to where I was." Believe me, help will be on the way. Because that's what your community is there for.

Now all this said, it's much better to stay clean and sober without relapsing. And there's a way your community of family and friends can help. No recovering addict or alcoholic just goes out spontaneously one day and puts chemicals into their body again. They always behave their way into relapse before they actually pick up the bottle or the drug.

So send the following message to your family and half a dozen friends: "I can't tell you how grateful I am for your help in keeping me clean and sober these past months. But you can do me a very real favour by noting when I'm in what's called 'relapse behaviour' because this is always the danger sign that I'm headed for a relapse. I'm asking you to do this because I'm the last person to see the signs myself. The main symptom of addiction is that the afflicted person denies having it. And for heaven's sake, don't tell me that you think I look tired, or am getting a little busy at work, or that I'm obsessing about getting back all my losses. I'll of course deny it or try to change the subject. So tell Joe Blow, my therapist. You can call him at 416 555-2839 or e-mail him at joe@blowmedown.ca. He'll talk to you, then he'll talk directly to me – believe me."

That's what your community is really there for.

Bob Ramsay, A FORMER SPEECHWRITER FOR FORMER ONTARIO PREMIER BILL DAVIS, IS A 2005 RECIPIENT OF THE COURAGE TO COME BACK AWARD, WHICH RECOGNIZES PEOPLE ACROSS ONTARIO WHO HAVE SHOWN COURAGE AND DETERMINATION IN THE FACE OF MENTAL ILLNESS AND ADDICTION.

On delusions The torment and the euphoria

BY MICHAEL ARMSTRONG

THE MOST TERRIFYING EPISODE OF MY LIFE, SUNK DEEPLY into an experience of hell, came 10 years ago. I had "failed" at saving Canada from evil forces, and had run into the winter streets half naked. I arrived at the emergency room of the hospital strapped to a gurney, and was convinced that the hospital staff were going to torture me to death. I thought they were going to chop me up with meat cleavers for having failed to save the country. The fright was so complete that I was rendered mute.

I was, of course, never in danger; yet, I believe my emotional memory from that experience is just as real as that of any human knowingly awaiting torture.

This psychotic episode is one of 10 that I have experienced over the last three decades, at times when I was off medication, not getting enough sleep or, more likely, being treated with the wrong drugs. For at age 20, I was incorrectly labelled schizophrenic, a diagnosis that was only corrected 23 years later when I was then identified as having bipolar disorder.

In my various states of psychosis, I have gained entry, through my wounded brain, to fantastic worlds, sometimes terrifying, yes, but also joyous, luxurious, fabulous environments. At these times, I have often identified myself as a saviour, in keeping with my strong Catholic faith – though I always still knew I was Michael.

Just as some delusions are filled with terror, others are quite blissful. I remember sitting in the reception area of the hospital, believing I was helping to welcome in the new era. The basic goodness and love of the universe was going to manifest itself. "My people" came to join me in the waiting room, the tenderly loved insane ones brought to the shelter. It was all over. All the pain of a species, of millennia, all was now resolved. We had made it. We were safe. We were loved. It was all so obvious. Who could ever have imagined it could be so beautiful?

Through this highly unusual exercise of human emotion, I have been "there," tasted a piece of heaven. I wish every human on this sorrowful planet could feel to the depths of their being the beauty, the calmness, the serenity, the wholesomeness, the joy of this "Second Coming."

Thus, a journey in a circle. The bliss of this last episode was tempered by reminders or, rather, hints of my condition: the fact that friends visiting me on the ward found my long, tangential ramblings on the Bible to be confusing, and my silly word games, so typical of a manic episode, to be bizarre.

I believe I had a spiritual conversion experience that day at the hospital. I do not deny the mental illness. I needed desperately to be locked up in order to weather the storms, unpleasant and pleasant, of my experience. I needed help and I got it.

But something unexpected has since occurred. On August 7, 2000, I became once more psychotic, in spite of my medication. However this time I was unusually aware of being psychotic, and I enjoyed once again the exciting radiation of joy and peace, as if



experiencing colour for the first time after a diet of black and white. Yet I managed to ride the event. Perhaps this time, my meditation practice helped to focus the chatter of my mind. I deliberately set aside my usual boisterous ego in such a complete way that the whole nine-hour episode was noticed by no one.

I don't know what this new event means for my future, or for my take on the medical model – on the fact that I have, until now, attributed my psychotic symptoms to a disease that I felt was beyond my control. I am tempted to explain what happened as a mystical experience. For this time, there was no pathology. I didn't increase my meds to end the psychotic experience, and there wasn't a change in my dose to precipitate it.

Perhaps I have been "in training" all my life for this: a happy ending to a history of delusional altered states – for my life has never been as beautiful or as joyful, and I have never been as full of gratitude. I hope this is possible for other people with bipolar disorder.

Yet what happened is also disturbing because I have no ultimate understanding of what happened. And while we can stretch our imaginations looking for an explanation for this event, even if it was due to mysticism, I will still continue to take my medication.

I have read that psychiatry and religion are slowly reconciling. I run some risk by my revelation, but perhaps it's time.

Postscript: After the publication of this article five years ago, I suffered a severe psychotic break that required hospitalization in August 2001. I was experimenting with my medication and paid the price. I believe in the medical model of mental illness, and I have no doubt that extremely convincing religious characteristics are part of the situation as well. I thus do not see my experience of bipolar psychosis as being "either/or." It remains for me definitely "both/and."

Michael Armstrong IS AUTHOR OF *Stable in Bedlam*, ABOUT HIS JOURNEY WITH BIPOLAR DISORDER. HE WORKS AT THE INFORMATION CENTRE AT THE CENTRE FOR ADDICTION AND MENTAL HEALTH.

Reprinted from the former *Journal of Addiction and Mental Health* (now *CrossCurrents*)

Psycho, patient, person

Perspectives on being labelled mentally ill

Three writers were assigned the task of providing their perspective on the term “consumer/survivor.”

So cliché to say what’s in a name. If you get to call me Helen and I have to call you Dr. Hook, there’s a built-in power imbalance. That’s pretty standard stuff. If we are patients first and even worse, diagnoses – the schizo in 3B, the junkie in room 229, how can we hope to be seen as people with a chance for real recovery and a full life?

What people call us, and even more importantly, what we call ourselves, is a huge issue – a constant struggle and a shifting sand. When clinicians, family, my support network and I see me as Helen first, it gives me strength because my own identity remains central. If I’m a “consumer/survivor” of the mental health system, it means that I have choices, that I’m an active participant in my treatment.

Contrast this with the passive images conjured up when you call me a “patient.” I wait to be told what I should do, where I should go. The term “client” has been in vogue for several years, but it makes me think of my customers when I used to sell advertising. “Ex-psych” ignores my reality that the demons keep coming back. Some people use “psych survivor” because of the negative experiences they’ve had. I’ve had some bad experiences, but not all bad, so I hesitate to use that term. But you don’t know how many calls I get at the Consumer/Survivor Information Resource Centre of Toronto from people wanting help for broken toasters or other consumer-type problems!

I’ve recently come across the term C/S/X for consumer/survivor/ex-psych. It’s a really short form that identifies who the person is talking about, but for me, it takes out all the personhood. I don’t have the answers.

Helen Hook IS CO-ORDINATOR OF THE CONSUMER/SURVIVOR INFORMATION RESOURCE CENTRE OF TORONTO.

Along with many other former mental patients, “consumer/survivor” would be my umpteenth label (had I accepted it). I have been diagnosed bipolar, seasonal affective disorder, clinically depressed, hypo-manic, borderline personality disorder, and, they tell me, I have an organic brain injury.

Imagine introducing me at a cocktail party: “This is Sue. She’s a ‘consumer/survivor.’” Suddenly, I’m written off everyone’s A-, B- and C-lists. My phone won’t ring for months. Let’s be honest. Being next to a mental patient gives most people the willies. “Consumer/survivor” is just a disguise word for mental patient. I’ve had people stop talking to me and move away when I’ve come out of the closet about my mental illness.

I wish people would stop seeing us as monsters that lurk in the basement waiting until bedtime to attack and kill the entire family. Maybe this is why some folks are embracing the term “consumer/survivor” – it sounds so “unmonster-like.” But not only does “consumer/survivor” suck; it totally lacks sex appeal. And I happen

to be approaching that age when you desperately want to appear, sound and be sex appeal incarnate.

I believe we have to all remain individuals (you know, Sam, Trudy, Margaret and so on) and not be lumped together as “the anything.” Labelling us limits our opportunities in all aspects of life. We need assistance, not barriers.

You think I’m obsessed about society’s penchant for classifying degrees of normalcy? Surprised that my spiritual side cries out not to be separated from the rest of the herd? Scoff if you want, but mental patients were on no one’s wish lists not so long ago in Nazi Germany. And I’ve heard of mental patient bashing in my lifetime.

Please don’t call me a “consumer/survivor.” Just call me Sue.

Sue Goodwin IS A TORONTO-BASED WRITER AND ARTIST.

Whatever differences exist between psychiatric survivors and mental health consumers, our common experiences in the cracks of the psychiatric system may cement our identities and visions. During Mad Pride Week, for example, consumers and survivors re-uptake our strengths and abilities as resilient people. I’m an activist and advocate, working for a decade or more with people who experience the psychiatric system, and I’ve seen a lot of disagreement about psychiatry. Consumers and survivors hold varied, sometimes overlapping, perspectives on behaviour and how to deal with it, but these differences do not outsize our common experiences. For example, people in our community help each other despite relentless poverty, sometimes mocking the prejudice openly shown to us. Over successive generations in asylums, we’ve developed a culture of assistance and acknowledgement. Still other experiences show how institutions responding to our emotional lives may actually cause increased isolation, deprivation and even death. Tragically, such experiences of abuse are often occluded by professional and family voices seeking solutions to their own concerns.

Nevertheless, everyone can recover consumer and survivor voices during Mad Pride, held every year on July 14, the day of the storming of the Bastille, in cities around the world. I attended Pride 2005 and loved it. I was struck by the continued presence of both survivors and consumers. A survivor once asked me, “What is there for us to be proud of?” We are proud of our resilience in the face of crushing social contempt and “therapeutic” distancing. We are proud of our surviving abuses that continue in spite of revolving and relapsed systemic reforms. We are proud of our ability to engage and appreciate social differences that others find grotesque or alarming. Most importantly, we are proud of being who we are, despite what we’ve been told about ourselves. Consumers and survivors continue to rise from the ashes.

Erick Fabris WAS CO-ORDINATOR FOR THE FORMER QUEEN STREET PATIENTS COUNCIL.

Between two worlds

My prescription for culturally competent care

BY CAROLINE FEI-YENG KWOK

I IMMIGRATED TO TORONTO IN 1974 FROM HONG KONG. I had studied in the United States, but I wasn’t used to Western culture and my English was far from perfect. As a result of friction with my ex-husband and my parents, I was admitted to a hospital in 1980 and diagnosed with manic-depressive disorder. Since then, I have been admitted to various hospitals in Toronto.

Being new to Canada, I did not know much about hospitals in Toronto. What hospital was best? I was shuttled from one hospital to another. I didn’t know my rights as a patient. What was meant by involuntary admission? Or voluntary admission?

As I wrote in my memoir, *The Tormented Mind*, “Not knowing much about the rules and regulations of these hospitals, I was at the mercy of the doctors and nurses. But did they understand me as an individual? Or did they only see me as one of those new Asian immigrants? Did they carefully examine my chart and recognize my cultural difference?” It is important to understand that I’m an individual within a cultural framework. I think my diagnosis might have been different had I been Caucasian.

I was almost always seen by Caucasian male psychiatrists. Given that English is my second language and I was distressed, I must have sounded odd. Perhaps that is why they diagnosed me as they did. The psychiatrists didn’t realize that as a Chinese woman I would never confide personal information to a doctor. And I would never question medical authority. I was always intimidated during my visits. I expected a “quick fix” and I never spoke up for myself. Talk therapy was new to me.

I didn’t know the various medications – lithium, haloperidol, clonazepam – or their side-effects. And I didn’t have the courage to ask the doctors about them. I also didn’t know about admissions – what is a Form 1? A Form 3? I received little information that I could comprehend. But again, I was afraid to ask. Medical jargon confused me. My confusion made me appear more ill than I was.

Research shows that Asian women should receive lower medication dosages than Caucasians, but how many psychiatrists know this? In 1999, I lapsed into a two-week coma after a psychiatrist over-prescribed me. I needed a tracheotomy.

My mother did not know English, nor did she know much about medicine. Throughout my hospital stays, she never received professional support to help her understand my illness. Psychoeducation through a translator would have helped us cope with my illness. My mother might have been able to see my illness more positively, rather than considering it a loss of face to the family.

One admitting psychiatrist called me “manic” and my aspirations “grandiose.” I had told him that I would like to be a great Chinese-North American writer, a journalist, a professor, and that I wanted to learn French. Twenty years later, I have achieved most of my “grandiose” ambitions. I have written my memoirs; I studied at Yale University’s Creative Writing Department and have published articles in the *Toronto Star*. I have given guest lectures at several universities in Toronto. And I can speak French.

My successes give me hope. Here then I offer suggestions for culturally competent mental health services so care providers can instill hope in their clients:

Provide educational programs to ethnoracial minorities about mental illness. At the very least, this would allay their fears of psychiatrists and psychiatric institutions.

Reduce barriers to mental health care. Help ethnoracial communities to combat shame, stigma and discrimination toward people with mental health problems and build trust in mental health professionals. Develop workshops and awareness campaigns in ethnic newspapers, magazines and television programs. Build partnerships between mental health organizations and ethnoracial organizations so information reaches the targeted communities. We also need more family outreach.

TEACH SERVICE PROVIDERS CULTURAL COMPETENCE AND ANTI-RACISM. Develop training to be sensitive to the cultural and linguistic backgrounds of clients. Ask clients about their immigration experience, their feelings of being a newcomer, the role and attitudes of family in their culture. Invite immigrant consumers to present at workshops for health care professionals.

Provide funding for cultural research and programs. Health ministries and other funding bodies should fund culture-specific Research and programs.

Address linguistic and cultural barriers. Psychiatry requires verbal competence from clients. Minorities whose native language is not English feel uncomfortable expressing themselves in English to mental health professionals. Diagnostic assessments should be conducted in the client’s language. In their home countries, many clients were used to taking only medication and have never had talk therapy. We need informed interpreters.

Caroline Fei-Yeng Kwok IS AN ESL/LITERACY TEACHER AT ACROSS BOUNDARIES, AN ETHNORACIAL COMMUNITY MENTAL HEALTH CENTRE IN TORONTO.

Me and them

Keeping up appearances on a psychiatric crisis unit

BY HEMA ZBOGAR

“Areas for improvement: Uncomfortable with hospitalization.”

That’s what an occupational therapist wrote on the first of my nine days as a voluntary inpatient in the crisis unit of what was then the Clarke Institute of Psychiatry in Toronto. Now, 15 years later, I’ve accessed my health records. I carried the notes around for five weeks, too afraid to read them – it’s hard to revisit in cold, clinical detail the most painful time of your life and face the horrible revelations about yourself that might emerge all these years later. But I wanted to write about the experience, so when I finally read the many pages of notes, I was almost disappointed by their eventlessness – no big crises, no confrontations with staff or fellow patients – and no horrible revelations. I had been a model patient. So what on earth could I write about?

What emerged subtly from the notes, what in fact lay behind my “model behaviour” was the fear and internalized stigma of being a psychiatric inpatient. Who *wouldn’t* be uncomfortable with hospitalization?

Stigma isn’t always about “those people.” Those of us who are stigmatized may ourselves carry it. It’s not surprising that the admitting

psychiatrist tried to discourage me from admission, saying it wouldn’t be good for my self-esteem. But I insisted, and there are lessons to be learned from my experience. I want health care workers to read about it and understand that what they see doesn’t always reflect what we are experiencing. I provide excerpts by psychiatrists, social workers, occupational therapists and nurses from my records and compare these observations with what I was actually going through.

“Patient was bright, cooperative, smiling, denied suicidal ideation.”

“Patient became upset and close to tears during a.m. group; patient stating “ I don’t belong here.” Co-patient XX asserted patient does belong here and patient became increasingly upset.”

“Patient voiced feeling stigmatized and feels PAs (psychiatric assistants) and others who do not know her are thinking she is “nuts.”

“Eager to tell (occupational therapy) group that she is a university student when performing activity she perceived as below her capabilities.”

Reading repeated descriptions of a “bright, cooperative, smiling” patient, I wondered, could unit staff not see my distress? Only hours and days earlier I had wanted to die. But my pleasant demeanor was necessary to preserve my individuality. Yes, it was a huge relief to be in a place where I would be taken care of, but admission came at a cost – my fear of being identified as crazy – as one of “them.” So throughout my stay, I tried to separate myself from my fellow patients. I was proud to not be on medication. I made a point of paying attention to my appearance. I chatted easily with unit staff and fellow patients to show them that I was “normal.”

Out on a pass to attend a university night class, I left class early and wandered through the streets crying. Out there, people would simply think I was sad, not crazy.

Yet despite my struggle against the crazy label, I developed connections with fellow inpatients. We played ping-pong together. One woman offered me the cashew chicken her husband brought. The woman with whom I shared a room sketched my portrait. I defended a man who was being ridiculed. Maybe I was trying to ingratiate myself with staff and patients. Or maybe I was simply acknowledging our bond as human beings, regardless of who we are or how healthy we are.

Fifteen years later, I work at the very place where I was an inpatient. Many of the staff who wrote these excerpts are now my colleagues. Is it still a case of “me and them” – this time “them” being not patients, but the clinicians who were involved in my care? When I speak with these clinicians, I’m sure they wouldn’t remember me, but I can’t help feeling a bit nervous and trying extra hard to appear confident and competent and “normal.” And when I pass by the unit where I spent nine days, I sometimes wonder whether the people inside look out at me and think “I hope she doesn’t think I’m one of ‘them.’”

Hema Zbogor IS THE EDITOR OF *CrossCurrents*.

A sibling’s story

Brothers and sisters need support too

BY A FROM GRIEF TO ACTION MEMBER*

I ADORE MY YOUNGER BROTHER. HE MEANS THE WORLD to me. There isn’t anything I wouldn’t do for him if it meant that he would be happy.

My brother and I are 14 months apart in age, so we went through the same stages together. We partied together at university, experimenting with alcohol and pot. As siblings, we formed an alliance and shared in our silly and irresponsible behaviour. Together we made an invincible team, popular and busy. When I left home to study law abroad, my brother and I were sadly separated. It was while I was obtaining my degree that my brother’s illness surfaced and changed my life forever.

I will never forget the family intervention we held in the kitchen, mid-morning on a sunny summer’s day. I was the one who guessed crack cocaine. I felt such guilt as a sibling when I discovered that I was the one who survived the haze of those years unscathed. It’s like names were pulled out of a hat and I got lucky. I got to move on with my life while my brother got to enter a treatment centre. We were all so fragile

and scared and so ill-equipped. I craved knowledge and understanding and peace. I watched my parents wilt and fade. This was the hardest part of all, to see their sadness and helplessness.

The easiest way I can explain the dynamic of my family is to say that it is like a triangle. In the right-angle corner is me; I have one kind of relationship with my parents and one with my brother. But it is the relationship between my parents and my brother, the hypotenuse, that is the most difficult to watch. I remember one Mother’s Day when I called to wish my mom a wonderful day and to say flowers were on their way. All my dad could say was that my brother had called from jail in Iowa. Jail in Iowa and I, a thousand miles away. How was I to comfort them and who was there to comfort me?

Discussing an addiction is a difficult thing, especially at a young age and in a peer group and society where overindulgence is socially acceptable. I had had to alter my own beliefs and ideas of addiction and was not yet ready to fight against the stereotypes of others. It was a lonely and confusing time. Every time I called home, the updates grew more and more depressing. The conversations were always about him: my brother, the addict.

During my brother’s relapses, our relationship seemed to collapse, and during times of recovery, we made the effort to rebuild what had been lost. This continuous rebuilding is what took the most strength and was the most exhausting. After the tears dried, I spent hours listening and trying to understand and forgive what he had done. The forgiving was always faster for my parents. They carried him endlessly through relapses and recoveries. As time went on, the debates between my parents and I on how to deal with my brother grew sharper and louder. He was taking up so much time, money and energy. I did not have to forgive him as quickly or support him as readily because he was not my child. As a sibling you can keep your distance, but my parents felt that distance and it was hard on them. In the end I would always relent and let my brother know that my love and support would always be there for him. It just took longer sometimes – to tell him, to see him, to hug him again.

This past summer, my brother performed the ceremony at my wedding. He was four months clean and on controlled medication. I was really seeing him for the first time. In his speech, he thanked me for being a key element of support in his rough road to recovery. Little does he know the impact he has made on my recovery. My brother, my hero.

WHAT SIBLINGS WANT PARENTS AND SERVICE PROVIDERS TO KNOW

Based on a discussion among siblings of people with disabilities, the Sibling Support Project in Seattle, Washington, developed 20 recommendations for families and service providers, including:

- **Respect siblings’ right to their own lives.** Parents and service providers should not make assumptions about responsibilities siblings may assume.
- **Acknowledge siblings’ concerns.** Brothers and sisters may experience ambivalent emotions about their siblings’ needs. Address these feelings as they evolve.
- **Expect typical behaviour from siblings.** Conflict among siblings can be a beneficial part of social development. It is more likely to result in feelings of guilt when one sibling has special needs But siblings should be allowed to sometimes misbehave, get angry and fight with one another.
- **Parental attitudes are important.** When parents seek support and information, they model resilience and healthy attitudes and behaviours for all their children.
- **Include siblings in the definition of family.** Many health care and social service agencies claim to offer family-centred services but overlook sisters and brothers.

Source: www.thearc.org/siblingsupport
HEMA ZBOGAR

*From Grief to Action ADVOCATES IMPROVEMENTS IN THE LIVES OF PEOPLE WITH SUBSTANCE USE ISSUES, AS WELL AS THEIR FAMILIES AND FRIENDS.
Reprinted from *Visions: BC’s Mental Health Journal* (Spring 2004)

What do men want from support groups?

BY HOWARD FLUXGOLD

WHEN I WAS ASKED TO WRITE ABOUT WHAT MEN WANTED from a support group, I was truly dumbfounded. I didn't understand the question. My jaw dropped, my eyes glazed and I spluttered, "I dunno what men want."

Why should men be singled out? What specific needs could they possibly have?

As I pondered these questions, I recalled my Family-to-Family course with three men and 10 women. One day in class, when I was the only male in attendance, I had noted the lack of men and wondered aloud if anyone knew why. There was silence in the room. Quietly, the woman beside me confided that her husband didn't want anything to do with mental health or mental illness. She was on her own, trying to learn about the ravages of schizophrenia to help her teenage nephew living in the Okanagan.

Maybe there was something I didn't understand.

I started wondering whether men approached this tragedy differently from women. In the class, I remembered that whenever there was a call to arms – a suggestion that we demand better services from the government – the men (all three of us) always volunteered. We were joined by a few reluctant women. Maybe there are differing needs, I thought.

When the class ended, I started going to a support group, but once again it was almost all women who attended. The group arranged interesting and informative speakers. The more you know about mental illness and the mental illness system, the more you can cope with both; and in a way, that is support. Knowledge is power. Still, I was one of only two men.

To fill in the time when speakers were unavailable, our group leader (a woman) asked us to tell our stories. The stories were similar, however. They were sad tales of how these women had been victimized by the system.

The stories taught me mostly that things could get worse, that misery loves company and, what I already had figured out: if you sit there and take it, you're sure to get it.

For the women who came regularly, I think it was some sort of support in that they could complain to someone and have a social hour or two with likeminded friends. For me, it was no support at all. Frankly, I don't need or want support on a daily, or weekly basis.

I don't want to keep repeating the same story of broken dreams, bizarre behaviour and bureaucratic incompetence.

In all the support groups and classes I have attended over the last 18 months, I have received information on how the illness works, but never on how the system works. After almost two years, I'm not sure how someone is involuntarily committed or why. I don't know why or how hospitals decide to release their mental patients, because they are obviously not well when they are discharged. I don't know how an extended leave order works, and I strongly suspect that those working in the system don't either. I don't know how the legal system works when it deals with a mentally ill person. I don't know what a disability allowance is, or about the different kinds of supported housing – like what a SIL is [supported independent living program] or what a super SIL is [program for individuals with intensive housing support needs]. I have no literature on any of this. Maybe no one really knows. Maybe things are changing so rapidly that no one can keep track of which service has been dropped or morphed into something else.

If I were king and could wave my magic wand, I would form a support group of socially compatible people. It would meet 10 times a year – never in the summer. The meetings would provide information on how the system works, as well as how the illness works. They would be designed to exchange experiences and information. The group would decide – and they would be asked their preference. My first speaker would be an expert on how men handle mental illness, someone who could tell us why there are so many who behave like ostriches.

I would also create a crisis help-line where group members could phone one another for advice and support when they need it most. My experience has been that in a crisis, there is no one to turn to for advice. You muddle along as best you can until someone provides you with the needed information. I would suggest that we play golf, go bowling, or skiing or hiking – do some male bonding.

In the meantime, I haven't gone to my support group since the winter. I have been lucky that my extended health benefits include 12 visits each year to a psychologist. I find it very supportive going once every two months to discuss whatever is on my mind. I get his viewpoint and expertise, sometimes about myself and sometimes about schizophrenia or the system. He also says I can call him in a crisis, which is a great comfort.

Right now we're between crises.



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Reprinted from *Visions: BC's Mental Health and Addictions Journal* (Summer 2004)

Beyond therapeutic models

Do therapists know what clients *really* want?

BY KATE KITCHEN

IF IT IS TRUE THAT "LIFE IS WHAT HAPPENS TO YOU WHILE you're busy making other plans," as John Lennon said, then it might also be true that therapy is what happens while the therapist is busy following various therapeutic models.

According to Scott D. Miller and Barry Duncan's web site, TalkingCure.com, four weighed factors account for change in psychotherapy: extratherapeutic factors – 40 per cent; collaborative relationship – 30 per cent; placebo, hope, expectancy – 15 per cent; and structure, model, technique – 15 per cent.

Yet most psychotherapists focus on refining skills in their favourite therapeutic model of practice. Miller and Duncan report that since the mid-1960s, the number of therapy models has grown from 60 to more than 250. I have studied many of these models and teach a few.

Miller and Duncan are not trying to say that psychotherapy does not work – they can cite many studies saying that it does – but they do think we focus too much on particular differences among therapies. They suggest that various approaches work about equally well, and that it is the similarities, rather than the differences, that make therapy effective. Which takes us back to the four factors.

Miller and Duncan are also not saying that we should ignore models and techniques. But they do suggest that in discussion about what works in therapy, too much attention is paid to the elements that interest therapists, like models and techniques, and not enough to the other partner in the therapeutic process – the client. By focusing on what Miller and Duncan call the "client's theory of change," therapists can tap into those extratherapeutic factors that make up 40 per cent of change in therapy.

In a section on client competence in their 2000 book *The Heroic Client*, Miller and Duncan encourage therapists to cast the client in the role of "primary agent of change. They suggest that therapy is most successful when clinicians pay more attention to the client's ideas about what works best for them and then follow the client's lead in, letting the choice of techniques be guided by the client's wisdom.

Miller and Duncan are not suggesting that client-focused care is not already happening in various therapies; rather, they think the different therapies may be working more, not because the model or technique is particularly effective, but because the clinician matches the client's idea of what is helpful. Miller and Duncan shift the focus from differences to similarities because they claim it is the similarities that account for effectiveness when models of change in therapy are researched.

Miller and Duncan also suggest shifting the view toward what works in therapy to the client's point of view – the client's theory of change should guide the therapist's work, including decisions about which models and techniques might be helpful. Therapists have many well-developed theories about mental health and addiction and about how people change – biological, psychosocial, behavioural, psychodynamic models and so on; but Miller and Duncan suggest that therapy works best when the therapist focuses on the client's theory of change. When therapists ask and listen for what their clients believe to be the cause of their problems and how they believe they will get better, the direction can tailor therapy to the individual client. Not only will the techniques be tailor-made, but the other factors affecting outcome will also be enhanced.

Too much attention is paid to the elements that interest therapists, like models and techniques, and not enough to the other partner in the therapeutic process – the client.

The therapeutic relationship (accounting for 30 per cent of the outcome) is enhanced when clients feel understood and respected. Miller and Duncan report that therapists can listen for those under-appreciated extratherapeutic factors – accounting for 40 per cent of change – as well. In fact, they suggest digging for more information. A therapist whose antenna is out for that unseen 40 per cent will be listening for references to people and places and situations that the client looks to for support, inspiration and learning. Regarding the client as the very heart of change gives psychotherapy the collaborative quality that can allow a client who is suffering to take steps toward healing and happiness. It can also give therapists the gift of being allowed to observe the courage of their clients in taking those steps.

John Lennon's quote is a reminder that we get so caught up in our ideas of things and how they should be that we forget to actually notice how they are. This wisdom can also serve therapists. In *The Heroic Client*, Miller and Duncan state, "The different schools of therapy may be at their most helpful when they provide therapists with novel ways of looking at old situations, when they empower therapists to *change* rather than make up their minds about clients" (p. 58).

Kate Kitchen IS AN ADVANCED PRACTICE CLINICIAN IN THE MOOD AND ANXIETY DISORDERS DIVISION AT THE CENTRE FOR ADDICTION AND MENTAL HEALTH IN TORONTO.



Common questions about intimate relationships and people with mental health issues

BY HEMA ZBOGAR

This Q&A is based on an interview with Dr. Janos Botschner, chief researcher with the Canadian Mental Health Association (CMHA), Waterloo Regional Branch and Wellington-Dufferin Branch in Ontario. Botschner is involved with the People Acquiring Intimate Relationships (PAIR) project, which helps people with serious mental health issues pursue personal relationships.



Describe the PAIR project.

In 2003, CMHA, Waterloo Regional Branch received a three-year grant from the Ontario Trillium Foundation to develop a service to support people with significant mental health issues who wanted to pursue intimate relationships. During the development phase, we did in-depth interviews and focus groups with people with significant mental health problems to find out how they think of intimacy and its role in their well-being. We piloted the service in Waterloo Region and Wellington and Dufferin counties. We are now about to implement the service components in London, in partnership with CMHA, London-Middlesex, and in Toronto, with the Centre for Addiction and Mental Health. In the past year, PAIR has also carried out a self-help education series across Ontario, focusing on various aspects of intimate relationships.

What are some of the relationship myths/stereotypes about people with mental health issues?

One myth is that people with mental health issues can't or shouldn't get involved intimately with anyone. This often comes from focusing on deficits like lack of motivation or on medication side-effects like impotence. Others believe that people with mental

health issues can't handle relationship stresses and that a break-up will provoke a crisis. Still others think people with disabilities shouldn't reproduce because they wouldn't be able to care for their children or that the children would inherit the problem.

Many service providers don't ask about intimacy because they assume it isn't relevant or that they need special training to explore the topic. If they do ask about relationships, they tend to focus on friends and family, not intimacy and sexuality. But people tell us they want to discuss these issues with their case managers, social workers and psychiatrists. Questions about the impact of medication on sex drive and performance can be as important as how it affects appetite or concentration.

Do people with significant mental health issues have different relationship needs than other people?

Needs vary. But the literature tells us a lot about the impact of psychiatric disorders on people's ability to engage with others. For example, some people benefit from having casual acquaintances that allow them to withdraw from time to time. Because they may have few friends and family, they may struggle to meet people in ways that promote the development of intimate relationships. People with histories of abuse may be reluctant to consider an intimate relationship with someone of the same gender as the perpetrator. And medications can represent a trade-off between psychological and sexual function. Some people we've spoken with had given up on the idea of ever resuming sexual activity because of medication side-effects.

Other challenges involve how people with mental health issues are treated by society. Defining a person's entire identity in terms of an illness label is stigmatizing and can lead to low self-worth and motivation, along with reduced access to valued resources, and risk of poverty and homelessness. Imagine having someone over for a date if you live in a cramped space or shared accommodation? Where would you even get the money to spruce up your wardrobe, take someone to a movie or go out for a meal?

Why are intimate relationships important?

Our experience at CMHA over the last 10 years suggests that personal relationships can be a key factor in recovery success. Because of social isolation, stigma and disruptive periods of hospitalization, people with significant mental health issues often find it difficult to develop and maintain personal relationships. Helping them develop meaningful relationships can enhance a quality of life to which everyone is entitled. In our research on the role of relationships within the experience of recovery, my colleague John Sylvestre at the University of Ottawa and I argue that along with having a home and a meaningful occupation, significant personal relationships constitute a foundation for recovery, as well as being a social determinant of health in their own right.

What have you learned about the intimate relationship needs and goals of people with serious mental health issues?

We're learning that engagement or re-engagement with the world of intimate relationships is as variable as the people involved. But common features are emerging. One is that a person may make rapid progress in some areas, for example, meeting people online, going on dates, but may be very cautious and unsure in other areas, particularly around readiness for or interest in sex.

People involved in PAIR are experiencing benefits in three areas: relational experiences with others; opportunities to express different aspects of themselves; and self-awareness and motivation, developing a sense of personhood that goes beyond the label of mental illness and engaging in more self-advocacy with health care providers.

Health care providers need to help their clients engage with the world of relationships, which involves viewing and supporting clients as whole persons. PAIR participants are showing us that this is a central feature of intimate personal relationships. It's also a useful reminder for participants in all kinds of relationships that involve intimate disclosures.

For more information about PAIR, contact Janos Botschner at botschnerj@op-i.ca or Don Roth at CMHA, Waterloo Regional Branch, at rothd@cmhawrb.on.ca.

Homework in psychotherapy: Creative ways for getting it done

Homework (by any name) is still homework and is an integral part of psychotherapy. In this day of evidence-based care, time-limited, manualized therapies are popular. Typical treatment manuals are disorder-specific and include a section on homework. Years of clinical experience lead us to the obvious – effective homework can positively influence client outcomes in therapy. Much of my understanding about the successful use of homework in therapy has come from my own mistakes with clients. I have probably encountered most of the “homework obstacles” – sending clients home without a clear understanding of the homework, not writing down homework, not assessing client's commitment or resources for completing the work and not reviewing it when the session agenda takes up the entire therapy hour. Having learned the lessons in *Using Homework in Psychotherapy: Strategies, Guidelines and Forms* the hard way, I wish it had been available years ago.

This is the first book dedicated to designing, implementing and evaluating homework in therapy. Author Michael Tompkins has provided a comprehensive, clearly written text with utility for a broad audience by using a combination of specific strategies, scripted role plays and completed sample forms. Additionally, the appendix is replete with blank sample forms for clinicians.

The book begins with a general introduction to the benefits of therapy homework. It covers general factors that influence clients' abilities to complete homework such as features of the homework task, the therapist's manner and intrapersonal client factors. Tompkins then identifies five broad therapeutic goals of homework: 1. increasing awareness, 2. scheduling activities, 3. improving emotion regulation, 4. interpersonal effectiveness, and 5. testing assumptions. The text is completed with specific chapters on addressing homework noncompliance and working with special populations.

The chapter on obstacles to compliance addresses therapists' beliefs and attitudes as potential obstacles to the use of homework and encourages therapists from all treatment orientations to try it out. The book also provides recommendations for reaching unique populations such as adults with severe depression and anxiety, adolescents, older persons and couples.

A chapter on increasing awareness identifies the goals of increasing client awareness of the problem and assessing awareness and understanding of the nature and extent of the problems, using monitoring forms and psychoeducation. Shared understanding facilitates development of other essential aspects of therapy, including therapeutic alliance, and increases the likelihood of homework compliance.

The section on scheduling activities addresses increasing activity and pleasure and using homework to improve functional status, increase follow-through on goals and decrease suicidal thoughts and impulses. Breathing strategies and relaxation techniques are provided to deal with intense emotions, as well as exacerbation of mood episodes in bipolar disorder and acute episodes of depression or chronic mental illness. Suggestions for enhancing interpersonal effectiveness include assertiveness training, basic communication skills and strategies for changing problematic interactions. The chapter on testing assumptions provides suggestions for examining beliefs related to anxiety, depression, anger and interpersonal relationships.

The most creative and clearly explained homework will be of no value if the client does not complete it. This manual addresses non-compliance in a systematic manner; aspects of the assignment, features of the homework task and therapist manner are examined before targeting client factors. Tompkins suggests assessing each client's potential for homework noncompliance by examining beliefs and expectations about homework, level of skill and knowledge, history with completing homework and social, cultural and physical restraints on compliance. Reading the many suggestions in this chapter will fill new therapists with exciting potential for trouble shooting noncompliance. More experienced clinicians will enjoy Tompkins' ability to get the creative juices flowing to overcome a therapeutic impasse.

Using Homework in Psychotherapy: Strategies, Guidelines and Forms. Michael A. Tompkins. Guilford Press, New York, 2004, 285 pp., \$35US.

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SHEILA LACROIX

YOUR STORY, MY STORY, OUR STORIES

The Internet has opened up opportunities for people affected by addiction and mental health issues to share experiences and have a presence, a voice and sometimes even a face. Many health consumer organizations make personal narratives a part of their web presence.

HereToHelp (www.heretohelp.bc.ca) by BC Partners for Mental Health and Addictions Information, features a monthly “My Experience” and provides an “Experiences” page with a collection of personal stories organized by type of mental health or substance use issue. Individuals are invited to submit a personal story. Many are reprinted from the organization's quarterly journal, *Visions*, which is available online.

The Moods Magazine web site (www.moodsmag.com) is another source of personal accounts. The site features a link to submit a personal story and a “Your Stories” selection. One personal narrative is provided by a well-known person, former hockey player Ron Ellis.

Schizophrenia Bulletin (<http://schizophreniabulletin.oxfordjournals.org>) is unique as a scholarly journal in that since 1979, it has had a tradition of including a feature entitled “First Person Accounts,” in which clients, family members and others have an opportunity to share stories about the impact of mental illness on their lives. The full articles are available online only to subscribers.

Ontario doesn't *need* a treatment advocate – we already *have* them

DAVID SIMPSON

It is encouraging to see discussion regarding advocacy in the mental health system in Ontario and the recognition that it is an essential and integral component of care and treatment. Unfortunately, Dr. Richard O'Reilly's column in the summer issue of CrossCurrents failed to recognize the full range of services provided by the Psychiatric Patient Advocate Office (PPAO), or its contribution to the mental health system in Ontario. We provide much more than just "rights-based" advocacy. Every member of our community has been touched by mental illness and the staff of our office are no different.

For the past two decades, Ontario has been a leader in providing independent advocacy and rights advice services to inpatients in the current and divested provincial psychiatric hospitals. But Ontario needs to take the next step and extend these rights protection services to all individuals with mental illness, regardless of where or from whom they receive their care and treatment. Equitable access to services is essential if we are to support all individuals with a mental illness in their quest for wellness and recovery.

The PPAO was established in 1983 as an arms-length program of the Ministry of Health and Long-Term Care to protect the civil and legal rights of inpatients in the 10 current and divested provincial psychiatric hospitals. The PPAO also provides rights advice services at more than 50 general and specialty hospitals. It provides more than 18,000 rights advice visits annually and addresses more than 3,000 instructed and non-instructed advocacy issues and more than 75 local and provincial systemic advocacy issues. The PPAO website (www.ppa.gov.on.ca) receives more than 500,000 hits annually, illustrating the thirst for information regarding patients' rights and mental health legislation in Ontario.

We agree with many of the issues O'Reilly highlighted. A lack of hospital resources (i.e., beds) often results in clients being denied admission when they clearly meet the criteria for civil commitment, or being discharged prematurely as a "cost savings" measure or to make a bed available for another patient. Others are languishing in jail awaiting a hospital bed, while countless

others are disempowered by the devastating effects of stigma and discrimination associated with mental illness. Patients and/or families and community supports may reach out for support from the hospitals, but that support is often sadly lacking. Many individuals have reached out for help only to be turned away. Would David's story that O'Reilly recounts have ended differently if there had been sufficient resources and an available bed?

We agree with O'Reilly's assessment that "the evidence that we are failing to provide a basic level of care is all around us." But it isn't all negative. We see treatment teams and individuals doing great things and providing quality care while developing very caring and personal relationships with their clients. Resources are required to support and foster a quality and caring mental health system.

Increasingly, on their clients' instructions and behalf, PPAO patient advocates are involved in advocating admission to hospital, the prevention of premature discharges, the right to be actively involved in formulating care plans, and access to community resources and supports. Patient advocates do assist clients in ensuring their rights and entitlements are protected, but they also frequently support clients in restoring communication with treatment teams and service providers. It is not uncommon for advocates to help clients broker time with their psychiatrists, whose caseloads are stretched to the limit. Our clients want to be involved in all decisions that affect their care, life and treatment, and to be treated with dignity and respect while having choices and options and having their decisions respected. Experience has shown that independent advocacy and rights advice services enhance quality of care and life of patients, which leads to improved outcomes.

The PPAO believes that the current mental health system in Ontario is in urgent need of reform and revitalization. In many cases, the mental health system is not meeting the needs of clients and families. It is not providing the individualized care and treatment that are vital to supporting individuals in their quest for wellness and recovery.

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



There are many success stories, but there are also many stories with unsatisfactory and sometimes tragic endings. Many of the tragedies could have different endings if we put the "care" back in mental health care and make every effort to support people when they are at the low point of their illness. We must learn from the failures and create a system in which the individual, not a lack of resources, becomes our primary focus.

Does Ontario need a treatment advocate? No. There are many treatment advocates including patients, families, physicians, other health practitioners and community agencies. What we need is a system that is co-ordinated, seamless, accessible, responsive to individual need and consumer-focused and consumer-centred. It must provide access to timely care and treatment; a re-dedication to patients' rights, options and choices; and the hospital and community-based supports and services necessary to support recovery and re-integration into the community. We must think of a "cradle to grave" strategy that supports people in all life stages, should they require access to mental health supports, services or treatment. Currently the "system" is fragmented and disjointed.

A society is often said to be judged by how it treats its most vulnerable citizens. Will history be kind to us in assessing how we have treated individuals with mental illness, or will we be found wanting? Let's take action now by creating a mental health system that is grounded in consumer involvement, compassion, respect and acceptance, and that receives adequate resources to support every individual with a mental illness in the quest for wellness and recovery.

David Simpson IS ACTING DIRECTOR OF THE PSYCHIATRIC PATIENT ADVOCATE OFFICE.