2003/2004
Annual Report to the Community

Centre for Addiction and Mental Health

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

2003/2004
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Contents

cover: Dr. Samuel Noh, encircled by colleagues from the Culture, Community and Health Studies Section (CCHS). The CCHS Program is a joint program of CAMH and the University of Toronto. See page 22.

Mission

Improving the lives of those affected by addiction and mental health problems and promoting the health of people in Ontario and beyond.

Vision

Strong and healthy communities, in which people with addiction and mental health problems can access appropriate and effective services and live as full participants.

Core values and commitments

Client-Centred Practice

Continuous Learning

Diversity

Evaluation & Accountability

Holistic View of Health

Partnership

Goals

Improve Care and Enhance Health

Discovering, Sharing and Applying New Knowledge

Influencing Public Policy and Promoting Positive System Change

Being the Best Place to Work and Learn

Ensuring Long-Term Sustainability and Development

Providing Effective Information Management Systems and Technology

Developing Innovative Facilities

Message from the Chair and President

After-effects of SARS

Just over a year ago, the Centre for Addiction and Mental Health (CAMH), along with all other health care facilities in the Greater Toronto Area, faced an unprecedented crisis. In the space of a few days at the end of March, hospitals went from business as usual to a near-complete lockdown, while staff scrambled to understand and cure a highly communicable and life-threatening illness.

Undoubtedly, as we reflect back on the past year, SARS was a significant event in 2003. In hindsight, it is of note not only for the risk and anxiety we faced, but also because our collective plight highlighted the extent of our interconnection. Hospitals became acutely aware of how much we rely on one another, given that patients move frequently from one site to another. Outside the health care arena, communities of students, religious groups and many others were affected by quarantines. Further, the entire city suffered from isolation, as travellers, wary of endangering themselves, simply chose not to come here. SARS touched us all.

Like a sudden fire, SARS compelled us to act. We changed our infection control policies and practices, screened everyone who came to our doors and, once the crisis was over, enacted new ways of protecting our clients and staff in an emergency.

While crisis compels us to act and act quickly, changes that are harder to make are ones that don't result from crisis, but from a slow and dawning realization that things could and should—and must—be better.

Time for a review

Four years ago, CAMH undertook a review of who we collectively were and how we operated as an organization from a diversity perspective. When the final report was released, we were braced for bad news. Yes, we could say we had some remarkable programs in place for staff and clients, programs that took into account race, ethnicity, sexual orientation, age, ability, religion, family and marital status, and socio-economic status. Yet for every stellar example of what we were getting right, there were other instances where discrimination, harassment and exclusion were allowed to fester.

It was abundantly clear that we needed to improve the way our employees felt about working at CAMH and the way we dealt with our partners in the community. But most of all, we needed to take a hard look at our cultural competency in the area of clinical care.

Before we could look outside our walls, we had to act decisively to address major concerns inside our walls. We had to start making things right for our employees. To do this, we created a Diversity Programs Office. At the same time, we developed a diversity policy to help guide our business both inside and outside.

In our provincial services, diversity was clearly identified as a priority. A diversity plan was developed

to provide the framework within which we work with other service providers in Ontario, to increase their capacity to offer services that address diversity issues.

Today, we can say with confidence and pride that our workplace is more inclusive, and that our diversity policy and practices measure up exceptionally well with policies and practices in other hospitals throughout the Greater Toronto Area, in terms of comprehensiveness, accountability and expectations. At CAMH, whether we are working with clients, hiring staff, providing training, doing research, deciding on contract bids, conducting staff performance reviews, building budgets, organizing health promotion programs or strategies, making Board decisions, or initiating any other important activity, we are committed to making diversity part of our thinking. We want to ensure that all people are included, validated and represented in all aspects of our organization. We expect nothing less.

As the largest addiction and mental health organization in Canada, we have embraced the opportunity to provide leadership, creating and developing programs that focus on clinical care, research and health promotion in partnership with outside agencies, organizations and governments. This will ensure that everyone responds effectively to the diverse cultural and linguistic needs of all clients and stakeholders in the health care arena.

The importance of highlighting diversity

"Why diversity?" we are often asked. Why diversity in the face of so many other urgent priorities?

Imagine you were experiencing hallucinations, feeling extreme anxiety or using illicit drugs to get through the day, and could not find a place that offered help where the staff understood you. There is a pretty good chance that your pain would go untreated and you would become increasingly afraid, isolated and marginalized. Addiction and mental health problems are infinitely more subtle and complex than most physical ailments, and can only be conveyed in a therapeutic environment of shared understanding. As a leader in this field, we cannot allow ourselves the luxury of treating people with a one-size-fits-all package. Nor would we want to.

We are part of a global community: substance use and mental health problems span the world. By embracing diversity, we move from "us and them" to a much larger community that includes all of us: more of us helping, more of us being treated and more of us working to ensure the resources we need are there when our friends, family members and community members need a place to get help.

To those who ask, "Why diversity?", we offer three answers:

- We want to provide the best possible care and increase access to services. As a large health care organization, we want to provide our services broadly, to every single person who needs them. It is unacceptable to turn anyone away, for any reason, in his or her worst moments of pain and fear. Diversity is an essential ingredient to providing the best care to clients. Because we are located in one of the most diverse cities and one of the most diverse countries in the world, it is simply the right thing to do—legally, practically and in terms of our professional responsibilities as caregivers.
- We want to employ the best people. To be where we want to be as an organization, we must employ people who embody excellence—in terms of skills, experience, and the ability to learn and change as our organization learns and grows. This will happen only if we cast as wide a net as we can and draw the best people from a diverse pool of talent.
- We want to be leaders and to set the standard for other organizations, both public and private.

The remainder of this year's report highlights our diversity journey, sharing some successes and opening the doors to the areas we need to focus on in the future. For example, we have not paid enough attention to our diversity practices in research, and have learned that research is only as good as the

Jamie Anderson and Dr. Paul Garfinkel visiting the Integrated Rehabilitation Unit

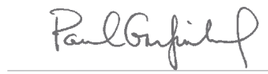
questions we are asking. Asking the right questions is one place to start. Being sensitive to differences, in every interaction we have, is another.

Celebrating other accomplishments

While we work to address our limitations, we can also take a moment to celebrate that CAMH was recognized in late 2003 for some of our ground-breaking research, by having two published research projects named best science papers of the year by the prestigious magazine *Science*.

Looking ahead, we are excited as we proceed with the redevelopment of our Queen Street site. Your support, feedback and participation are critical to our common goals and success. Consider yourself invited to join us in building not only a community but also a future, where well-being, acceptance, healing and interdependence join like hands to help us hold our community together.

JAMIE ANDERSON
CHAIR, CAMH BOARD OF TRUSTEES



PAUL GARFINKEL, MD, FRCP(C)
PRESIDENT AND CEO

Highlights of the year

Here's a snapshot of some of this year's highlights:

- launch of the Krembil Family Epigenetics Research Laboratory
- opening of the R. Samuel McLaughlin Addiction and Mental Health Information Centre and support line
- release of the 2003 Ontario Student Drug Use Survey report
- establishment of the Office of International Health
- arrival of a state-of-the-art positron emission tomography scanner
- launch of the Pamela Fralick Community Forum on Addiction in London, Ontario
- opening of the Jean Simpson Artist Studio.

Check out our website at www.camh.net to learn more.

Why diversity?

We understand and respect each person as unique. We show this respect through sensitivity, dignity and inclusive practices that include people from diverse groups in our decision making, information sharing and access to services.

We believe in the principles of equity and access; we recognize the diversity of race, culture, ethnicity, socio-economic class, language/accent, gender, sexual orientation, age, religion, physical and mental abilities, literacy level and immigration/refugee status. We also respect the diversity of communities we serve by having inclusive practices and policies for our governance, service and employment.

—from the 2003/06 Strategic Plan

The theme of this year's report is diversity. We have chosen this theme because diversity has been an organizational priority since CAMH was created in 1998. We recognize that globalization, technology and the media have made it necessary to look beyond our borders. We must look to many different cultures for wisdom, guidance and understanding, because the world we live in today is far more complex than it has ever been before.

In addition, we know from extensive research and experience that the social determinants of health affect people from marginalized groups, particularly in areas such as employment, housing, racial identity, education, food security and social exclusion. If you are female, a person of colour, an immigrant, a person with a disability or have low income, your chances of ill health increase dramatically. This has major implications for our work in substance use and mental health.

By embracing diversity at work and in our personal lives, we not only enrich our own learning, but are also better able to serve those who come to us for help and guidance as they work through their addiction or mental health problems toward recovery. To make diversity part of the fabric of our workplace, we have a Diversity Programs Office (DPO) that, by providing resources and support, promotes the integration of diversity into everything we do at CAMH.

Internally at CAMH, not only has the DPO helped to create new diversity policies, it has also provided leadership in the areas of programs and services, human resources, community and stakeholder relationships, training and development, internal CAMH diversity education and promotion, and innovation leading to new organizational directions.

Externally, our diversity plan guides our work with others in the community to help develop tools and educational programs that will help improve the quality and accessibility of services for diverse populations across Ontario's addiction and mental health systems.

It is through the dedication of the staff, clients and volunteers at CAMH that we bring the work of the DPO and our diversity plan to life. The following pages will tell you their stories.

Being understood is no easy matter

Imagine if you became seriously ill in a foreign country where you couldn't speak the language. How could you convey what was wrong and also be confident that people understood you? The key to your care, especially for an addiction or mental health problem, is not just about taking the spoken words and interpreting them literally. It is also about understanding the culture, the values, the nuances and the meaning that lies behind those words.

Interpreters who work with the Cultural Interpretation Services at CAMH are all professionally trained. They all know the importance of interpreting as accurately as possible. They help clinicians to better understand the problem, diagnose it correctly, then recommend an appropriate treatment plan that will lead the client back to health.

"I truly know how important it is to bridge the language barrier," says Stella Rahman, Clinical Services Consultant. Originally from Bangladesh, Rahman once worked as a family physician in the Middle East. Not knowing a single Arabic word, she had a full-time interpreter when speaking with patients, allowing her to make critical medical decisions.

Rahman works with interpreters at CAMH to ensure that they speak clearly in the first language of the client, and that they understand substance use and mental health terms and issues. She also trains CAMH professionals in understanding how to work with interpreters. Sometimes the clinician may find it necessary to meet with the interpreter after the appointment, without the client, to understand some of the nuances of the interview.

For example, a Filipino interpreter speaking in the voice of his client explained a bruise on the client's arm as: "Someone did a coining on me." In the post-interview discussion, the puzzled clinician learned that it's common practice in the Philippines to rub a coin on the skin to ward off a fever.

As our community continues to expand, so does our service. When the service began three years ago, it was receiving 10 requests per month. Today that figure has been as high as 120 requests per month. The number of interpreters has quadrupled to 92 and the number of languages spoken is now at 50, including American Sign Language. Interpreters are available for emergencies any time of the day or night, using Language Line, a telephone interpretation service.

With Toronto and the rest of the province as its diverse base, Cultural Interpretation Services is destined to grow. In fact, just recently, Rahman hired an interpreter of Amharic, an Ethiopian language.

Stella Rahman, with Kaye Myers, American Sign Language Interpreter, having a post-interview discussion

Sharing knowledge through training

If you're an able-bodied, middle-aged white female service provider working in northern Ontario, your clients, especially among First Nations people, may not see you the same way you see yourself.

This was never more evident than during a recent diversity training session co-ordinated by CAMH's Education and Health Promotion Department. Facilitator Janine Robinson challenged other service providers from northern Ontario to look at themselves, no matter what their ethno-cultural identity, and examine how their access to privilege could affect their relationship with clients.

The experience for the participants was eye opening, to say the least. Says Robinson, "Some service providers became visibly upset and later confided that it was a disturbing day for them. I heard comments like: 'I never understood how blind I was to my own privilege. It threw me for a loop.' Throughout the day, I saw a lot of people dramatically shift their attitudes during the training as they considered marginalization as well as privilege."

In the north, where First Nations people make up approximately 30 per cent of the population, there's an even greater need for cross-cultural training between community service providers and traditional healers, to minimize cultural misunderstandings that can often lead to a misdiagnosis.

The Cross Training Pilot Project was developed in response to a need identified through a diversity needs assessment survey, conducted by CAMH with community members, service providers and allied professionals in a number of communities throughout Ontario in 2003. The results showed that training is one of the keys to bringing diversity beyond the walls of CAMH and to building partnerships in communities on the communities' terms. This project provides training around addiction, mental health, diversity awareness and organizational change.

"This training program allows us to provide a valuable service to the service providers across the province, as well as an opportunity for them to meet others within their own community who are undertaking the same work and facing similar issues. It also provides us with the opportunity to let them know what CAMH and other service providers have to offer, and how we can all work together to better serve diverse communities," says Drupati Maharaj, Diversity Knowledge Exchange Manager.

CAMH trainers held 16 consultations with key stakeholders and will continue to hold training sessions on subjects as varied as introductory addiction and mental health training for immigrant and refugee serving agencies to cultural awareness training for ethnic communities. With the proper training, caregivers serving clients from diverse populations will greatly improve their care and can take advantage of existing resources.

Tony Jno Baptiste and Janet Mawhinney leading a diversity training session

Asking the right questions

If you want to know how to ask the question, then go to the source. That is precisely what Angela Barbara, Research Analyst, and Farzana Doctor, Manager of Rainbow Services at CAMH, did when they set up focus groups around the province to find out what questions lesbian, gay, bisexual, transsexual, transgendered, two-spirit, intersex and queer (LGBTTTIQ) individuals/communities wanted care providers to ask about their sexual orientation and gender identity.

CAMH's Rainbow Services provides assessment and counselling to LGBTTTIQ individuals, couples and groups who are concerned about their use of alcohol or other drugs. To offer clients the most effective addiction or mental health treatment, Doctor and her colleagues knew that care providers needed to be aware of a client's sexual orientation or gender identity, but were often unsure how to raise questions about these areas with the client.

When they asked clients and community partners about how clients should be questioned, they found out helpful information. The most beneficial was: "Be direct. Ask us what you want to know." Out of their testimonials came *Asking the Right Questions* in 2001 and *Asking the Right Questions 2* in 2004, with the research co-ordinated by Barbara.

One client admitted the following, as noted in *Asking the Right Questions 2*: "When I found out about an LGBTTTIQ-positive program, I was happy. I was ecstatic to learn of a program where I knew I wouldn't be judged. I could open up easily and get the help I needed."

The revised manual addresses substance use and mental health issues. Doctor and her colleagues have already begun training care providers around the province to address the shortage of services to the LGBTTTIQ community.

"With this guide, we have the potential to change the face of addiction and mental health treatment in Ontario and make it a more positive experience for people who are LGBTTTIQ," says Doctor.

AN IMAGINARY CASE STUDY

Dani* is addicted to cocaine. She's been abusing drugs since she was 13, around the same time that she first became aware that she was a lesbian, and was dealing with a great deal of stress and oppression. Now that she's 20, she wants to stop using and make something of her life. In a positive move, she visits a counsellor. He asks if she's sexually active and she says "yes." Continuing with his questions, he asks if she uses birth control. She decides that she'll just say "yes" again to avoid divulging that she's a lesbian.

In a move that could have been more helpful to Dani, he could have instead asked, "Are you currently dating, sexually active or in a relationship? If yes, is (are) your partner(s) female, male, bisexual [and other choices...]?"

Then, he would have been a step closer to creating a positive rapport and understanding of Dani's problems.

** Dani is an imaginary client, yet her situation is similar to many others.*

Farzana Doctor and Angela Barbara with *Asking the Right Questions 2*, which they developed

Seeking diversity in our research

Reflection is one of the keys to a person's self-improvement. The same is true of an organization, especially when it comes to a complex issue like diversity and research.

Dr. R. Michael Bagby, Director of the Clinical Research Department at CAMH and a Professor in the Department of Psychiatry at the University of Toronto, and his research colleagues have been going through a period of organizational reflection. Over the past several months, they have been analyzing CAMH research publications to find out how well CAMH research represents issues relating to diversity.

This review is part of a three-phase research proposal conducted in collaboration with the Diversity Programs Office and the Research Division. The review also included asking key researchers at CAMH what they thought about integrating diversity into their work and what our community partners thought about how we could better address the issue of diversity.

The good news is that some aspects of diversity, such as age and gender, were consistently part of the research from 1999 to 2002. The bad news is that race, ethnicity, religion, immigrant/refugee status, language, sexual orientation and physical ability were often overlooked. As well, there were few partnerships with community organizations working on these problems, and most of this research was the production of a single research section (see profile on page 22). This review has given CAMH a template and corresponding benchmark to measure the progress being made year over year regarding diversity in our research.

"The importance of integrating some aspect of diversity into research cannot be overlooked," says Bagby. "Findings can change based on who is being asked the questions. There is a chance that some wrong conclusions could be reached if certain groups that have different levels or kinds of needs are excluded or not identified in certain types of research." For example, if a clinical trial examining the effects of psychotherapy versus anti-depressant medication only looks at effects on Canadians of European descent who were born and raised in Canada, can we safely generalize the results to include effects on those who are recent immigrants to Canada?

In the second phase, researchers conducted interviews with CAMH section heads to gauge the importance of diversity in their research. It became evident that we are integrating diversity into our research but it doesn't show because we lack the expertise and resources to use the data. More importantly, however, staff expressed an overwhelming desire to learn more about integrating diversity into their research protocols.

The third phase is underway. In this phase, community partners are being interviewed to determine important research areas around diversity and to examine potential barriers to conducting such research. This phase will also look at the best ways of ensuring community collaboration in determining community needs, establishing questions and co-ordinating information dissemination. This phase will be completed by the end of the year.

Once all the results are compiled, the Clinical Research Department will look at the results and work closely with the CAMH clinical and research program leaders to incorporate these findings into their programs. As well, we will begin to develop closer links and partnerships with diverse communities outside of the organization.

Dr. Michael Bagby, right, with Research analyst, Devita Singh

Eliminating harassment and discrimination

In a workplace of 2,700, differences of opinion are expected.

It was a sobering moment when the senior management team at CAMH heard from the employee survey done in 2000 that some employees at CAMH had experienced racism, sexism, ageism and homophobia as part of their life on the job at CAMH. It was even more disconcerting to hear that they did not feel safe about reporting these incidents when they did occur.

"This validated our belief that there was a problem, and with this information we knew we had to act sooner rather than later," says Rhoda Beecher, Vice President of Human Resources and Organizational Development. "A policy on harassment and discrimination is essential in any large organization, but in one with a strong commitment to diversity it becomes even more important. We also knew we couldn't do this alone."

That is when Human Resources approached the two unions representing staff at CAMH (ONA and OPSEU) and asked them to be a part of the discussion. These groups collaborated with the Diversity Programs Office to create a policy that is respectful of staff while clearly stating what's unacceptable behaviour and how staff should deal with complaints.

"I am thrilled that we had a relationship with the two unions representing CAMH that allowed us to work together. The unions took an active role in designing the policy and the training. All three parties have just reviewed the policy after its first year. The changes we made make the policy more comprehensive than ever, with language about bullying (that didn't exist before) and terminology to include transgendered and transsexual people," says Beecher.

Danielle Larmand is especially pleased about the inclusion of bullying. The bargaining unit president of the Ontario Nurses Association and a registered nurse at CAMH says, "We may be flooded with complaints and concerns, but it will capture everything not included under harassment and discrimination." She agrees about the need for the policy and applauds the joint venture. "I think we're the only local that has a joint policy with its employer."

To date, over half the staff at CAMH have been trained on the policy under the watchful eye of Rhonda Mauricette, the Organizational Development and French Language Services Consultant responsible for the training. She says our staff has welcomed the policy: after every session, at least one person comes forward to talk with her about specific issues relating to diversity, discrimination or harassment. Sometimes she can give them suggestions on how to approach the issues on their own; other times she refers them to Human Resources.

Since the inception of the policy, the number of complaints received about harassment and discrimination in Human Resources has decreased. "We are proud of this fact," says Beecher. "To me, that means our policy and training about the policy is working and that people now feel they have permission to step forward."

Sometimes the issues end up at hearings. "It's very gratifying to get notes after a harassment or discrimination hearing," said Beecher. "People do not always agree with the end result but they do say that they appreciate being heard and that they felt they were treated respectfully through the process."

Rhoda Beecher, Danielle Larmand, Rhonda Mauricette and Michele Choma discuss policy changes

Capturing the face of addiction and mental illness

Carlos, a young boy of about 10, is sitting on a washroom floor, head pressed down between his knees, which are drawn up tightly to his body. He has just run out of his classroom, frightened after hearing a loud fire-alarm bell. Carlos is the lead character in a new 14-page photo story booklet on post-traumatic stress disorder, produced by CAMH in partnership with Citizenship and Immigration Canada.

Available in French and English, this booklet, along with four others, has been created by CAMH to help promote a greater understanding and acceptance of people with substance use and mental health problems. These "photo-novellas," styled after comic books, are intended to complement and support CAMH's health promotion and prevention agenda across the province.

Antoine Derose, Project Consultant in Education and Health Promotion at CAMH, helped to develop these booklets. "We analyzed the information we received from six community focus groups that were helping us identify gaps in service in various communities. In this process, we discovered that there was a lack of knowledge about substance use and mental health problems and the services that are available for them, especially within the underserved French-speaking ethnoracial/ethnocultural groups," says Derose.

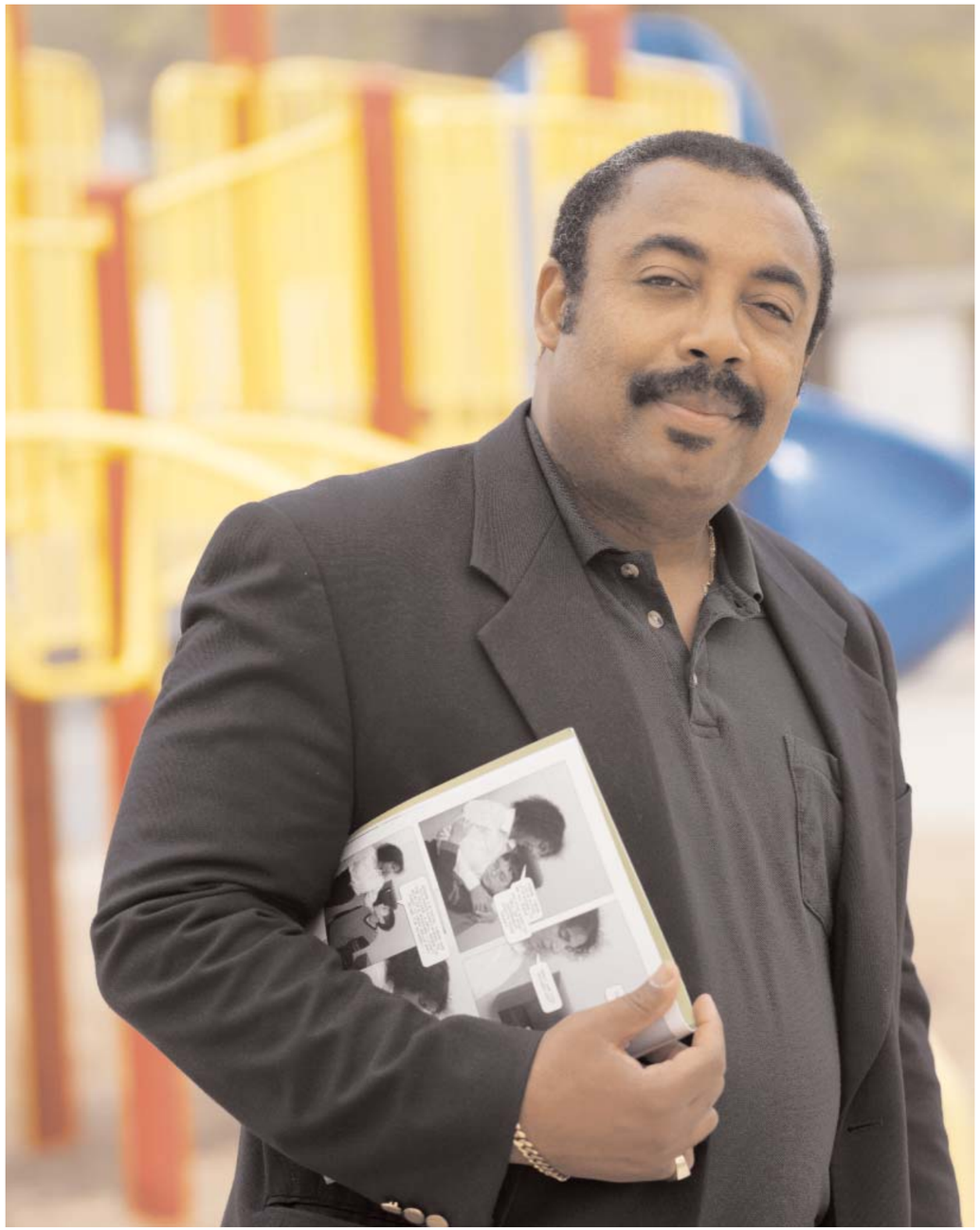
The focus groups recommended that CAMH:

- produce linguistically and culturally sensitive educational material along with training that delivers the material to designated communities
- create material that is intellectually challenging, artistically interesting, humorous and conscious of the multiple identities of francophone youth from diverse ethnocultural/ethnoracial communities
- produce material specific to the needs of women and children. Women from marginalized groups often face collective trauma from sexism and racism and bear most of the burden of family survival and support.

Based on these recommendations, CAMH began an awareness campaign with TFO, the French language unit of TV Ontario, and published the photo-novellas in French and English. Others topics in the series include depression, drugs, alcohol and problem gambling.

As next steps, religious and community leaders identified by focus group participants as the best people to inform their communities will receive training on how to use the booklets. Plans are underway to translate the booklets into Arabic, Swahili, Lingala and Vietnamese.

And as for Carlos, we later learn he is frightened because the sound of the alarm evokes the terror he had felt previously in his war-torn country. The story depicts Carlos's reaction and the realistic response of teachers and classmates to his problem, with pictures relaying most of the story, along with brief dialogue and explanations. At the end of the booklets, the reader can learn more about post-traumatic stress disorder, its symptoms, methods of treating it and locations to get help.



Antoine Derose with a photo-novella on post-traumatic stress disorder

Preserving memories in many languages

Imagine the fear that you would feel if you started to realize that organizing your thoughts properly has become a monumental task or that you sometimes forget your way home to the house you have lived in for 50 years. Add to that the fact your first language is not English, and although relatives—recognizing your symptoms—have been searching, they cannot find anyone in the medical profession to whom you can describe your symptoms, in your own way, using your own language.

That is precisely how Juanita*, 69, who came from a South American country, must have felt. Her husband brought her through the doors of the Multicultural Multilingual Memory Clinic (MMMC) at CAMH last year describing her sad decline, which included an inability to take the subway anymore. The husband sobbed, "We're losing her."

Speaking with Juanita in her own language, Dr. Luis Fornazzari, Behavioural Neurologist and Acting Clinical Director of the Neuro/Geriatric Psychiatry Program at CAMH, and a Professor in the Division of Neurology at the University of Toronto, conducted various tests on her. He quickly realized that her sudden onset of symptoms was inconsistent with most forms of dementia. Juanita was able to open up to Dr. Fornazzari and confided that she had been raped by her father at the age of nine.

Despite this traumatic incident, Juanita married well, had two wonderful daughters and moved to Canada, where she had lived for decades. Recently, she received a call from relatives that her father had died. Within five days, she received another call; her brother was also dead. Soon after that, she became disoriented and depressed.

Dr. Fornazzari knows that depression in the elderly often mimics symptoms of dementia. He concluded that the deaths triggered some repressed memories for Juanita. Once she was able to deal with the cause of her post-traumatic stress and the resulting depression, she improved markedly.

This experience, along with many others, prompted Dr. Fornazzari and his team to ponder whether a memory clinic existed anywhere in Toronto (or Canada, for that matter) that could offer client services in multiple languages. The answer was no. Seeing an opportunity, Dr. Fornazzari looked around the clinic and realized that up to 18 languages, including Swahili, were spoken by program staff. At that moment, he realized he could vastly improve his memory clinic by serving the growing multicultural population of Toronto and the province in languages other than English and French. As a result, the Multicultural Multilingual Memory Clinic was born.

So far, the clinic serves clients in nine languages: English, French, Italian, Spanish, Portuguese, Greek, Mandarin, Cantonese and Hindi. A multidisciplinary team assesses each client and suggests treatment. All clients seen at the clinic receive follow-up appointments every six months for clinical and also research purposes. Clients range in age from 60 to 85 years.

As part of a provincial Alzheimer's initiative, care providers at the clinic are now working with family physicians across Ontario, to offer them awareness, training and education about Alzheimer's and dementia.

Multidisciplinary research is also taking place in the MMMC. Currently, Dr. Fornazzari and his team are engaged in a number of multi-centre dementia studies across Canada and the U.S. and internationally.

*(not her real name)

Anita McGann and Dr. Luis Fornazzari from the Multilingual Multicultural Memory Clinic assessing a client

Analyzing the effects of discrimination on newcomers

Discrimination hurts. It hurts in more ways than many of us can imagine. Scars are left that cannot be seen but can remain a lifetime. Twenty-five per cent of people who immigrate to Canada, and are part of a visible minority, report experiences of racial or ethnic discrimination. In some groups, this figure is as high as 85 per cent.

Research scientists in the Culture, Community and Health Studies (CCHS) Section at CAMH and the University of Toronto are committed to finding out why the mental health of some immigrants is better than others. We are confident that the knowledge gained through our research will be useful in developing innovative ways to prevent some of the adverse effects of settlement stress and will lead to improved mental health for newcomers to Canada.

A good start has been made with the Ethiopian community. Findings from a study entitled *Pathways and Barriers to Mental Health Care for Ethiopians in Toronto*, jointly released with the Ethiopian Community Association of Toronto, has shown that the rate of depression among Ethiopian immigrants in Toronto was three times higher than the lifetime prevalence of depression in southern Ethiopia. Through this research, which has been funded jointly by the Centre of Excellence for Research on Immigration, we hope to to strengthen our partnership with the Ethiopian community so that we can continue to work together to plan for their social and health care service needs.

Dr. Samuel Noh, CCHS Head, and Dr. Violet Kaspar, a CCHS Scientist, have recently published an article in the *American Journal of Public Health* about Korean immigrants and Southeast Asian refugees. In the article, it is suggested that when people perceive discrimination, they have a related increase in depression. This perception can change according to how well people cope in their new country and how influenced they have been by cultural and social factors.

New immigrants who felt more at home in their new country adopted more active coping skills. Conversely, the more closely linked they were to their ethnic network, the more passively they responded to discrimination. While Dr. Noh and his colleague found that the latter group had fewer social supports and suffered greater instances of depression, he states that the research is still in the early stages, with conclusions needing further confirmation.

Undoubtedly there are many factors that contribute to the health of those arriving in Canada for the first time. "There are so many trends that we believe are true. We have just begun to understand why some immigrants to Canada can cope better than others," says Dr. Noh. Through research and determination, Dr. Noh and his team have provided a small glimpse into the world of an immigrant. They hope to open the door on research even wider to determine factors that influence the mental health of racial and ethnic minorities, including new immigrants, refugees and their children.

Photo on cover. Caption on p. 2.

Diversity initiatives at CAMH

In addition to the diversity profiles demonstrating our work within CAMH and across the province, we present a few examples of diversity projects and initiatives in four areas of our organization: care, health promotion/prevention, research and employee education.

CARE FOCUS

- The Building Bridges, Breaking Barriers Access Project, a three-year joint initiative with five ethnocultural groups, which ensured equitable access to high-quality addiction and mental health services at CAMH. Plans include expansion to other communities, now that the original project has been completed. Our psychiatry and addiction programs have integrated recommendations from the project into their everyday work and have hired diversity consultants to provide leadership, support and expertise.
- An organizational change project with Hong Fook Mental Health Association, St. Michael's Hospital and the Chinese Canadian National Council, starting with staff diversity training. This is an innovative change model for community-based organizations.
- CAMH's Spiritual and Religious Care Services, which welcomes and celebrates all faiths and is staffed by spiritual caregivers who are trained professionals.
- A partnership with Chinese Family Services, for the joint provision of methadone treatment for Cantonese-speaking clients.
- The Interdisciplinary Plan of Client Care, which is just being implemented across CAMH, and will deal with cultural competence and diversity as a component of care.
- The Supportive Housing and Diversity Group, a Toronto-based multi-agency partnership to improve housing stability, which targets people from diverse ethnoracial/ethnocultural groups who have addiction or mental health issues.
- The Disability Working Group, with representation from CAMH staff, members of the client/consumer/survivor community and the community at large, which has been working to promote universal and inclusive access to existing and future CAMH facilities. A study is currently underway to determine the barriers to universal access in existing CAMH facilities. The results of this study will be used to develop the CAMH Accessibility Plan, a requirement for all public facilities, under the *Ontarians with Disabilities Act*.
- Aboriginal Services partnership with the Native Canadian Centre of Toronto (an agency that provides cultural and social services to Aboriginals residing in Toronto), for substance use and mental health issues.

HEALTH PROMOTION/PREVENTION FOCUS

- The Healthy Aging Initiatives and Older Adults Working group, which promotes awareness of older adult issues, both within communities and at CAMH.

- The recently published booklet *Women, Abuse and Trauma Therapy: An Information Guide for Women and Their Families*.
- CAMH's R. Samuel McLaughlin Addiction and Mental Health Information Centre, which has staff responding to calls in several languages; public information materials in up to 19 different languages (with 10 languages in addition to English and French on the website); and a toll-free Information Line with recorded information in 16 languages.

RESEARCH FOCUS

- Completion of the pilot study, "Perceived racist discrimination and its relation to depression and anxiety in Canadians of African descent."
- The initiation of a study to examine the important issue of postpartum depression.
- Provincial project underway of "Best practices in community education on addiction and mental health with ethnocultural communities," whose primary objective is to identify best practices in community education and knowledge exchange initiatives to effectively address the addiction and mental health needs of ethnoracial/cultural communities.
- Completion of the pilot study "The incidence of depression in traditional vs. non-traditional Muslims and related variables."

EMPLOYEE EDUCATION

- Completion of introductory diversity training for most CAMH staff, and follow-up training for staff involved in clinical work, staff involved in managing diversity, and those who work with communities.
- The creation of a Diversity Champions team, composed of staff at all sites and regions who provide leadership and support on diversity issues.
- CAMH representation in the Diversity Health Practitioners' Network, in which health care representatives implement diversity initiatives.

Financial Snapshot

YEAR ENDED MARCH 31, 2004

SOURCES OF REVENUE	$
Ministry of Health and Long-Term Care	**206,166,457**
Out-of-province clients	**334,441**
Differential charges for preferred accommodation	**251,739**
Grants, contributions and donations	**21,580,489**
Ancillary	**13,643,126**
Amortization of deferred capital contributions	**4,548,422**
Interest	**1,476,768**
Total	**248,001,442**

ALLOCATION OF EXPENSES	
Salaries, wages and employee benefits	**182,567,449**
Supplies, rent and other expenses	**44,803,316**
Depreciation	**5,827,014**
Rent	**2,129,357**
Drugs and medical supplies	**3,367,390**
Medical and surgical	**603,288**
Total	**239,297,814**
***Excess of Revenue over Expenses**	**8,703,628**

*$3,044,170 was used for capital acquisition (net of contributions) with the rest contributing to an increase in working capital

For a copy of CAMH's audited financial statements, contact us at 416-535-8501, ext. 4250 or visit our website at www.camh.net/pdf/camh_financials2004.pdf

CAMH by the numbers

(BASED ON THE FISCAL YEAR, APRIL 1, 2003- MARCH 31, 2004)

CLIENTS

Unique[1] clients	20,031
Inpatient admissions	3,415
Outpatient visits	374,761
Visits to Emergency Services	3,642
Average length of stay in days	63.3
Ranking of alcohol in top diagnoses for addiction clients	1
Ranking of crack/cocaine in top diagnoses for addiction clients	2
Ranking of schizophrenic disorders in top diagnoses for mental health clients[2]	1
Ranking of mood affective disorders[3] in top diagnoses for mental health clients[4]	2
Top four languages indicated by clients at time of admission, other than English and French	Spanish, Serbian, Chinese and Italian

STAFF

CAMH staff	2,687
CAMH physicians	237
Research grants/contracts	257
Amount of research grants/contracts	$33,543,310

VOLUNTEERS AND DONORS

Volunteers (approx. per quarter)	935
Hours contributed by volunteers	255,187
Donors	4,615
Amount of donations	$5,910,704

INFORMATION/EDUCATION

Calls to CAMH's R. Samuel McLaughlin Addiction and Mental Health Information Centre	58,839
Contacts (visits, email and letters) to CAMH's R. Samuel McLaughlin Addiction and Mental Health Information Centre	5,316
People who participated in professional education, training or development courses	6,419
Visits to the website	1,544,196

MULTI-FAITH INFORMATION

Regular worship services in the multi-faith Spiritual and Religious Care Services serving diverse needs of CAMH's clients and staff	520
Special holiday services	19
People attending services	5,670
Faith groups	7
New faith groups this year	2 (Hindu and Rastafarian)

Most of the statistics from this page came from CAMH's Balanced Scorecard, which measures and monitors CAMH's performance. Hard copies of the scorecard are available at CAMH libraries.

1 Unique: individual people who received care, regardless of number of visits.
2 Inpatients/clients have a higher percentage of schizophrenic disorders.
3 Includes manic episodes, bipolar affective disorder and depressive episodes.
4 Outpatient/clients have a higher percentage of mood affective disorders.

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AS OF MARCH 31, 2004

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Dr. L. Trevor Young
Physician-in-Chief

PUBLIC SECTOR SALARY DISCLOSURE ACT

As a publicly funded hospital, CAMH is bound by the *Public Sector Salary Disclosure Act* to publish the names, positions and salaries of employees receiving annual salaries of $100,000 or more. This information is available on our website at http://www.camh.net/about_camh/camh_sunshine_list2003.html

PAHO/WHO COLLABORATING CENTRE IN MENTAL HEALTH AND ADDICTION

CAMH applied and successfully received another four-year term as a Pan American Health Organization / World Health Organization Collaborating Centre in Mental Health and Addiction. This recognition of excellence is a great honour, recognized worldwide.

How to reach us

EXECUTIVE OFFICE

Queen Street Site
1001 Queen St. West
Toronto, Ontario
M6J 1H4
416 535-8501 ext. 6076

CAMH MAIN SWITCHBOARD
416 535-8501

WEBSITE
www.camh.net

SITES

Brentcliffe Road Site
175 Brentcliffe Rd.
Toronto, Ontario
M4G 3Z1
416 535-8501

Assessment Service
416 535-8501 ext. 7064

College Street Site
250 College St.
Toronto, Ontario
M5T 1R8
416 535-8501

Emergency
416 535-8501 ext. 6885

Assessment Clinic
416 979-6878

Russell Street Site
33 Russell St.
Toronto, Ontario
M5S 2S1
416 535-8501

Assessment Service
416 535-8501 ext. 6128

Queen Street Site
1001 Queen St. West
Toronto, Ontario
M6J 1H4
416 535-8501

COMMUNITY OFFICES

Hamilton
905 525-1250

Kenora
807 468-6372

Kingston
613 546-4266

London
519 433-3171

North Bay
705 472-3850

Ottawa
613 569-6024

Sault Ste. Marie
705 256-2226

Sudbury
705 675-1195

Thunder Bay
807 626-8111

Timmins
705 267-6419

Toronto
416 535-8501 ext. 6028

Windsor
519 251-0500

CLINICAL SATELLITE OFFICES

501 Withdrawal Management
501 Queen St. West
Toronto, Ontario
416 535-8501 ext. 7297

Aboriginal Services
393 King St. East
Toronto, Ontario
416 535-8501 ext. 7652

Archway
1451 Queen St. West
Second Floor
Toronto, Ontario
416 535-8501 ext. 7500

Central Link
393 King St. East
Toronto, Ontario
416 535-8501 ext. 7670

DARE
95 Browns Line
Toronto, Ontario
416 535-8501 ext. 7600

Dual Diagnosis Resource Service
700 Lawrence Ave. West
Toronto, Ontario
416 535-8501 ext. 7800

Dual Diagnosis Service—Peel
1001 Queen St. West
Unit 4, Room 470
Toronto, Ontario
416 535-8501 ext. 2870

First Assessment Clinical Team (FACT)—Peel
30 Eglinton Ave. West
Suite 755
Mississauga, Ontario
416 535-8501 ext. 7700

Lakeshore Outpatient and Community Clinic
3170 Lakeshore Blvd. West, Suite 201
Etobicoke, Ontario
416 535-8501 ext. 7233

LEARN
1709 St. Clair Ave. West
Toronto, Ontario
416 535-8501 ext. 7300

Metro Addiction Assessment And Referral Service (MAARS)
175 College St.
Toronto, Ontario
416 599-1448

PACE Central/East
1001 Queen St. West
Room 1046
Toronto, Ontario
416 535-8501 ext. 3448

PACE Peel
30 Eglinton Ave. West
Suite 755
Mississauga, Ontario
416 535-8501 ext. 7716

PACE West
3170 Lakeshore Blvd. West, Suite 202
Toronto, Ontario
416 535-8501 ext. 7206

Problem Gambling Service
175 College St.
Toronto, Ontario
416 599-1322

Spectrum
658 Danforth Ave.
Suite 402
Toronto, Ontario
416 535-8501 ext. 7450

Mail clerk, Behrouz Shahbod, and Volunteer Co-ordinator, Norma McDowall, next to project created by clients, volunteers and staff

All photographs by Sandy Nicholson

For more information on the Centre for Addiction and Mental Health, please contact:
Public Affairs
Centre for Addiction and Mental Health
33 Russell Street
Toronto, ON M5S 2S1
Tel.: 416 979-4250
Fax: 416 595-6881

For information on other Centre for Addiction and Mental Health publications or to place an order, please contact:
Marketing and Sales Services
Centre for Addiction and Mental Health
Tel.: 1 800 661-1111 or
416 595-6059 in Toronto
E-mail: marketing@camh.net

To make a donation, please contact:
Centre for Addiction and Mental Health Foundation
Tel.: 416 979-6909
E-mail: foundation@camh.net

If you have questions, compliments or concerns about services at CAMH, please call our Client Relations Co-ordinator at:
Tel.: 416 535-8501 ext. 2028.

For information on addiction and mental health issues or other resources, please contact CAMH's R. Samuel McLaughlin Addiction and Mental Health Information Centre and volunteer assisted telephone support line:
219 Dufferin St., Suite 3B
Toronto, Ontario
or phone the 24-hour Information Line:
Ontario toll-free: 1 800 463-6273
Toronto: 416 595-6111

camh
Transforming Lives

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Affiliated with the University of Toronto

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