



**Alberta Health
Services**

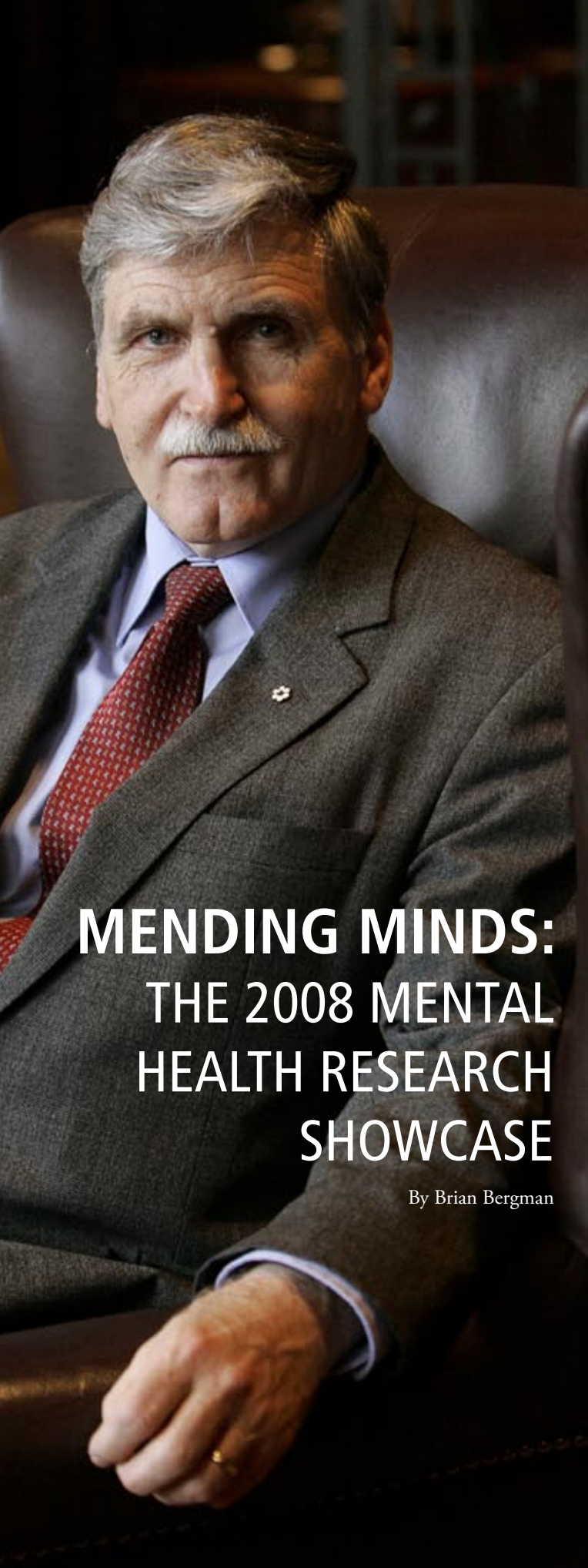
Alberta Mental Health Board

Mending Minds

In partnership with BC Mental Health and Addiction Services and the Norlien Foundation, the Alberta Health Services - Alberta Mental Health Board hosted the fourth Mental Health Research Showcase in Banff in the fall of 2008. This conference brings together world renowned researchers with practitioners, consumers and advocates from across Alberta and Canada to advance mental health.

Highly respected and popular Canadian Lt.-Gen. the Hon. Roméo Dallaire and Rwandan genocide survivor Denyse Umutoni raised awareness that mental illness affects anyone. Their personal stories shed light on why mental health should matter to us all.

Next showcase dates are January 27th-29th, 2010.



MENDING MINDS: THE 2008 MENTAL HEALTH RESEARCH SHOWCASE

By Brian Bergman

In the spring of 1994, Romeo Dallaire witnessed first-hand one of the most horrific acts of modern history—the slaughter of more than 800,000 Rwandan civilians by their fellow countrymen in the space of 100 days. As commander of the United Nations Assistance Mission for Rwanda, General Dallaire tried in vain to focus world attention on the unfolding genocide. The United Nations rejected General Dallaire’s pleas for sufficient troops to quell the violence. Instead, the U.N. cut his force to a mere 500 soldiers. The general and his small contingent persisted and together they are credited with saving thousands of lives. But that was scant comfort as they helplessly watched the murder, rape and mutilation of hundreds of thousands of innocent Rwandans.

General Dallaire returned to Canada bearing the latent symptoms of a psychological injury, later diagnosed as Post-Traumatic Stress Disorder (PTSD). After years of trying to bury himself in his work, Mr. Dallaire, who had been promoted to Lieutenant-General, experienced a mental collapse in 1999. “I crashed,” is how he describes it now. “For seven months, I couldn’t even talk or read.” [see Q&A with Romeo Dallaire, page 12]. He was medically released from the Canadian Forces in April, 2000.

With therapy and medication, Mr. Dallaire got better. In 2003, he released his account of the Rwandan genocide, *Shake Hands With The Devil: The Failure of Humanity in Rwanda*. Two years later, he was appointed to the Canadian Senate. Mr. Dallaire remains an outspoken advocate on behalf of children affected by war and on the need for the military to deal compassionately with Canadian Forces personnel who struggle with PTSD.

It was in the latter capacity that Mr. Dallaire came to Banff as a keynote speaker at the fourth annual Mental Health Research Showcase. Hosted by Alberta Health Services, the Showcase conference brings top-flight mental health researchers and clinicians from across Canada and around the world. For three days, the experts present their latest research findings and interact closely with Showcase delegates, including front-line health workers, policymakers and mental health consumers and their families.

Mr. Dallaire told delegates that PTSD is far from a new affliction for military personnel. For decades, however, it went unrecognized and unacknowledged. Many Canadian veterans returning from the two World Wars and the Korean conflict exhibited symptoms commonly associated with what we now call PTSD, including recurring nightmares or flashbacks in which sufferers relive the stress and horror of combat as well as an emotional numbing and withdrawal from friends and families. Feelings of extreme guilt are also common.

Mr. Dallaire recalled, as a young officer, being in a military mess hall during “happy hour” and how he and some friends cajoled an older Major into showing them his war wounds. “He had been shot through the cheeks of his buttocks,” said Mr. Dallaire, “and we were impressed.” At the same time, there were a few other veterans sitting at the back of the bar. “They were not very communicative,” said Mr. Dallaire. “They seemed sullen and often angry. They had been injured also. But it wasn’t an injury we could see or comprehend. It wasn’t an ‘honorable injury.’ It was an injury of the mind. We didn’t want to talk to them—and they didn’t want to talk to us.”

In the post-Cold War era such injuries are, if anything, on the increase. Mr. Dallaire attributes this to the ambiguity and moral complexity of modern warfare and peacekeeping missions, which often forces military personnel to make some impossible choices.

Mr. Dallaire gave an example from his Rwandan experience. A U.N. patrol was taking stock of killings by Hutu extremists in a village when it discovered about 100 people still alive, huddling in a chapel. The patrol sergeant called headquarters about moving them to a safe place. As he did so, about 30 youths opened fire on his soldiers and the people they sought to protect. Then, from the other side

of the village, about 20 girls, some visibly pregnant and others as young as nine years old, served as a human shield behind which other child soldiers shot at the patrol and the civilians. Observed Mr. Dallaire: “And so the question is: what does the sergeant do? Do you kill children who kill?”

In the end, the order to fire was issued. Mr. Dallaire went on to describe the effect on one member of that patrol. Despite later receiving medication, therapy and other support, Mr. Dallaire says there are days when the young man “all of a sudden hears the sergeant giving the order to fire, he feels his finger going to the trigger, and he sees—digitally clear and in slow motion—the cartridge flying out and, through the gun-sight, sees the head of a child exploding. Was that the right answer? In terms of tactics, you have the right to defend yourself. But how many times can the father of two or three kids shoot other kids? How many times can he handle that until he becomes a casualty?”

One of the insidious things about PTSD is that it often takes years to surface. “It was four years before I crashed,” said Mr. Dallaire. “Of the 12 Canadian officers sent to Rwanda to reinforce me after everyone else had abandoned us, nine have fallen to PTSD—the last one just two years ago. Recently, the first of our group committed suicide, 15 years after the mission to Rwanda ended.”

“HE SAVED MY LIFE”

In the four-year history of the Mental Health Research Showcase, there had never been a speakers’ introduction quite like this one. Denyse Umutoni, a survivor of the horrific Rwandan genocide of 1994, came to Banff to introduce Romeo Dallaire, whom she described as “the one man who stood up against unspeakable violence to save thousands of lives in Rwanda.” In fact, Ms. Umutoni credited Mr. Dallaire with saving her own life—not just once, but twice.

Ms. Umutoni, who now lives in Calgary, told conference delegates that, after losing her parents, brothers and sisters to the genocide, she had been raised by her cousin. The woman who became her guardian had escaped by chance and was herself saved by the United Nations peacekeeping mission Mr. Dallaire commanded in the summer of 1994.

Fast forward 13 years. In the fall of 2007, Ms. Umutoni went to the Canadian embassy in Kenya seeking a visa to visit Canada. The immigration agent at the embassy told her that, “just because Romeo Dallaire invited you, we are giving you the visa, so you are lucky.” Barely one month later, her cousin was murdered in Rwanda after testifying in Ms. Umutoni’s place against those who had killed their relatives during the genocide.

“It may be hard for many of you to understand or believe,” Ms. Umutoni told a hushed conference hall, “but in some places in this world people develop a strong sense that death is looking for them. I myself did not believe this until my cousin was murdered. I became a survivor for the second time in my life—and I owed this to Romeo Dallaire.”



Denyse Umutoni

Mr. Dallaire said the military has made great strides recently in dealing with PTSD. Troops are now instructed about the risk of stress-related injuries before seeing combat and much more is being done to identify the afflicted and get them the help they need. One particularly effective initiative is a network of “peer support”—some 400 PTSD sufferers from across Canada who are now relatively stable and who volunteer to help colleagues who are struggling. “Often all that’s needed is to sit there between therapy sessions for four hours and not ask a question—to just listen,” said Mr. Dallaire. “They are doing this and we estimate they’ve saved us a suicide a day since the program began.”

The Mental Health Research Showcase is an annual conference designed to advance mental health research in a way that makes a real difference to those who struggle with mental illness and addictions. The initiative flows directly from a provincial mental health plan developed in 2004 by the Alberta Mental Health Board (now part of Alberta Health Services), which set out a vision for making Alberta a world-class leader in mental health research. This, in turn, led to the Alberta Mental Health Research Partnership Program, which is charged with realizing that vision.

The four recurring themes at the Mental Health Research Showcase reflect the key priorities of the Partnership Program: the effectiveness of mental health services, child and adolescent mental health, workplace mental health issues, and mental illness and addictions. The over-arching theme of the 2008 conference was “advancing mental health through knowledge translation.” The idea is that, for research to have a real impact on health outcomes, it needs to be widely and easily disseminated to health care providers, policymakers, mental health consumers and their families as well as the public at large.

“To improve mental health care, we need to be able to translate research findings into change at both policy and practice levels,” says Laurie Beverley, Vice President, Programs and Research, Alberta Health Services—Alberta Mental Health Board, and Chair of the Showcase steering committee. “By gathering together experts from so many different fields, this conference is a key mechanism for doing just that.”

Ken Hughes, Board Chair for Alberta Health Services (AHS), made this point forcefully in his opening address to Showcase delegates. AHS is the provincial health authority responsible for overseeing the planning and delivery of health supports to more than 3.5 million adults and children living in Alberta. Declared Mr. Hughes: “Only through increased collaboration, sharing of knowledge, and the creation of strong credible links between researchers, service

providers and policymakers, can we hope to make gains in better diagnosis and treatment of mental illness. We are committed to that work and to providing the best possible support to the mental health mission in this province. We believe it is fundamental to a healthy population.”

Those views were echoed by this year’s Showcase co-sponsors. “The term ‘knowledge exchange’ reflects our belief that knowledge and understanding of best practices flows in many directions,” said Shannon Griffin, Director, Planning, Strategy and Development, for the B.C. Mental Health & Addictions Services. “For example, we learn as much from our clients and their families as we do from our research partners.” Added Arlene Weidner, a consultant with the Norlien Foundation: “Knowledge translation is one of the primary objectives of the work we do. We are trying to decrease the number of years it takes to turn research into practice—to better help those in need.”

The fourth annual Research Showcase also featured strong representation from the Mental Health Commission of Canada (MHCC), which was established in 2007 and headquartered in Calgary. David Goldbloom, Vice-Chair of the MHCC, updated delegates on the commission’s progress on its three key initiatives—a pan-Canadian anti-stigma campaign, a national strategy to address mental illness, and a knowledge exchange centre to help disseminate mental health research.

Dr. Goldbloom also expressed confidence that the MHCC, which is to receive more than \$200 million in federal funding over its 10-year mandate, would help inspire what he called a “citizens’ army” to advocate on behalf of the mentally ill. Observed Dr. Goldbloom: “If you look at other causes—whether it’s cancer, diabetes, or heart and stroke—part of their success is in creating a citizens’ movement. I believe we can do the same for mental health.”

The scope of the mental health challenge ahead is enormous. Statistics show one in three individuals will experience a mental health problem at some point in their lives. In Canada, that translates to more than 10 million people. It’s been estimated that mental illness costs the Canadian economy \$33 billion each year in disability and lost productivity. As a nation, we currently spend another \$6 to \$8 billion annually to treat mental disorders. More hospital days are consumed by people with mental illness than by cancer and heart disease patients combined.

Alberta Health Services, working with partners across Canada, will continue to play a significant role in addressing the mental health challenge—with the information gleaned from the annual Research Showcase helping to pave the way. As they had at the three previous conferences, delegates resisted the lure of the snow-peaked Rockies in favor of marathon presentations and networking. For three days, November 19 to 21, 2008, they listened intently to expert

speakers and peppered them with insightful questions. They pored over more than 100 academic abstracts on everything from engaging youth in mental health promotion to providing mental health services for abused women. They reached out to each other for advice and expertise and came away with a renewed determination to harness the best in research to advance mental health.

What follows are some highlights of what this year's Showcase conference participants learned.

FIRST STEPS: IMPROVING CHILD AND ADOLESCENT MENTAL HEALTH

“Over a third of young people who have either thought about suicide, or attempted it, have never told anyone about their thoughts or behaviours—not even a friend. Those numbers are scary, because that’s how quiet the conversation about suicide has been.”

--Ian Manion, Executive Director, The Provincial Centre of Excellence for Child and Youth Mental Health, Children's Hospital of Eastern Ontario



Ian Manion

There is increasing awareness about the need to intervene early to promote better mental health. Research shows more than 70 per cent of adults living with a mental illness had their first onset before the age of 18. The stigma associated with mental illness at all ages is particularly hurtful for the young, who desperately want to fit in. One result: three-quarters of adolescents who experience a mental illness never seek help.

Showcase delegates heard several perspectives on this critical issue. Sherry Thompson, an Alberta-based researcher and policy consultant, talked about how the early environment can influence a child's long-term mental health and well being. Citing groundbreaking work by the University of California's Dr. Vincent Felitti (a keynote speaker at the 2007 Showcase conference), Ms. Thompson described how children who endure neglect, abuse and household dysfunction are far more likely to develop a mental illness than those who are spared such experiences. Individuals who suffer multiple adversities in childhood are at a much greater risk of attempting or completing suicide.

Ms. Thompson also pointed to research showing that children with high cognitive abilities at birth will fare very differently depending on their socioeconomic status. The children from affluent families are likely to become high academic achievers while those from poor backgrounds will tend to lose much of their scholastic potential even before they hit school age.

All of this, said Ms. Thompson, makes a compelling case for early intervention. In addition to preventing a lot of human suffering, it also reduces the demand for more expensive services and treatments for adults. “Intervening at early childhood is more cost-effective than at any other point in a person's life,” said Ms. Thompson. “For every dollar spent, you get more outcome.”

Simon Davidson, an Ontario-based child, adolescent and family psychiatrist, spoke passionately about the need for Canadians to be more proactive about child and youth mental health. Research shows the prevalence of psychiatric disorders among the young is quite high—in the range of 13 to 22 per cent. But too few are getting the help they need.

“Because of the high demand for service, limited access and long waits, only one-in-six children or youth get any kind of attention,” said Dr. Davidson. “What do you think would happen in this country if only one-out-of-six adults needing a hip or knee replacement got it? I would suggest provincial governments would fall over that. And I ask you: why should it be any different for our children and youth with mental health problems?”

Dr. Davidson is also Chair of the MHCC's Child and Youth Advisory Committee. One of its key initiatives is to develop a national strategy document detailing where child and youth mental health needs to go in the next five,

10 and 15 years—and provide a roadmap for how we get there. “Creating success in child and youth mental health is really not rocket science,” said Dr. Davidson. “It all revolves around cooperation, collaboration, integration, leveraging and partnership—something we have failed fairly miserably at up until now.”

Delegates also heard about efforts to detect and treat schizophrenia at an early age. Jean Addington, a Professor of Psychiatry at the University of Calgary, described research into what’s known as the “prodromal phase” of schizophrenia—when individuals are experiencing deficits in cognitive and social functioning but have not yet developed full-blown psychotic symptoms. Traditionally, what’s been known about this stage has been learned retrospectively from people who went on to develop schizophrenia.

Dr. Addington’s research looks instead at young people who are exhibiting some of the early signs of schizophrenia, but who may or may not develop the illness. For example, they might experience some perceptual abnormalities—such as sitting on a bus and feeling people are talking about them—but they are not yet delusional enough to be convinced these perceptions are real. In one study of 50 such individuals, 20 per cent went on to develop full-blown psychosis.

And what of the rest? “I suspect some will develop other disorders, some will get better and some will stay the same,” said Dr. Addington. “I think psychotic illnesses are on a dimension. So there are people who need help—who may have what we call a sub-clinical version of a psychotic disorder but who don’t get help because they do not meet the current diagnosis.”

Dr. Addington, who was recently appointed the Alberta Centennial Research Chair in Child and Adolescent Mental Health, is now part of a \$20 million, multi-site study across North America that will examine more thoroughly the early stages of schizophrenia and possible treatment alternatives. “We want to know what mechanisms are at work,” she said, “and start thinking about specific targets for early intervention.”

When it comes to youth mental health, perhaps the grimmest statistics of all have to do with suicide. In Canada, suicide accounts for 17.3 per cent of adolescent mortality, making it the second leading cause of death after accidents. More alarming yet: for every completed adolescent suicide, there are another 220 attempted suicides.

One of the most promising avenues for preventing youth suicides are community-based programs that promote mental health while also helping to identify youth at risk. One such initiative is Youth Net/Reseau Ado, a bilingual program that began in Ottawa and now has satellites across Canada and in the United Kingdom.

Ian Manion is an Ottawa-based clinical psychologist and co-founder of Youth Net. He gave Showcase delegates an overview of this innovative program, which to date has served more than 20,000 young people, ages 12 through 20.

Youth Net goes into the community to talk to young people about the stress in their lives. They are asked specifically about feelings of depression and suicidal thoughts or behaviours, and how they deal with these issues. Youth Net participants are then offered a number of support programs, many of them designed and evaluated by young people.

One of the earliest programs revolved around snowboarding. “This one was devised by a 16 year-old young woman,” Dr. Manion told delegates. “Her goal in life was to be dead by the time she reached 18. She had been in every specialized service in the mental health system. She was a victim of abuse, she was into drugs and had no real purpose in life. But she told us she felt well when she snowboarded.”

Youth Net encouraged her to organize a program for street youth and others with mental health issues who had never previously snowboarded. “This was incredibly powerful for the people involved and for this young woman who was able to actualize her idea,” said Dr. Manion. “She’s now 25 and works for the federal government.”

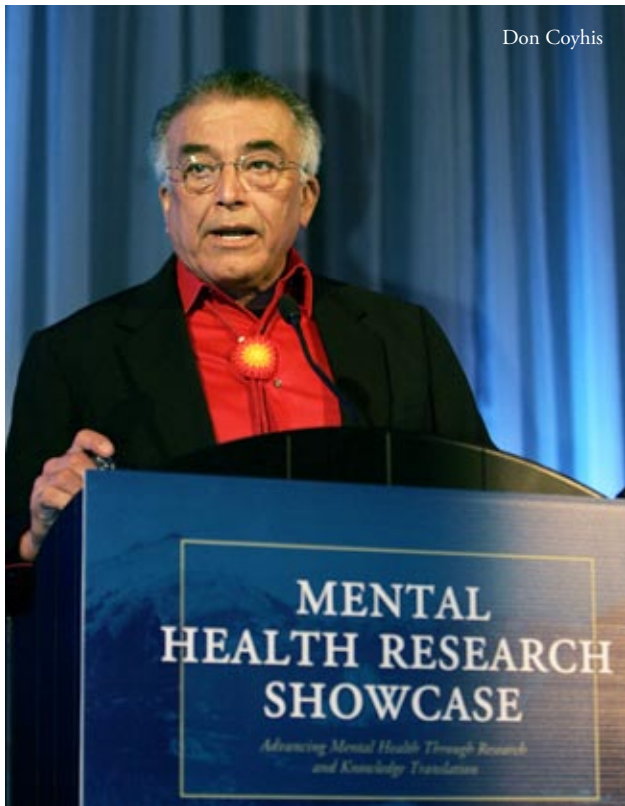
Youth Net is run by trained facilitators in their twenties, although clinicians are on call at all times. “The young people feel comfortable disclosing to these young adults,” said Dr. Manion. “It’s an amazing relationship that’s forged within minutes. Then, when someone is identified as at risk, the facilitators seek, with the young person’s permission, clinical backup. These are young people who, prior to this, would have never considered seeking professional help.”

PARALLEL HEALING: MENTAL HEALTH AND ADDICTIONS

“When a person comes in with an alcohol problem, they need treatment as well as spiritual, family and mental health support. We all have to work together to address the issue of one person.”

--Don Coyhis, Founder and President, White Bison Inc.

It’s now widely accepted that mental illness and addictions share a close, and often insidious, relationship. People who suffer from the one affliction very often suffer from the other. For too long, though, mental health and addictions services operated in their own silos. That’s beginning to change as



more jurisdictions integrate service delivery and research in both fields, either formally or informally. But there's still very little solid evaluation of whether these integrated programs are making a difference to those who suffer from what is commonly referred to as "concurrent disorders."

Brian Rush, a Senior Scientist with the Centre for Addiction and Mental Health in Toronto, gave an overview of the integration movement and what's driving it. He noted that, in the general population, there's only a 15 to 20 per cent overlap between those who have mental disorders and those with substance abuse issues. But the relationship is much stronger when you look at particular groups. For example, among young males who are mental health inpatients, some 60 per cent also struggle with substance abuse. In the correctional system, up to 90 per cent of the inmates exhibit concurrent disorders.

Dr. Rush said that integrated programs offer the greatest potential benefit to these subgroups and to individuals with the most severe disorders. But to date, he added, these groups and individuals have been largely ignored. Dr. Rush also lamented the lack of thorough scientific evaluation of how well integrated programs are working and called for more action on this front.

Delegates also heard about several practical initiatives aimed at people with concurrent disorders. These included a study that found an integrated approach worked best for individuals grappling with both anger management issues

and gambling addictions; a clinical program that utilizes psychiatrists, psychologists, social workers and nurses to treat adolescents with mental disorders and substance addictions; and an educational initiative that uses on-line programs to teach health professionals how to better treat people with concurrent disorders.

One of the most intriguing front-line efforts is the Edmonton-based Police and Crisis Team (PACT). This initiative grew out of Alberta Health Services' Crisis Response Team (CRT), a mobile mental health service that operates 24 hours a day, 7 days a week. The CRT gives quick, appropriate care to individuals in crisis, typically by stabilizing them in the community and limiting the need for hospitalization. Because about a third of CRT's clientele make their first contact through the police, CRT decided to partner with Edmonton Police Services. There are now four PACT teams, each consisting of a CRT member and a police constable.

CRT coordinator Pam Cousin described the impact of the mobile team on one 53 year-old woman who has a long history of anxiety disorders and substance abuse. The woman had been going to the hospital up to seven times per day, where she was always seen, assessed and then released. She was going broke because of mounting ambulance bills. PACT worked closely with a therapist and an addictions counselor on a plan of care. The police were alerted that whenever they came into contact with the woman they should notify PACT to assess and attempt to stabilize her.

The result? The woman had made only three appearances at the hospital in the previous six months. In addition to helping the client, noted Ms. Coulson, this represented a huge cost saving for Alberta's health care service.

Showcase delegates also heard a powerful presentation from Don Coyhis on the Wellbriety movement—a grassroots effort to help Native Americans who struggle with alcoholism to be both sober and well. The wellness part is related to living out the healthy parts of the principles, laws and values of traditional native culture. Mr. Coyhis, a member of the Mohican Nation and himself a recovering alcoholic, founded White Bison Inc. in 1988. This non-profit organization is currently leading a nationwide Wellbriety campaign aimed at bringing 100 native communities into a state of healing by 2010.

Mr. Coyhis talked about the lessons learned from the first community his group worked with. An assessment of 4,000 tribal members revealed an alcoholism rate of 85 per cent among those aged 12 or older and an estimated 25 per cent rate of fetal alcohol syndrome among children born in the community. Physical and sexual abuse was also commonplace.

Mr. Coyhis consulted community elders. "The elders told us alcohol was not the problem," he said. "It is a symptom of something else."

The “something else” had to do with the disease, violence and cultural dislocation Native Americans experienced following the arrival of European settlers. The introduction of residential schools, which saw native children taken from their families and punished for speaking their language, accelerated the breakdown of family and community life.

“We were masters at raising children at one time,” said Mr. Coyhis. “We had a system that was based on culture, ceremony, tradition. But then something took us from that community to this. Alcoholism, co-dependency and sexual abuse—all of these are rooted in anger, guilt, shame and fear.”

The Wellbriety program adopts the 12 steps of Alcoholics Anonymous and adds to it traditional teachings like the Medicine Wheel. To date, some 2,000 “recovery coaches” have been trained. Sessions are designed to deal with different age groups and genders as well as targeted groups, such as Native Americans in prison.

“We have a program called Warrior Down, which helps our relatives in prison re-enter the community,” said Mr. Coyhis. “We did the first pilot in Boise, Idaho. Two years after the first 50 people went through the program, all 50 are still sober and only one has gone back to prison. That’s the power of our culture.”

Mr. Coyhis said he’s seen great progress, but there is still one area that wrenches his heart. “Last year, we had two second-graders commit suicide,” he said, his eyes welling with tears. “It shouldn’t even be in their data base—I just don’t get it.”

JOB ONE: MENTAL HEALTH AND THE WORKPLACE

“Occupational health and safety, focused on physical risk, is now very accepted and very successful. It’s been shown we can significantly reduce the risk to workers and the likelihood of injury. We can do the same with mental health and safety.”

--Dan Bilsker, Adjunct Professor,
Faculty of Health Sciences, Simon Fraser University

Mental illness takes an enormous toll—emotional and financial—on the workplace. Research shows that one in four employees struggle with mental health issues, most commonly depression or anxiety. It’s estimated that mental illness results in 35 million workdays lost each year in Canada. Mental disorders also account for up to 40 per cent



of short-term disability insurance claims and are a secondary diagnosis in more than 50 per cent of long-term claims.

Awareness about how mental health impacts the workplace has increased dramatically over the past decade. Now, the challenge is to find practical interventions. This was the central theme of a presentation by Dan Bilsker, a psychologist who consults to a mental health services research group at Simon Fraser University and works in an emergency psychiatric unit at Vancouver General Hospital.

Dr. Bilsker told delegates about a series of self-care manuals he has helped develop, including one called Antidepressant Skills at Work. The idea is to give workers with mild to moderate depression a set of self-care skills based on cognitive behaviour therapy (CBT) principles. Among other things, they learn how to identify useful actions to deal with their disorder, replace distorted thinking patterns and set goals to help reactivate their lives.

Dr. Bilsker described another practical tool, Guarding Minds @ Work, which is being funded by the Great West Life Assurance Company. This is a web site and a guide that shows employers how to protect employees’ psychological health. It includes a psychological risk survey and audit and a step-by-step guide to identifying risks, implementing a response and evaluating the results.

In all cases, the aim is to provide materials that can be easily disseminated at little or no cost. For example, the antidepressant workbook can be downloaded for free (at www.carmha.ca/antidepressant-skills/work/) or printed at a cost of \$12, while employers will be able to access the Great Life documents for free at the Guarding Minds @ Work website starting in the spring of 2009.

Such tools are very timely. “When you’re headed into tough economic times, you invest in infrastructure,” observed

Dr. Bilsker. “I’d argue these kind of tools represent an improvement of our psychological infrastructure.”

Delegates also heard from one of Canada’s foremost suicide experts on efforts to prevent suicides in the Toronto subway system (on average, 24 people a year kill themselves by jumping in front of Toronto subway trains). Paul Links, incumbent of the University of Toronto’s Arthur Sommer Rotenberg Chair in Suicide Studies—the first Chair in North America dedicated to suicide research—described work he has done over the past decade with the Toronto Transit Commission (TTC) to increase employee awareness about the potential for subway suicide attempts and methods for intervention.

Dr. Links also talked about a study that is just underway to provide more effective treatment for TTC workers traumatized by subway suicides on their watch. “Right now, these individuals will usually end up with their family doctor and may not get the mental health care they need,” said Dr. Links. “What we hope is that, after identifying at-risk individuals, they’ll more quickly get into a specialized treatment program and also get specific help with returning to work.”

Helping employees with a mental disorder return to work was the central theme of a presentation by Mary Ann Baynton, director of Mental Health Works, an initiative of the Canadian Mental Health Association of Ontario. Ms. Baynton consults directly with employees and employers on the difficult issues that often arise when a worker returns after a mental health leave of absence. In such cases, both sides are apprehensive. Employers worry they might do something to trigger a mental health relapse while employees are concerned about the reception they’ll get from workplace colleagues.

Those latter concerns are sometimes quite justified. Ms. Baynton cited the case of one returnee who had done things she described as “grossly inappropriate, unethical, immoral—and just shy of illegal.” Added Ms. Baynton: “I knew people who were outraged this person was returning to work. They were shaking, crying and visibly distraught.”

Key to dealing with this situation, said Ms. Baynton, was the employee’s willingness to make a statement apologizing for the harm he had done. He also described the exact nature of his mental illness and how his actions had occurred during a period when he failed to comply with treatment. He then committed to full compliance in the future and gave work colleagues the phone numbers for his spouse and psychiatrist and told them to contact these individuals if they saw any evidence of a relapse and didn’t get a reasonable response from him.

“And you know what?” said Ms. Baynton. “It worked. This person was accepted back and his career is now intact and thriving.”

MAKING IT ALL WORK: TURNING RESEARCH INTO PRACTICE

“Knowledge translation is a journey. The destination is that we all want a better mental health system. And to get there, we can all agree good policy and good research should play a part.”

--Paula Goering, Director, Health Systems Research and Consulting Unit, Centre for Addictions and Mental Health



Paula Goering

To the layman, there is something slightly off-putting about the term “knowledge translation.” What exactly is that supposed to mean? But when it comes to mental health, the concept is critical. Stated bluntly, the best research in the world is pointless if it can’t somehow be used for the benefit of those who struggle with mental illness.

Only a fraction of the knowledge generated by mental health research is successfully translated into practice. According to Alan Best, Senior Scientist in the Centre for Clinical Epidemiology at the Vancouver Coastal Health Research Institute, part of the problem is that too much research is a one-way affair. In other words, a researcher produces knowledge and then simply hands it off to potential users to either use or ignore.

Dr. Best called for more research generated and disseminated in ways that encourage knowledge exchange and integration. Ongoing social relationships and networks involving research producers and research consumers would help ensure that more of the knowledge generated is actually put into practice.

Pam Whiting, Director, Networks, for B.C. Mental Health & Addictions Services, expanded on the role of health care networks in transferring knowledge. The beauty of such networks, said Ms. Whiting, is they extend beyond any one organization to engage policymakers, health care managers, clinicians and researchers. They also provide a forum through which information is exchanged, resources are shared and members influence each other.

Ms. Whiting said the use of networks is one way to speed up the process of knowledge translation. As it stands, she noted, researchers are producing an ever-expanding body of evidence, but it's still taking up to a decade or more to incorporate evidence into practice.

Dr. David Goldbloom described initiatives just underway by the MHCC to develop a national mental health knowledge exchange centre. Among the projects is an online peer support network for families and caregivers of individuals with mental illness. The idea, modeled on work already done for people with cancer, is that when an individual becomes psychiatrically ill, it should be possible to link them, either electronically or via a 1-800 phone number, within 24 hours to another family that's been through the same journey.

"Such initiatives are reflective of two basic Canadian realities," said Dr. Goldberg. "Firstly, we are among the most wired nations in the world. Secondly, we are the second largest nation on earth with huge geographic disparities and distances between people."

Dr. Paula Goering gave delegates an example of what she called the "long and winding road" of knowledge translation. She described a 2004 study she did for the City of Toronto on health care services for the homeless. She found homeless shelters were providing healthcare by default and residents' health and mental health needs were not being well met. There was need for greater investment and better case management and community-based treatment.

The study got zero uptake. But two years later, a young psychiatrist, Vicky Stergiopoulos, contacted Dr. Goering to say that she had read the report and wanted to use it to help improve services for the homeless in Toronto. Dr. Goering gave her some advice and many of the recommendations of the 2004 report were finally put into practice.

Then, in early 2007, Dr. Goering received an urgent call from Senator Michael Kirby, Chair of the MHCC. He was looking for a template to tackle mental illness and homelessness and asked Dr. Goering to come up with a proposal in a matter of days. She, in turn, called up Dr. Stergiopoulos and together they came up with a plan. With Senator Kirby's enthusiastic backing, the end result was \$110 million in new federal funding for a nationwide demonstration project to improve services to the homeless.

Among the lessons Dr. Goering took from all this is the value of researchers building long-term relationships and involving policymakers at an early stage. She also urged delegates to be willing to go off the beaten path. "This is not always an orderly process," she said. "Sometimes you put things in that reservoir of knowledge and, much later, they reappear in ways you never expected."

UNCONVENTIONAL WISDOM: THE POWER OF PROVOCATIVE THINKING

As well as highlighting the best mental health research in the Showcase conference's four recurring theme areas, the annual event typically includes keynote speakers whose main purpose is to inform and provoke discussion on a wide range of issues. In addition to Romeo Dallaire, the 2008 Showcase conference featured two other keynote speakers, both of whom brought a wealth of unconventional wisdom.



Sir David Goldberg

Sir David Goldberg, Professor Emeritus & Fellow at London's Kings College, is an internationally renowned psychiatrist who has devoted his professional life to improving the teaching of psychological skills to doctors of all kinds and enhancing the quality of services for those with severe mental illnesses. For his Showcase presentation, Dr. Goldberg opted to gore one of the sacred cows of his own profession—the way mental illnesses are diagnosed.

Dr. Goldberg noted that the two “bibles” of psychiatric and medical diagnoses—the Diagnostic and Statistical Manual (DSM) of mental disorders and the International Classification of Diseases (ICD)—get thicker and more unwieldy with each successive edition. The whole classification system, he argued, has become unnecessarily complex—to the detriment of doctors and patients alike.

Part of the problem, said Dr. Goldberg, is that the diagnostic manuals encourage physicians to view patients who exhibit a combination of symptoms—for example, depression and anxiety—as having distinct disorders rather than a single illness. “You often see depression along with panic attacks,” he said. “But you don’t have to treat the panic attacks. You treat the depression and the panic is gone.”

Too often, argued Dr. Goldberg, doctors use manuals like the DSM to try to fit patients into a diagnosis that may bear little correspondence to their symptoms. At the same time, they sometimes ignore symptoms patients are experiencing that don’t easily align with a particular diagnosis.

Dr. Goldberg advocates a much simpler classification system that would encourage physicians to listen carefully to the actual symptoms patients are experiencing—and then form a plan for managing those symptoms.

Dr. Goldberg has taken his case to the medical authorities overseeing the DSM and the ICD. Their response, he conceded, ranged from “stupefied and slightly incredulous respect” to “total rejection.”

As a self-described free thinker, Dr. Goldberg is undeterred. “When I give a talk like this one, I’m not wildly unpopular,” he said in an interview following his Showcase presentation. “The audience knows damn well what I’m talking about. It corresponds to a reality for them. So I think it’s time to shake the cage a bit.”

Delegates were treated to an equally thought provoking presentation by Reid Meloy, a clinical professor of psychiatry at the University of California. An expert in forensic psychology, Dr. Meloy talked about the differences between “affective” and “predatory” violence. Affective violence, said Dr. Meloy, is reactive and immediate, and is typically in response to a perceived threat. Researchers often refer to affective violence as impulsive, emotional and hostile. Predatory violence, on the other hand, is characterized by the absence of emotion and threat. It is premeditated and often described as cold-blooded.

“The evolutionary basis for affective violence is self-protection,” said Dr. Meloy. “The evolutionary basis for predatory violence is hunting.”

Dr. Meloy has studied the role of predatory violence in political assassinations in the United States. Some common

factors: the victims were carefully stalked, extensive research and planning preceded the crime, and the perpetrators rarely, if ever, signaled their intentions. “These individuals are hunters and so they are not going to communicate a threat,” he said.

The stealth of such violence, and the fact it is relatively rare, makes it difficult to predict and prevent. Dr. Meloy described some promising research models for doing just that, but said they would inevitably depend on having a good “intelligence network” of clinicians, law enforcement officers and others concerning individuals who appear to be on the pathway to violence.

“Now, some of you may cringe at the thought of good intelligence,” said Dr. Meloy. “But I think some of the diminishment in school shootings we’ve seen in the United States is because of programs we’ve initiated to make students more willing to trust and talk to their teachers about classmates they see at risk of turning violent.”

BRINGING IT HOME: THE DRIVE TO DO GOOD

The point of a conference like the Mental Health Research Showcase is not simply the polite exchange of ideas or the pleasant social interaction it affords for researchers, clinicians and policymakers who otherwise spend their working lives consumed by their own projects and priorities. What becomes clear when you gather this many mental health and addiction experts in one place is that they have a collective desire to do good. Conference participants are constantly asking themselves: how do we use what we know, and what we are learning, to make a real difference in people’s lives?

Roger Bland acknowledged this phenomenon in his closing address to the 2008 Showcase. “A lot of people have noted the high level of enthusiasm here,” said Dr. Bland, Executive Medical Director, Alberta Health Services—Alberta Mental Health Board, and Chair of the Showcase Program Planning Committee. “I see it this way: people want to do the best job they possibly can and, if they can pick up some useful information here, they’ll take it home and try to use it.”

By that standard, among many others, the fourth annual Mental Health Research Showcase proved a resounding success.

“WE HAD TO BLOW THIS THING OPEN”

Retired Lieutenant-General Romeo Dallaire spoke at the 2008 Mental Health Research Showcase about efforts by the Canadian military to deal with Post-Traumatic Stress Disorder (PTSD) and his own experience with this condition after serving as a U.N. commander in Rwanda during the 1994 genocide that claimed more than 800,000 lives. Following his keynote address, Mr. Dallaire elaborated on these themes in an interview with Mending Minds. Excerpts:

Stigma is a major challenge for anyone with a mental illness. Traditionally, has that sense of stigma been even greater in the military?

Yes. The military is a very Darwinian organization, where people are expected to be at the top of their performance, because of the life-and-death stakes involved. Leaders whose troops are not performing to that level are held accountable. So when you have something that's difficult to discern, like a psychological injury, that goes against the grain of military leadership. We need to treat these injuries the same as physical ones. If a guy loses an arm, he needs to be deployed back home and given all the necessary support. Well, the guy who is traumatized needs to be dealt with in the same way.

After you were diagnosed with PTSD, you began treatment very quietly so as to minimize the stigma. What made you decide to go public?

After I came back from Rwanda, I was dealing with a lot of personnel issues. I felt we were trying to keep a low profile on the casualties—and also on the suicides and family breakdowns. It got to the point where I thought we were being unethical. So that was the professional element. But I was also becoming aware that I had also been injured. So I went public. I felt that was the only way to break the logjam. Because doing the bureaucratic stuff, we were getting nowhere. We had to blow this thing open.

One of the things you did was to appear in a military video urging those who had been psychologically injured to come forward and seek help. What was the thinking behind that?

By using me, a two-star general, it removed a lot of barriers to more junior officers and troops speaking about it. They would say, 'If a two-star general is willing to talk about this injury, and not be ashamed, then I can do the same.' Actually, we were more successful than we imagined, because this video became public quite quickly. We found we were also demystifying this condition for the civilian world, including

police, journalists and NGO people who suffered the same trauma with few supports. They said, 'hey, if the military is talking about this, surely we can.'

You experienced your own mental health crisis in 1999. Since then you've written a book on your experiences in Rwanda and participated in a documentary film based on that book. Do you now feel your psychological injury is behind you?

No. Speaking and writing about this—I never saw it as therapeutic. Because every time I do it, I feel like I'm going back to hell. Writing that book for three years was literally reliving hell. So it doesn't attenuate. All we're able to do is build this mental prosthesis, which allows us to cope. But I never feel I am free of this—as if my arm has grown back. I sleep better now—I've got less dreams—but I still take medication and participate in therapy.

How much progress has the Canadian military made in dealing with PTSD and what still needs to be done?

It's a million per cent improvement. They've put significant resources into this, including several clinics. We've got recruitment and pre-deployment programs where we talk openly about PTSD and the injuries personnel could face. We deploy psychiatrists into the field. And we've got programs to help the troops readjust to civilian life. But we need to continue to get better at discerning those who are injured and encouraging them to seek the support they need. And we need to constantly reinforce that dealing with this issue must remain a priority.

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