CJNR 2003, Vol. 35 N° 1, 89–93

Happenings

Mental Health and Addictions: Renewed Hope for Better Care

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Examination of the care needs of individuals suffering from mental illness and addictions shows that as many as 75% of the people who need care receive none at all (Ontario Ministry of Health, 1990). Further, about 20% of the general population in Canada are afflicted with mental illness or addiction in any given year, and 3% have severe and persistent disablement (McEwan & Goldner, 2000; Offord et al., 1996). This figure is even higher amongst those in diverse ethno-cultural communities who face not only high levels of stigma but also language and other cultural barriers (Garfinkel, 2002).

In terms of addictions, there are many devastating effects. One in 10 adults reports problems with drinking, and in 1995 more than 6,500 Canadians died as a result of alcohol use, while over 80,000 were hospitalized for alcohol-related health problems (Canadian Centre on Substance Abuse [CCSA], 1999). The health-care cost of alcohol in Canada is 2.7% of GDP, 30% to 90% of people receiving alcohol/drug services have a concurrent disorder, and 65% of people receiving mental health services have a concurrent disorder (Murthy, 2001).[1]

Smoking is also a large factor in mortality in Canada; one in six deaths is attributed to smoking (CCSA, 1999).

The *Canada Health Act 1984* proclaims that protecting, restoring, and promoting the physical and mental well-being of Canadian residents and facilitating reasonable access to health services, without financial or other barriers, is a primary objective (c.6 s3). The above statistics make it abundantly clear that the objectives of the Act are still far from being realized. Since the early 1990s, the Province of Ontario has made a concerted effort to direct comprehensive services to those who are most in need of mental health and addictions care. The principles underlying the mental health reform system and policy development in Ontario include: creat-

[1] Concurrent disorder refers to having both a mental health problem and an addiction problem.

ing a system in which the consumer is at the centre; tailoring services to consumer needs, with a view to improving quality of life; linking and coordinating services so the consumer can move easily from one part of the system to another; and basing services on best practices. One of the most important components of the government's operational framework is the notion of shared service models of care and a comprehensive continuum of services (Ontario Ministry of Health, 1999). In this article I will attempt to illustrate that the commitment of the Centre for Addiction and Mental Health to the health needs of the people of Ontario is supporting the principles of mental health reform and providing care for those who suffer the effects of mental illness and addictions.

The Centre for Addiction and Mental Health, CAMH (formed in 1998 through the successful merger of the Addiction Research Foundation, the Clarke Institute of Psychiatry, the Donwood Institute, and the Queen Street Mental Health Centre), is the largest mental health and addictions facility in Canada. Here, clinicians, researchers, clients, and many other stakeholders are brought together to provide focused, client-centred care, with a strong commitment to developing new research and practice initiatives that have implications for population health.

Not only is there a responsibility for treatment, research, health promotion, and education, but there is also a need to convey the complexities of mental illness and substance abuse, the difficulties that patients face, and the urgent need for advances in basic and clinical sciences. Of utmost importance is the need to convey the necessity for advocacy regarding housing, employment, and income support.

The merging of mental health and addictions resources has brought models of care to the fore and facilitated the development of new understandings. For example, we have developed a best-advice paper on what is effective in terms of immediate and long-term help for youths with alcohol and drug problems (Centre for Addiction and Mental Health, 1999). In terms of new models, our approach to addictions care includes the principle of harm reduction, and we are now better able to understand and provide care for those who have combined pathogeneses. As another example, among women with depression, substance-use problems, and anorexia nervosa, the rate of sexual abuse is 2.5 that among control women. As a result of the merger, we are able to offer treatment for these problems.

We are offering care that is tailored specifically to the needs of those with mental illnesses and addictions. For example, our Addiction Medicine Program includes methadone maintenance treatment, a nicotine dependence clinic, medical withdrawal management, and pain and chemical dependency consultation. Our addictions assessment and

general treatment program offers services for impaired drivers, day and residential services, and treatment programs for special populations. These services include the Rainbow Service for lesbian, bisexual, gay, and transgendered clients; OPUS 55 for older persons; a court diversion program; and services for women, youths, and families.

We have developed a screening instrument for clients with co-occurring addiction and mental health problems, to help us determine who needs specialized assessment. These clients are seen within CAMH's Concurrent Disorders Program, which offers several specialized treatment clinics: the Dialectical Behaviour Therapy Clinic for Borderline Personality and Substance Use Disorders, the Anger and Addiction Clinic, the Eating Disorders and Addiction Clinic, and the Integrative Group Psychotherapy Clinic. There are also services for trauma and addiction and support groups for people with severe, persistent mental illness and substance-use problems. Also worth noting is the Problem Gambling Service, which sees approximately one quarter of all those in Ontario who seek specialized treatment for this emerging issue.

After 4 years of operation, CAMH has gained much ground. Care delivery has increased by 25%, so that we are now serving 21,000 clients per year, while our research budget has doubled to $30 million per year.

In terms of nursing's contribution to the care we are providing, we have developed a number of projects to increase the capacity of programs to deliver care to those with mental illness and addictions. We are currently participating in the Registered Nurses Association of Ontario's pilot project for Best Practices Guidelines for Smoking Cessation. Eventually, the guidelines will improve the ability of nurses across the province to understand the process of smoking cessation and will increase their knowledge base and confidence in providing client-centred care. This project has completed the surveys pre- and post-training for smoking cessation and we are working on incorporating skills into daily clinical practice, since large percentage of our clients smoke with little being done to help them.

An initiative led by Caroline O'Grady, a member of our advanced-practice nursing staff, is designed to provide practitioners with comprehensive skills in concurrent mental illness and substance-use disorders. Currently we are offering training workshops to increase staff knowledge, competency, confidence, and skills in the identification, assessment, and treatment of co-occurring schizophrenia and substance-abuse/dependence disorders.

Funding is being sought for two other projects — one on the development and implementation of a support/psychoeducational group for family members of individuals with concurrent mental illness and sub-

stance-abuse disorders, and one on partnering with families on a program of family-focused support and education.

CAMH is involved in many partnering initiatives. We collaborate on a shared-care model with hostels and administer an aboriginal health program. We are also partnering with schools around addictions programs and are providing employment support to clients.

We are also moving ahead with electronic assessment tools. For example, The Roster of Electronic Assessment Tools (TREAT) is a Web-based program that has a number of assessment tools. It not only gathers data, but also calculates scores and provides immediate results. This means that clinicians get immediate feedback — they can see results of a single assessment, or see change over time. This tool includes both mental health and addiction assessment instruments.

Since our firm belief is that the context of care is as important as the care itself, we are very excited about our site-redevelopment project. By redeveloping the site we will be able to break down the barriers facing people as they seek care, and ensure that care, prevention, research, and education are inextricably linked. Further, we will link up programs and other providers in order to improve access to the best possible care as close as possible to the place where it is needed. Therefore, our new model of care will help connect a greater range of communities and enable access to culturally competent clinical services in the field. This model is related to our plans to create a health-care, research, and education village at our Queen Street site as part of our redevelopment plan. By de-institutionalizing the institution itself and replacing it with an "urban village," with public streets, sidewalks, and private green spaces, we will create the conditions of a real community setting that is familiar to those who seek treatment. As I cannot really describe all the components of this village here, I invite readers to view the concept more fully at www.camh.net

This article has provided an overview of the many initiatives of the Centre for Addiction and Mental Health. We are following the principles of expert knowledge development in the field and the *Making It Happen* document (Ontario Ministry of Health, 1999) as we work to improve the lives of those who are suffering from mental health and addictions problems. Our clients deserve nothing less.

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