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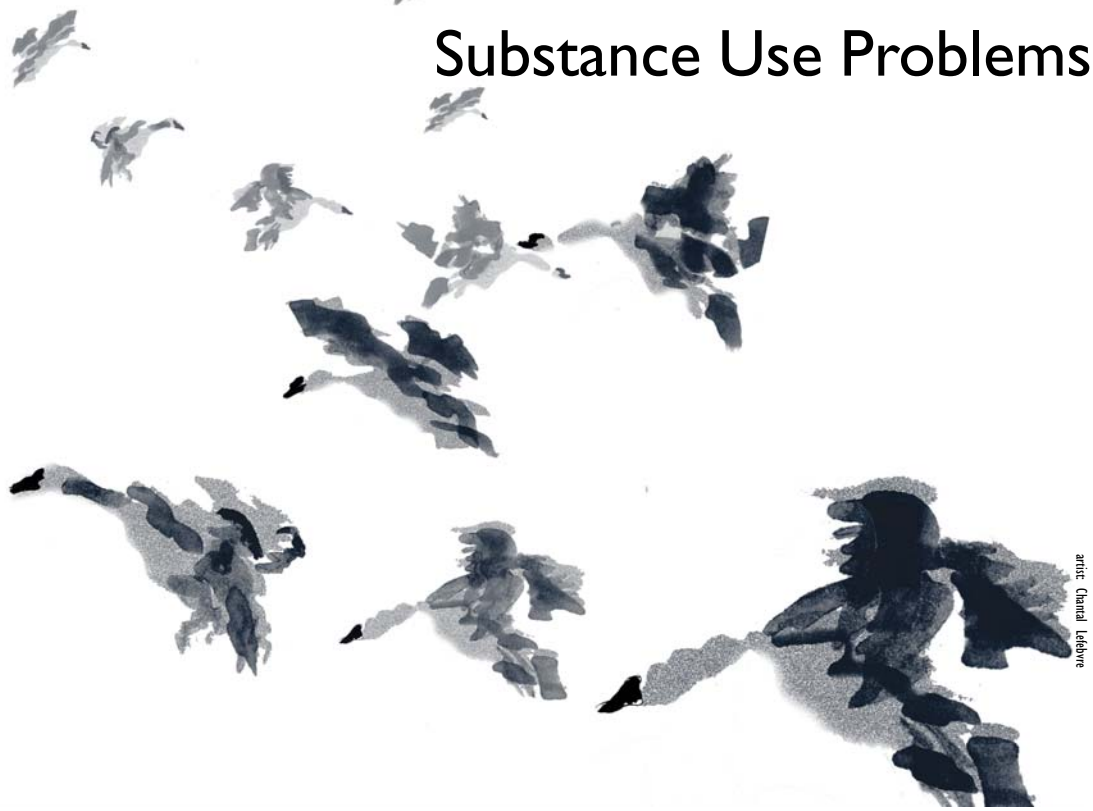
BC Partners for Mental Health and Addictions Information
EMPOWERMENT THROUGH INFORMATION

BC's Mental Health & Addictions Journal

Visions

Concurrent Disorders

Mental Disorders and Substance Use Problems



artist Chantal Lefebvre

background

experiences & perspectives

alternatives & approaches

bc partners | Seven provincial mental health and addictions agencies are working together in a collective known as the BC Partners for Mental Health and Addictions Information. We represent the Anxiety Disorders Association of BC, Awareness and Networking around Disordered Eating, British Columbia Schizophrenia Society, Canadian Mental Health Association's BC Division, FORCE Society for Kids' Mental Health Care, the Kaiser Foundation and the Mood Disorders Association of BC. Our reason for coming together is that we recognize that a number of groups need to have access to accurate, standard and timely information on mental health, mental disorders and addictions, including information on evidence-based services, supports and self-management.

visions | Published quarterly, *Visions* is a nationally award-winning journal which provides a forum for the voices of people living with a mental disorder or substance use problem, their family and friends, and service providers in BC. *Visions* is written by and for people who have used mental health or addictions services (also known as consumers), family and friends, mental health and addictions service providers, providers from various other sectors, and leaders and decision-makers in the field. It creates a place where many perspectives on mental health and addictions issues can be heard. To that end, we invite readers' comments and concerns regarding the articles and opinions expressed in this journal.

regional programs

As Dr. John Anderson points out in his guest editorial, what were once two solitudes are now coming together. The most unfortunate impact of the old approach was experienced from the perspective of the consumer, whose concurrent mental health and addictions issues often went undiagnosed, and when recognized, represented two separate service systems for the individual and/or his or her caregivers to navigate. But this is starting to change, and the evidence is all around us.

At the ministerial level, addictions and mental health have merged, and a consistent policy framework is being developed to guide service delivery throughout the province. At the regional level, health authorities are coordinating and integrating mental health and alcohol and drug services. At the service delivery level, mental health and addictions personnel are coming together to learn from each other and to develop collaborative approaches to dealing with people who struggle with both issues. And people with concurrent disorders themselves are developing their own approaches for dealing with both.

As many of the articles in this issue of *Visions* suggest, we need to respect similarity – but within a diversity of approaches – since what helps may be different depending on gender, diagnosis, severity, age, or ethnocultural community, for example. Ultimately, a successful approach to managing concurrent disorders depends on the unique relationship that the two issues have for any given individual. This relationship, and the hows and why of their coexistence, needs to be teased out for each person before a fighting chance at recovery can be created.

It is fitting and in keeping with this idea, of a common approach that respects diversity, that this issue of *Visions* is the first to be published under the banner of the BC Partners for Mental Health and Addictions Information. We represent a number of separate agencies, dealing with both mental health and addictions concerns, who are now speaking with one voice, as we continue to help people with one or both issues achieve, as our tagline says, 'empowerment through information.'

Eric Macnaughton

The BC Partners are grateful to the Ministry of Health Services for providing financial support for the production of Visions

subscriptions and advertising | If you have personal experience with mental health or substance use problems as a consumer or family member, or provide mental health or addictions services in the public or voluntary sector, *and* you reside in BC, you are entitled to receive *Visions* free of charge. You may also be receiving *Visions* as a member of one of the seven provincial agencies that make up the BC Partners. For all others, subscriptions are $25 for four issues. Back issues are $7 for hard copies, or are freely available from our website. Contact us via any of the means listed below to inquire about receiving, writing for, or advertising in the journal. Advertising rates and deadlines are also online.

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Concurrent Disorders

From Solitudes to Similitude?

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The recent Health Canada document, *Best Practices: Concurrent Mental Health and Substance Use Disorders*,[1] defines concurrent disorders as any combination of mental health and substance use disorders that might affect an individual at the same time. The report emphasizes that many people experience overlapping mental health and substance use problems that require interventions that address both disorders concurrently. A concurrent disorders strategy should therefore include screening, assessment, treatment and aftercare interventions that target both types of disorders with equal emphasis and importance.

One particularly salient section in the *Best Practices* document includes a description of the historical separation of three distinct populations: mental health clients, people suffering from alcoholism, and people suffering from drug addiction. In the past, mental health clients were treated within a system of mental health clinics or institutions. Those suffering from alcoholism received assistance from informal support groups or, in some instances, specialized residential treatment facilities. Drug addiction tended to be managed from within a criminal justice context.

In British Columbia, an extreme example of this latter phenomenon was the Heroin Treatment Act passed into law by the provincial legislature in June 1978 but then repealed shortly thereafter in response to a court challenge. Under this legislation, heroin addicts who did not enroll voluntarily in a drug treatment or a methadone maintenance program could be taken into custody and compelled to attend a government-sponsored heroin treatment program that could include up to six consecutive months detention at the Brandon Lake Treatment Centre near Nanaimo.[2]

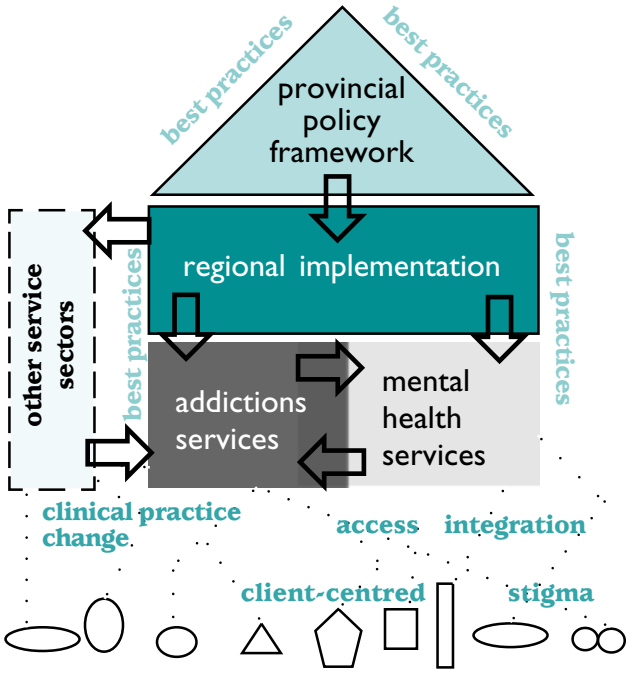
Over time, and for a variety of reasons, both public and professional perception of persons with mental health and substance use disorders has shifted from viewing affected individuals as belonging to separate and distinct populations to being part of a larger group with overlapping mental health and substance use problems.

Many are by now familiar with the barriers to effective and comprehensive treatment inherent in the separation between the mental health and addiction treatment systems. One barrier is exclusion criteria – that is, persons with mental illness denied entry into drug rehab programs, or persons apparently suffering from the effects of drug use not being served by the mental health system. Others are the lack of co-existing or connected expertise and resources to address both issues together, disagreement about treatment philosophy and lack of coordination of a continuum of services within the overall health care system.

A less common discussion, however, is about the similarities inherent to the two systems. These include:

- the relevance of a biopsychosocialspiritual model for both mental health and substance use disorders
- the need for a continuum of care that acknowledges and provides a range of services and interventions
- a legitimate role for self-help organizations
- an increasing role for pharmacotherapy (i.e., medications) in the treatment of both types of disorders
- the importance of providing support for family of those suffering from both types of disorders
- the significant impact of stigma in both populations
- the existence of common clinical outcome goals that extend beyond cure or abstinence to reduction in risk and incremental improvement in health and social well-being
- the fact that portions of both populations interact with the criminal justice system

a schematic of themes in this issue of Visions, showing a diversity of clients and client needs and how, ideally, any entry pathway to care connects the person with integrated services



In many ways, recent trends in the configuration of treatment resources and services for persons with concurrent disorders take advantage of these similarities in an attempt to reduce historical barriers and change entrenched attitudes and beliefs. Many articles included in this issue of *Visions* directly describe and discuss aspects of concurrent disorders from the perspective of commonality rather than difference. These include but are not restricted to:

- how medications for mental disorders might worsen or create substance use disorders (e.g. in the case of benzodiazapines), thus highlighting the importance of considering concurrent disorders issues when prescribing medication
- the increased impact of stigma and discrimination on persons suffering from concurrent disorders
- recently emerging problems related to 'drugs of choice' such as crystal methamphetamine, which can lead to crystal meth psychosis
- the importance of access to self-management options such as support groups that address both mental health and substance use disorders for persons suffering from a concurrent disorder
- the role of police and the criminal justice system in managing offenders with concurrent disorders
- the impact of government policy aimed at integrating mental health and addiction services at both the provincial and health authority levels
- the need to address concurrent disorders within special populations, such as young people, women and people of Aboriginal background

It is hoped that this issue of *Visions* will provide the reader with interesting and pertinent information about the management of concurrent disorders in British Columbia and also stimulate discussion and suggestions especially from the mental health and addictions consumer and advocacy community. Please join me in thanking the authors who have contributed their time and energy to this issue and who have given us all important information and insights into this emerging priority in mental health and addictions.

footnotes

1 Centre for Addiction and Mental Health. (2002). *Best practices: Concurrent mental health and substance use disorders.* Ottawa: Health Canada. See www.cds-sca.com

2 Boisvert, A. (1995). Compulsory heroin treatment in BC. *Cannabis Culture, 1.*

Addiction and Concurrent Disorders

What are They and How Can They be Dealt With?

This article was adapted from the The Primer: Fact Sheets on Mental Health and Addictions Issues. *The full document, as well as related fact sheets, can be found at mentalhealthaddictions.bc.ca*

Many *Visions* readers will be familiar with basic information about mental health problems. They may be less familiar, however, with addictions, (or any form of problematic substance use), what they are about, why they so often go hand in hand with mental health problems, or about how to deal with them when they occur together, that is, about *concurrent disorders*. As background to some of the more detailed articles that appear further on in the issue, this article gives a basic overview of the answers to these questions.

What is Addiction?

Addiction commonly refers to harmful preoccupation with substances like alcohol, or to behaviours like gambling. Technically, addiction is a disorder identified with loss of control, preoccupation with disabling substances or behaviour, and continued use or involvement despite negative consequences.

With respect to substances, it is often more appropriate to speak of 'problem substance use.' Many people use substances in a way that is not problematic. For instance, having a glass of wine with dinner, once or twice a week, is a way of using alcohol that is not likely to cause problems. Whether or not use of a substance is problematic depends on many factors, including the substance, the individual, the behaviour involved and the context.

The problems that can develop with substance use fall on a continuum from mild to severe. Someone who drinks too much alcohol every few weekends in a social situation may experience hangovers or slightly diminished overall health and fitness. They may also put themselves at increased risk of injury while they are drinking. However, if the frequency of excessive drinking increases, they could experience more severe problems such as family difficulties, significant physical symptoms, financial problems, and trouble at work.

Addiction and problem substance use are highly stigmatized, and we hear many misconceptions. Among these are the views that addiction is the result of moral weakness or lack of control, or that it is a purely medical condition like any other disease, that can be 'fixed' by a doctor.

In fact, there are a variety of factors that contribute to problem substance use, and if these factors act together, addiction may develop.

Risk factors for problem substance use include:

- a genetic, biological or physiological predisposition
- external psychosocial factors such as

references

- Kaiser Foundation, BC Addiction Information Centre.
- Alberta Alcohol and Drug Abuse Commission. *Just the Facts: What is Addiction?* Edmonton, AB.
- Health Canada. *Straight Facts About Drugs and Drug Abuse.* Government of Canada.
- Ruth C. Engs (Editor). (1990). *Controversies in the addictions field* Kendal-Hunt: Dubuque.
- Pacific Community Resources. (2002). *Lower Mainland youth drug use survey.* Surrey, BC.

approving attitudes within communities (including within schools), values and attitudes of one's peers or social group, and family situation
- internal factors such as coping skills and resources such as poor communication and problem-solving skills

These factors all influence each other, and the individual's ability to cope with stressful or traumatic events depends on all of them. A degree of rebellious substance use may be a normal part of growing up, but a vulnerability in one or more of these areas could lead ordinary experimentation into problem substance use. For instance, a child of alcoholic parents whose peer group approves of substance use is at increased risk of developing problems arising from substance use. He or she may observe parents using alcohol as a coping mechanism, and have this behaviour reinforced by a peer group that does not disapprove of such use. Alternatively, a person who manifests very few of these risk factors may develop problems arising from substance use as a result of a traumatic experience, for instance, they could become dependent on prescription drugs following a serious car accident.

the facts about substances

Addiction and problem substance use tend to be highly stigmatized, and there is a lot of misinformation around.

- The use of mood-altering substances has been a feature of human societies for thousands of years. Substance use has been regulated in various ways; it is only in the 20th century that it has been criminalized
- We all use substances, many of which affect our mood. Whether we eat something that gives us pleasure (such as chocolate or coffee), enjoy a glass of wine to enhance a meal, or take a prescribed medication to control pain from a recent injury, the use of substances is an accepted part of life
- All substances have effects. Some have greater risks. Risk is related to many factors beyond the substance
- Many people can use substances (whether legal or illegal) in moderation without experiencing problems. Usually when problems arise from substance use, there are a range of other factors at work
- Binge drinking on the weekend, over-use of prescription drugs, consuming 'club drugs' at a rave, drinking more than 5 cups of coffee, and smoking cocaine are all potentially problematic forms of substance use

Source: Kaiser Foundation

degrees of use

Substance use falls on a continuum based on frequency, intensity, and degree of dependency:

Experimental: use is motivated by curiosity, and limited to only a few exposures.

Social/Recreational: the person seeks out and uses a substance to enhance a social occasion. Use is irregular, infrequent and usually occurs with others.

Situational: there is a definite pattern of use, and the person associates use with a particular situation. There is some loss of control, but the person is not yet experiencing negative consequences.

Intensive: also called 'bingeing,' the person uses a substance in an intense manner. They may consume a large amount over a short period of time, or engage in continuous use over a period of time.

Dependence: can be physical, psychological, or both. Physical dependence consists of tolerance (needing more of the substance for the same effect) or tissue dependence (cell tissue changes so the body needs the substance to stay in balance). Psychological dependence is when people feel they need to use the substance in particular situations or to function effectively. There are degrees of dependence from mild to compulsive, with the latter being characterized as addiction.

Source: Kaiser Foundation

Concurrent Substance Use and Mental Illness

Concurrent disorders, that is, substance use along with mental illness, can be due to a number of factors. In some cases, people abuse substances as a way of attempting to treat psychiatric symptoms (or 'self-medication'). In other cases, substance misuse may trigger the onset of symptoms, especially in individuals who may be vulnerable to mental illness in the first place. Some research also suggests that people with mental illness and substance use disorders may have underlying vulnerabilities that put them at risk for developing both types of problems.

Whatever the cause, substance use, including addictions, complicates almost every aspect of care for people with mental illness, says Kathleen Sciacca, a New York-based expert on concurrent disorders. In part because people with concurrent disorders face additional barriers to adequate treatment and housing, they are more likely to experience relapses and frequent hospitalizations than people with mental illness alone. Other researchers say the toxic mix of prescription medication combined with alcohol and/or illicit drugs can cause severe drug reactions and may even trigger or worsen psychiatric symptoms. Additionally, the symptoms of a coexisting psychiatric disorder may be interpreted as poor or incomplete 'recovery' from alcohol or other drug addiction.

Despite this gloomy picture, people with concurrent disorders can recover from or learn to manage both issues if they receive appropriate treatments tailored to their needs. According to Sciacca, the key is to avoid the therapeutic approach of traditional addiction programs such as heavy confrontation and intense emotional jolting. This can cause levels of stress that work against recovery for people with mental disorders.

Sciacca recommends a non-confrontational approach that allows people with concurrent disorders to recover at their own pace, for example, through ▶

Best Practices

Guidelines for the Treatment and Support of People with Concurrent Substance Use and Mental Disorders

Brian Rush, PhD

Brian is Senior Scientist and Associate Director of the Health Systems Research and Consulting Unit at the Centre for Addiction and Mental Health, Toronto, Ontario. He was the Project Leader of Health Canada's Best Practices: Concurrent Mental Health and Substance Use Disorders initiative

Background

In the spring of 2001, Health Canada released a report on the topic of treatment and support of people with co-occurring substance use and mental disorders.[1] The report was developed by a multidisciplinary team, led by the present author, and was the outcome of more than twelve months of data gathering, research synthesis and consensus building. It concluded with best practice recommendations for improved service delivery and better integration across the specialized sectors of addiction and mental health service delivery.

My purpose in this article is to give an overview of the project and its main recommendations, and also to discuss some of the issues dealt with by the study team in the course of the project. I also discuss issues that have arisen in reaction to the *Best Practices* report and talk about the application of the report in the community and its potential to make a meaningful difference for people with co-occurring mental and substance use disorders.

Origins

The project was initiated by Health Canada's Federal/Provincial/Territorial Committee on Alcohol and Other Drug Issues as one of several initiatives undertaken within the Canada Drug Strategy. The focus on concurrent disorders was intended to build upon a series of other documents commissioned by this group concerning substance abuse treatment and rehabilitation (e.g., treatment guidelines, youth, women).

◀ *cont'd*

education and discussion in a group setting. She stresses the importance of non-judgemental acceptance of all symptoms and experiences related to both mental illness and substance abuse. Although abstinence from drugs and/or alcohol is the ultimate goal, it should not be required for entering treatment, she adds.

"Clinicians have to convey to the [participants] how hard it is to stop. They have to give [them] credit for any accomplishment. That's where the focus has to be — on any inch of progress."

Scope of the Work

In terms of overall project scope, the work commissioned by Health Canada was to address the gulf that had emerged over time between the specialized sectors of substance abuse and mental health services. Although the project team recognized the important role of more generic health, social and correctional services in the identification, treatment and support of people with concurrent disorders, for purposes of the project, priority was placed on the specialized services. We also gave priority to treatment and support services in relation to prevention or health promotion in order to keep the project manageable within the budget that we had been allocated. This priority also reflected the state of the current literature in this area, although it has been satisfying to see a recent report released in the US that has given more attention to prevention issues.[2]

Building the Case for Improved Services and Systems

With the benefit of hindsight, I can safely say that the easy part of our task was our review of the literature, showing the high rate of concurrent disorders – or *co-morbidity* – in both the general population and treatment populations, as well as the clear evidence of poorer outcomes and elevated risk of many other health and social consequences. Of particular importance is the research evidence showing poor treatment engagement and difficulties in establishing therapeutic alliances. I believe this reflects issues related to stigma and problems in current service delivery models as

much, if not more, than features of the co-morbidity itself. We also benefited considerably from a rich literature that has emerged from the US and elsewhere about the poor coordination between mental health and addiction services, a situation also seen to contribute significantly to poor consumer outcomes. A small Canadian literature, combined with our focus groups with consumers and interviews with key informants across the country, confirmed these systemic problems in Canada. In general, the information we collected and synthesized clearly pointed to the need for more integrated services as part of the solution. Defining just what was meant by integration, however, was another matter.

The Definition of Concurrent Disorders

Following similar work on treatment improvement protocols completed in the US,[3] and a standard approach seen in much of the literature, we adopted a diagnosis-based definition of concurrent disorders: namely any combination of a substance use disorder (abuse or dependence) and mental disorder as defined by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV). This generated considerable debate in the project team, especially among those more aligned with the addiction than the mental health field. We did reach consensus, however, on a DSM-based approach, in consideration of the need to build treatment and support recommendations upon a foundation of diagnosis (or diagnoses) arising from the assessment process. Our diagnostic approach was also validated during the consumer focus groups as we heard the personal stories of being bounced back and forth between the two systems without the benefit of a full psychiatric assessment that could, over time, untangle the interactive mix of addiction and psychiatric symptoms. However, it was during my first presentation to the Federal/Provincial/Territorial committee that I began to appreciate that our definition would be interpreted by some in the addiction field as a 're-medicalization' of addictions in Canada.

During workshops and other presentations on the *Best Practice* report, I soon began to devote as much as 20% of the presentation time explaining not only what DSM-IV was, but how addiction services in Canada had drifted so far away from the medical/psychiatric community that it was time for a rapprochement of sorts. When I made it clear that the assessment and treatment skills of psychiatrists as well as clinical psychologists† were needed among the community team for concurrent disorders, the concerns were allayed somewhat. But the sensitivities around the role of psychiatry in the addictions field in Canada need to be noted and dealt with constructively by anyone working to take the *Best Practice* report to the next level of community application. For me, a more important issue is the *limited availability* of psychiatrists and clinical psychologists to support the assessment process and, in the case of psychiatry specifically, to also assist through medication management and other treatment approaches.

Our use of a diagnostic approach also supported what I consider to be one of the major contributions of the report: namely, the need to consider several distinct sub-populations among people with concurrent disorders. Human nature being what it is, there is a tendency in this field to talk as if people with concurrent disorders represent one homogeneous group of people, when in fact the assessment issues and treatment and support recommendations are completely different for several important sub-populations. We separated mood and anxiety disorders, severe and persistent mental illness (sometimes known simply as 'severe mental illness' or SMI), personality disorders and eating disorders, each of which also can be broken down much further.

In the wake of the de-institutionalization of psychiatric hospitals, people with SMI have emerged as the priority population for community mental health services and, with respect to concurrent disorders, have been the subject of the most intense and systematic research program.[4] However, this high-need sub-population is rarely seen in addiction treatment services, compared to those with mood and anxiety disorders, personality disorders, and other problems related to anger, impulsivity and/or aggression. The fact that the people coming through each of the two systems are so different influences the choice of screening tools, referral linkages for follow-up assessment, and in-house requirements for clinical competencies or skills. Yet these differences get almost no consideration in the planning or policy development process.

The Best Practice Recommendations

Our subsequent recommendations were directed at two levels. The first was the system-level and, most importantly, included calls for top-down policy development necessary to support bottom-up community coordination activities such as service agreements, other local coordinating mechanisms and pilot projects. We also recommended improved training and educational curricula as well as local cross-training, where personnel from each system train one another. This is one of the lowest cost and potentially high impact approaches to improved coordination of services. We also decried the lack of evaluation at the system level that would produce better evidence about the link between various coordinating mechanisms and actual consumer outcomes.

At the service delivery level, we organized our recommendations in three areas: screening, assessment and treatment/support. As important as the treatment/support recommendations are for front-line workers, in terms of their potential for immediate and lasting acting impact at a system level, the recommendations concerning the need for universal screening for concurrent disorders in both mental health and substance abuse services may well be the most significant. The

note

† Clinical psychologists nationally, as well as MSW social workers in Newfoundland, are also certified to give psychiatric diagnoses based on DSM-IV

research is very convincing that a large percentage of people in contact with mental health and substance abuse services have concurrent disorders that go undetected. Of course, if this isn't detected in the first place, then the later steps in the process – assessment, treatment and support planning – will be negatively impacted.

I have discussed how our report segmented the concurrent disorder population into separate sub-groups, which clearly require different treatment and support approaches. I should note, however, that the research evidence supporting the recommendations specific to each sub-group is clearly stronger in some areas than others (e.g., substance abuse and SMI, compared to substance abuse and personality disorders or eating disorders).

The report also made an important and much neglected distinction between the *integration* of services and the *sequencing* of interventions. For example, the evidence is strong that services for people with SMI and substance use disorders are best delivered in an integrated service delivery model and simultaneously. This stands in contrast with our recommendation for depression and alcohol abuse where a sequenced approach makes more sense for a significant majority of consumers, given the high probability that the depressive symptoms will improve following a period of abstention or reduction in alcohol intake. While the recommended treatment in this case would be sequenced, the services would still be delivered in integrated fashion, meaning that the consumer him or herself wouldn't have to negotiate two separate and uncoordinated 'streams' of care. Also highlighted is the need for ongoing case monitoring and assessment to assess effectiveness of initial treatment plans.

Finally, we made an important and also much neglected distinction between program versus system-level integration. We noted that the repeated call in the literature for integrated services was based primarily on two things: (1) an almost exclusive focus on people with SMI and substance use disorders (i.e., the most severe and highest need sub-population) and (2) the inherent problems with so-called 'parallel' or 'sequential' services delivered by two or more programs that do not communicate with each other in the assessment, treatment/support and follow-up process.

In the emergent era of increased inter-agency collaboration, partnerships and service agreements, we felt it was important to also advocate for new innovative models of inter-organizational service delivery. Such approaches are needed as an alternative to a more restrictive vision of integration. At the local level, this all too often translated into having a capability for dealing with concurrent disorders *only* in the form of individual, highly specialized programs. Such exclusive, program-level integration also made no sense in the context of all the different sub-groups of concurrent disorders, where many people are quite adequately dealt with through programs that are still 'sequential' or 'parallel,' to use the old language, but which take a coordinated approach to delivering care to the individual. Our emphasis on systemic integration also points clearly to the need for upgrading the general capability for addressing concurrent disorders across *all* provider organizations and clinicians, as opposed to building only highly specialized services.

Chances for Making a Difference

Health policy and health services research are abuzz these days with terms such as 'knowledge transfer' and 'evidence-based practice.' Clearly our *Best Practice* report tapped into a groundswell of felt need and one would like to think that the enthusiastic response should auger well for the uptake of many of our recommendations. Unfortunately, effecting change at the levels of clinician and organizational behaviour, as well as making broad systemic change, will require more than information and enthusiasm. Meaningful change requires more than just additional funding – although I should point out the chronic underfunding of community mental health and addictions services across Canada, especially in comparison to the institutional sector. I recognize it is a challenge to talk about addressing the needs of particular sub-populations when budgets have been flatlined for several years, at least in Ontario, and programs are struggling to maintain base-level services in a quality manner.

> Human nature being what it is, there is a tendency in this field to talk as if people with concurrent disorders represent one homogeneous group of people, when in fact assessment, treatment and support recommendations are completely different for several important sub-populations

In some provinces, such as British Columbia and Ontario, we have seen an amalgamation of addictions and mental health at the provincial level, within the respective provincial health ministries. This is a good sign, but the integration process was underway or complete before the release of Health Canada report.

footnotes

1 Centre for Addiction and Mental Health. (2002). *Best practices: Concurrent mental health and substance use disorders.* Ottawa: Health Canada. See www.cds-sca.com

2 Substance Abuse and Mental Health Services Administration. (2002). *Report to Congress on the prevention and treatment of co-occurring substance abuse disorders and mental disorders.* Rockville, MD: Substance Abuse and Mental Health Services Administration. See www.samhsa.gov/reports/congress2002/index.html

3 Ries, R. (1994). (Consensus Panel Chair). *Assessment and treatment of patients with coexisting mental illness and alcohol and other drug abuse: Treatment improvement protocol (TIP).* Series No.9. Rockville, MD: Centre for Substance Abuse Treatment See www.health.org/pubs/catalog/ordering.htm

4 Mueser, K, Noordsy, DL, Drake, RE & Fox, L. (2003). *Integrated treatment for dual disorders. A guide to effective practice.* New York: Guilford Press.

5 Panzano, PC, Roth, D, Massatti, R, Crane-Ross, D & Carstens, C. (2002). The innovation diffusion and adoption research project (IDARP): Moving from the diffusion of research results to promoting the adoption of evidence-based innovations in the Ohio Mental Health System. *New Research in Mental Health, 15,* 149-156.

The BC health authorities *have*, however, been mandated to address the integration of these sectors at the regional service delivery level. In Ontario, very little movement has been made toward provincial policy development. We do have a provincial program of concurrent disorder activities underway though the Centre for Addiction and Mental Health – including for example, training activities, a stigma project, a family intervention project, research on screening tools, descriptions of program models – as well as service coordination activities in a number of communities.

These are all positive signs, which no doubt mirror to some extent the situation in most provinces. What is lacking, however, in each province and nationally, is a planned and well-funded research and development program with clear targets for system change and strategies grounded in current evidence regarding change processes and knowledge transfer. We have no national forum or focal point for discussion and sharing of ideas and experiences; no mechanism to prevent duplication of effort; no process to identify and support regional and provincial champions of the change process; no toolkits to transform the information from the *Best Practice* report and other sources into more user-friendly advice; and perhaps, most importantly, no baseline data or national research plan that will give us performance indicators to measure ongoing improvement in service delivery and consumer outcomes.

These are all elements of effective knowledge exchange strategies, and they are being implemented in some jurisdictions through more strategic planning and dedicated resources.[5] Although implementation of the *Best Practice* report is essentially a provincial responsibility, the dissemination process could benefit from more focus and leadership at a national level. This could be incorporated into ongoing activity in the context of the Canada Drug Strategy or an overall national mental health strategy, such as may be recommended by the anticipated Kirby Report and advanced by groups such as the Canadian Alliance for Mental Health and Mental Illness. It may also be the time for innovative bridges to be built across the Canada Drug Strategy and an emergent national mental health strategy. What better way than to lead by example.

Concurrent Disorders

Considerations for Evidence-Based Policy

Gulrose Jiwani and Julian Somers (co-authors)

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The term 'concurrent disorders' can refer to any disorders that occur at the same time. For the purpose of this article, concurrent disorders refers to being affected by both a substance use disorder and another mental disorder.

The US National Comorbidity Study (1996) reported that 29% of the general population aged 15-54 had a concurrent alcohol and/or drug problem and mental disorder in the past year.[1] Recent British Columbia data (2002) indicate that over 70% of people aged 15-64 receiving addictions treatment services are also receiving mental health services; and, 20-40% of people with mental illnesses also have been treated for an alcohol and/or another substance use disorder.[2] Numerous studies in different countries confirm that having either a substance use problem or another mental disorder increases the probability of having both types of problems at the same time.[3]

The presence of concurrent disorders increases the complexity of a person's treatment and the potential severity of their health condition. Persons with concurrent disorders generally have more severe psychiatric symptoms and are at higher risk for suicide, family violence, HIV infection, homelessness, incarceration and re-hospitalization. Concurrent disorders have also been associated with high rates of violence and criminal behaviour.[4,5] Despite the prevalence and burden of illness associated with concurrent disorders, the essential continuum of effective interventions is poorly understood and insufficiently supported.

Individuals presenting with concurrent disorders have historically encountered a treatment system that has been ill-prepared to meet their needs. Moreover, epidemiological studies such as the Ontario Health Survey suggest that the people most likely to present for help are those who have the most severe symptoms and multiple co-occurring problems.[6] This finding highlights two significant needs: first, that treatment for people seeking help must be responsive to multiple needs

simultaneously; second, that services must be provided for people with less acute symptoms, including early intervention and population health initiatives.

Historically, services for mental health and substance use have been administered and implemented separately. The separation of services results in treatment that is provided either sequentially – first one issue, then the other – or in parallel form – in which treatment providers at separate locations implement treatment plans to treat each condition separately but at the same time. The treatment needs of persons with co-occurring mental health and substance use problems differ from the treatment needs of those with either a substance use problem or a mental health problem alone. Evidence about best practice suggests strongly that treatment that addresses *both* the substance misuse and mental health issues should be present at the same time.

The recent Health Canada *Best Practices* report (see preceding article) focused on synthesizing research information and on developing recommendations for the screening, assessment and treatment/support of persons with concurrent disorders.

Based on the evidence, effective health policy would promote:

- general societal awareness of factors contributing to good mental health or to mental disorders with or without concurrent substance use disorders
- identification of at-risk populations for whom the development of mental health and substance use problems may be prevented or dealt with at an early stage
- access to relevant information and self-management resources that support active participation of individuals and families in addressing concurrent disorders
- evidence-based mental health and addictions treatment for individuals and families
- effective matching of treatments and resources to individuals in need
- flexibility in the systems of care and diverse services, affording individuals with a choice of services, and the ability to enlist in different services at different points in time
- case management providing consistent and supportive client contact
- support for siblings and family members in managing their own mental health
- continuous, integrated professional development for health care providers in mental health and addictions
- multiple entry points to services and supports
- sharing of relevant information between appropriate care providers
- co-ordinated planning across health authorities and other partners at the municipal, regional and provincial levels
- ongoing implementation of evidence-based practices for concurrent disorders

The BC Ministry of Health Services is developing an *Addictions Planning Framework* for the health system in BC. The Framework is intended to assist health authorities and other stakeholders in the development of integrated services for addictions, including concurrent disorders. In addition, the Ministry is supporting improved services for concurrent disorders through better integration of primary care and mental health service providers. Information on both initiatives is available from the authors.

No best practice can be presumed to be best long into the future, so we need to repeatedly redefine and implement better practices. To support this constant evolution, we need to consciously create a system that facilitates knowledge-sharing and the linkage of research with practice. This requires co-operation at all levels, from grassroots to policy-making, from groups of individual practitioners to groups of organizations with related mandates, and from individuals and families to researchers. All have roles in the synthesis of information, application of knowledge to practice, and within the cycle of continuously-feeding information from practice and research back into the world of evidence. Synergies are necessary and will develop through recognition of individual and collective responsibilities, mandates, capacities and resources. Best practices needs to be more than a goal or an endpoint; it needs to be a philosophy, a mindset that influences actions taken at every step in the process, by every stakeholder involved, and throughout every step in the evolution of the system of care for people with concurrent disorders.

In conclusion, we are currently challenged to develop an integrated, evidence-based continuum of mental health and addictions services throughout British Columbia. In so doing, it is important to ensure timely access to treatment options and support to increase people's capacity to make healthy choices. Health care providers need support for ongoing professional development regarding evidence-based prevention and treatment services in relation to concurrent disorders. Collectively, we are all responsible for ensuring that 'every door is the right door.'

footnotes

1 Kessler, RC, Nelson, CB, McGonagle, KA, Edlund, MJ, Frank, RG & Leaf, PJ. (1996). The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization. *American Journal of Orthopsychiatry, 66*, 17-31.

2 BC Ministry of Health Services. (2002). *Mental health and addictions analyses.*

3 Hall, W. (1996). What have population surveys revealed about substance use disorders and their comorbidity with other mental disorders. *Drug and Alcohol Review, 15,* 157-170.

4 Steadman, HV, Mulvey, EP, Monahan, J, Robbins, PC, Appelbaum, PS, Grisso, T et al. (1998). Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighbourhoods. *Archives of General Psychiatry, 55,* 393-401.

5 Wallace, C, Mullen, PE & Burgess, P. (in press). Offending in a population of people with schizophrenia. *American Journal of Psychiatry.*

6 Ross, HE, Lin, E, & Cunningham, J. (1999). Mental health use: A comparison of treated and untreated individuals with substance use disorders in Ontario. *Canadian Journal of Psychiatry, 44* (6), 570-577.

Collectively, we are all responsible for ensuring that every door is the right door

A History of Alcohol and Drug Services in BC

Ron Duffell

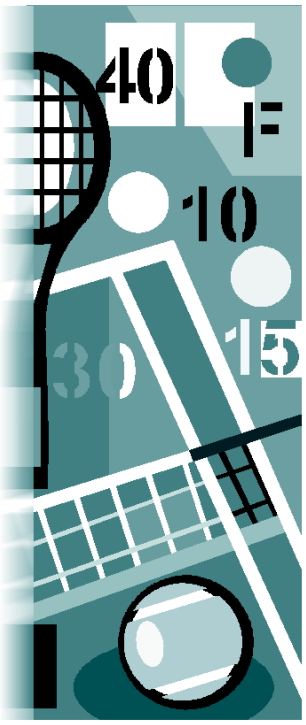
Ron is Director of Special Projects for Health Protection Planning in the Ministry of Health Services

Programs and services must adjust to reflect changing client demographics, public policy, emerging research, and fiscal realities. My experience in the public service is that all program areas can undergo subtle or significant change at any given time. Alcohol and Drug Services (A&D) is one of those programs that stands out as having undergone significant organizational and service delivery transformation since its inception.

In the 1950s, science and academic knowledge of addictions was rudimentary. The then-fledgling Addiction Foundation of BC opened an outpatient treatment centre in Vancouver and shortly after, the Narcotics Addiction Foundation was incorporated. Alcoholism and drug addiction were viewed as two separate streams of concern requiring two separate approaches. The methodology of treatment was primarily based on the self-help model most familiarly associated with Alcoholics Anonymous.

addictions services have bounced around from ministry to ministry

there are many passionate viewpoints as to the causal factors of addiction, how it can be treated or prevented, the adequacy of resources, where the resources should be allocated and who should or should not manage the service delivery system



As research demonstrated a need to establish one system to provide all substance abuse services, in 1973 the government of the day proclaimed the Alcohol and Drug Commission Act to establish a commission that was to assume responsibility for all services. While providing addiction services to the general population, the criminal impact and influence of addiction was a dominant focus of the commission's energies. One mainstay of the commission was its implementation of the methadone program and compulsory treatment for heroin users under the Heroin Treatment Act. The act enabled the detention of users in the province's heroin treatment centre.

Following a repeal of the Heroin Treatment Act in 1982 the government realigned addiction services to broaden its health focus. The Alcohol and Drug Commission was disbanded, and the services were relocated under the Ministry of Health within a new division called Alcohol and Drug Programs (ADP). The following years were a period of limited growth but resulted in the development of significant program expertise and knowledge.

In 1987, the province received the *Jansen Report* on liquor policies for British Columbia and the *Ryan Report* on alcohol and drug abuse in the workplace. Both recommended significant increases in funding for addiction services. Also in 1987, the Sullivan Commission on Education recommended the inclusion of a comprehensive school health program to include alcohol and drug use information within the curriculum. That year's budget speech verified the need for additional funding and stressed the need for better coordination of all the programs related to substance abuse.

As a result, the coordination of services and policy development was designated to the Ministry of Labour, as opposed to having it spread through a number of different ministries. Sixty million dollars in new funding was added for new program areas and for the first time in BC, prevention services. Funds were distributed to the Ministry of Education for school-based programs and the Ministry of Health to strengthen parenting programs. ADP was moved from the Ministry of Health to the Ministry of Labor and Consumer Services. The funding and restructuring was presented in the form of a three-year, province-wide T.R.Y. (The Responsibility is Yours) campaign.

In 1991, the Royal Commission on Health Care (the *Seaton Report*) made recommendations on sweeping changes to the delivery of health care in BC. While the report suggested establishing an independent commission to govern addictions services, the government determined that the services needed to be realigned and better integrated with health services and therefore moved them to the Ministry of Health in 1992. A great-

er focus on facilitating linkages between the community-based prevention services was made.

In November 1995, the report on the Gove Inquiry into Child Protection was presented to government. The author's recommendations were primarily intended to address child protection issues arising out of the tragic death of Matthew Vaudreuil; however, many of the recommendations were designed to make fundamental change to improve the quality of life of children in British Columbia, not simply from a child protection viewpoint. One of the suggested changes was to integrate all community services that were seen to be fractured. Alcohol and Drug Services was seen as an integral part of the community service delivery systems and was moved with 35 other program areas from across five separate ministries into a newly-formed Ministry of Children and Families (now known as the Ministry for Children and Family Development). Judge Gove reasoned that "professionals working together on a daily basis to meet the needs of their clients would not owe allegiance to a variety of authorities that may or may not share common values and priorities."

In the later part of 1990s, the Vancouver Downtown Eastside drug use problems, the interest in a four-pillar approach (prevention, harm reduction, treatment and enforcement), and the complexities in the successful treatment of the dually-diagnosed or concurrent disorders client caused a review of the alignment of addictions services. In 2002, Alcohol and Drug Services was moved to the Ministry of Health Services and Health Planning, where the policy responsibilities for treatment were integrated with Mental Health into a Mental Health and Addictions Division. Policy direction for prevention was aligned with the Population Health Division. As health services are delivered on behalf of the Ministry of Health by five regional health authorities, alcohol and drug prevention and treatment program delivery was transferred under their responsibility. All of the health authorities have developed close linkages between their mental health and alcohol and drug services. Many have developed a fully-integrated model of service delivery.

Managing the A&D portfolio is complex and never easy. There are many passionate viewpoints as to the causal factors of addiction, how it can be treated or prevented, the adequacy of resources, where the resources should be allocated and who should or should not manage the service delivery system. It is a subject area where almost everyone has experienced some impact in their lives and where everyone has an opinion. It is because of this that alcohol and drug services will always encounter tensions or a 'push-pull' in its service delivery focus and its organizational structure.

What is clear in my experience is that where a service is valued and relevant to the community it serves, it will sustain organizational change.

Discrimination²

The Double Stigma Against People with Mental Illness and Addictions

Harkirat Kaur

Harkirat is a volunteer and former co-op student at the Canadian Mental Health Association's BC Division

Prejudice can show its ugly head in many forms; racism, sexism, homophobia and other forms of social injustice are unfortunately still very much a part of our society. But while social movements have begun to address these forms of injustice and have made some gains in recent history, we are only gradually beginning to realize that discrimination against people with a mental illness and/or addiction are issues that need to be dealt with as well.

Mental illness and addiction are both conditions that can have an enormous impact on the lives of those affected by them, as well as on those around them. While these conditions can be very debilitating in and of themselves, their impact on peoples' lives can be increased greatly by the ways in which these people are treated in society. People with a mental disorder or addiction are often blamed for their condition. Many people believe that a mental illness or addiction represents a weakness, a behavioural choice or an inherent character flaw that needs to be changed.

This is worse for people with an addiction than a mental illness. In one research study, a sample of interviewed people – including caregivers of people with alcohol addictions, mental health professionals, educators and judges – blamed people with alcohol addictions twice as much as people with mental illnesses for their respective stigmas.[1] One thing is clear though: people with both these conditions are too often treated with anger, fear and resentment, instead of compassion and support. Consequently, people with a mental illness or addiction have so internalized their shame that they often feel unjustified in speaking out for their rights.

The impacts of prejudice and discrimination on people with a mental illness or addiction are manifold. They are at a much higher risk of having their human rights violated. For instance, a person with a mental illness is more likely to be the victim of an act of violence than the perpetrator.[2] This is in direct contradiction to the commonly-held myth in society that people with mental illness are more aggressive and violent. Moreover, people with a mental disorder or addiction are often dehumanized and seen in terms

The Hidden Addiction

Adverse Effects of Benzodiazapines and other Psychiatric Drugs

Janet Currie

Janet has been the director of a research consulting firm in Victoria for over twenty years. She is also a member of the international voluntary organization, The Benzodiazapine Awareness Network, and on the board of PharmaWatch, a national consumer organization that promotes drug safety

Sarah is a dynamic professional woman in her 40s who is also an artist and runs triathlons. When her husband of twenty years was diagnosed with terminal cancer a year ago, her world was turned upside down. In order to sleep and cope with the needs of her family, she reluctantly accepted a prescription of Ativan, a benzodiazepine tranquillizer. After several weeks, she found that the pills weren't working and again, at her doctor's suggestion, increased the dose. Instead of feeling better, she started experiencing symptoms she never had before: panic, crying jags, suicidal feelings, paranoia, rages, lack of concentration, dizziness, nightmares and insomnia. Adding other tranquillizers and an antidepressant made her worse. Shortly after her husband's death, she was hospitalized three times, once under the Mental Health Act, and treated as if her symptoms were due to a mental illness. Not knowing what had happened to her and still grieving the death of her husband, Sarah was frightened, depressed and bewildered.

In the mid-1990's Jean-Pierre, a journalist from Quebec, was in the process of adjusting to a painful divorce and separation from his only child. Problems with sleep and psychosomatic reactions (due to normal depression) led him to a psychiatrist who prescribed the benzodiazepine Loftran (Ketazolam), and a few months later the sleeping pill, Imovane (Zopiclone). Although he took the drugs only intermittently, within a few months Jean-Pierre started developing gastric problems, fatigue, dizziness, increased insomnia, and cardiac-like symptoms. The worst problem for this long-distance cyclist was the disabling muscle pains that became so severe it was sometimes difficult to walk. For two years, he visited a variety of specialists including rheumatologists, a gastrotenterologist, neurologist, cardiologist, allergist, and several psychiatrists and psychologists, and underwent many tests to determine why his health was worsening. Three more years of intense suffering passed before he began to solve the mystery.

Instead of being mentally or physically ill, both Sarah and Jean-Pierre were suffering from tranquillizer/sleeping pill dependence that had gone unnoticed by all the health professionals each of them dealt with. When tolerance to psychiatric drugs develops, the drugs lose much of their effectiveness, and withdrawal symptoms appear even when the user continues to take the drug. Benzodiazepines like Ativan, Serax, Klonopin, Rivotril, ▶

Discrimination[2] | *continued from previous page*

of a diagnosis, rather than as a person – not just by the public, but by mental health professionals as well. A 1990 British study found that psychiatrists were more likely to rate a patient (who had been arbitrarily diagnosed with an alcohol addiction for the purposes of the experiment) to be difficult and annoying than those who had not.[3] This is part of the process of justifying the continued discriminatory treatment of people with a mental illness and/or addiction.

Discrimination against people with a mental illness or addiction goes further than simple name-calling or public perceptions, however. It also means that they have more difficulty finding and sustaining employment, decent housing and a good education, and that they are more vulnerable to being treated badly by societal institutions like the legal system, the police and the health care system.

People who have a dual diagnosis of a mental illness and an addiction are faced with even more barriers to wellness. Mental health services may refuse treatment to a person with an active addiction, while at the same time, addiction services may not treat the addiction until the mental illness is dealt with. In this way, people with a dual diagnosis may end up being shuffled back and forth between the two systems, and may never get treated for either. While those who work in the mental health and addictions systems are now beginning to realize that both issues need to be dealt with concurrently, there are only a handful of available support services that are starting to do this.

Perhaps what is now necessary is for people with a mental illness or addiction (or both) to learn from other social movements and begin to stand up for their human rights by demanding essential services and a change of attitude towards the ways they are perceived and represented in society. In this way, we can move towards a society free from all forms of discrimination – and live up to our image as a society that protects the rights and freedoms of all its members, particularly those who are most vulnerable. i

references

1 Fulton, R. (2001). *The stigma of substance use and attitudes of professionals: A review of the literature.* Toronto, ON: Centre for Addiction and Mental Health.

2 Hiday, VA, Swartz, MS, Swanson, JW, Borum R, & Wagner, HR. (1999). Criminal victimization of persons with severe mental illness. *Psychiatric Services, 50*(1), 62-68.

3 Farrell, M & Lewis, G. (1990). Discrimination on the grounds of diagnosis. *British Journal of Addiction, 85,* 883-890.

Valium and others can cause dependency within a few weeks or months and should only be prescribed for a maximum of two to four weeks. Sleeping pills like Imovane, Ambien and Sonata also cause dependence. We also now know that SSRI antidepressants such as Paxil, Effexor, Prozac and Zoloft can also cause dependence (called discontinuation symptoms by drug manufacturers) which can include symptoms that are similar to medication side effects, and also mimic the symptoms of the original illness itself, upon withdrawing from the medication. While the chances of such problems can be minimized by gradually tapering the dosages, some people will still have significant difficulties stopping these medications.

Benzodiazapines and antidepressants can have adverse affects in addition to dependence. 'Benzos,' as they have come to be called, are central nervous system depressants which can cause depression. They can also lead to emotional blunting, memory loss, cognitive impairment, agoraphobia, loss of balance (leading to hip fractures), 'pseudo-dementia' (symptoms that appear to be dementia), suicidal ideation and violent outbursts. Known adverse effects of antidepressants include an increased risk of suicide, agitation, mania, depression, gastric problems, weight gain and sexual dysfunction.

It is a painful reality that people taking psychiatric drugs are often considered to have serious medical or psychological problems when they are simply experiencing the effects of the drugs they are taking. Many patients and physicians do not recognize the range of symptoms associated with psychiatric drugs. Nor are they aware of effective strategies for withdrawing from them. A phased-in substitution of a longer-acting benzodiazapine (such as Valium), followed by small drug reductions at regular intervals has been proven to be the most successful method for withdrawing from benzodiazepines and sleeping pills. Instead of slowly tapering their dosages, however, people may be advised to take additional drugs in order to address the drug's symptoms. Some become multiple prescription drug users with chronic health or mental health problems.

As Jean-Pierre states:

My worst enemies in solving my problems have been the medical system itself. If the physicians, specialists, psychologists, psychiatrists, pharmacists had accepted my questionings in those years, I would have stopped taking the tranquilizers and sleeping pills much sooner. Nobody admitted that my pills could have been behind my symptoms. And I saw lots of so-called experts.

The numbers of Canadian using benzodiazepines, sleeping pills and antidepressants is enormous. Psychotherapeutic drugs are the second most prescribed class of drugs. In 2002, over 38 million prescriptions were dispensed. And although Canada has programs to address drug/alcohol addiction, we do not have one specialized counselling/treatment program to help those who are addicted involuntarily to prescription drugs. Tapering and recovery from drugs like benzodiazepines, unlike withdrawal from illegal drugs such as heroin, is a long-term process that will likely take months.

As a society we need to look at personal and societal costs of adverse drug effects and dependence more seriously, to ensure that prescribing of psychiatric drugs is appropriate and that patients are advised of all potential risks. If dependence occurs, patients should be provided with support, information, reassurance and correct information about tapering.

This article is based on the author's piece "Manufacturing Addiction" written for the BC Centre of Excellence for Women's Health policy series. For full text, with references, see: www.bccewh.bc.ca/Pages/policyseries.htm

If this article has raised questions about medications you are on, talk about these concerns with a doctor who is well informed about the possible adverse effects of psychotropic medications. Never stop these medications abruptly. For more information, see www.benzo.org.uk

Substance Use by Girls and Young Women

Taking Gender into Account in Prevention and Treatment

Nancy Poole

Nancy is a research consultant on women and substance use for BC Women's Hospital and BC Centre of Excellence for Women's Health

Increasingly, we are seeing the importance of applying a gender lens, as well as attending to age and other types of diversity when working to prevent or treat addictions problems. A recent three-year study[1] undertaken by the National Center on Addiction and Substance Abuse (CASA) at Columbia University on the characteristics of girls and young women (ages 8-22) with substance use problems compellingly illustrates the benefits of taking into account sex differences and gender role influences in addiction.

The CASA researchers found unique risk factors for substance misuse by girls and women:

Physical Health Impacts

Girls and women have greater vulnerability to the physical health impacts of substance use in itself, which makes them more vulnerable to addiction and other health problems associated with use. The study explores specific adverse health consequences that are more serious for girls and young women related to alcohol, tobacco, ecstasy and prescription medications.

Transitions and Risk

Key transitions such as moving from one neighbourhood to another, or moving from high school to college are times when girls and women are at higher risk for substance misuse. This is related to increase in levels of use and risky changes in attitudes such as seeing substance use as 'cool' or a way to be rebellious.

Emotional Motivations

Girls and women tend to use tobacco, alcohol or drugs to improve mood, increase confidence, reduce tension, cope with problems, lose inhibitions, enhance sex or lose weight. These emotional and relational reasons can keep them in a destructive cycle, trying to find answers in drugs, rather than finding more adaptive supports and changes.

Links to Abuse

Sexual abuse and physical abuse, which are experienced more often by girls than by boys, are strongly related to abuse of substances. Girls who have been sexually abused are more likely to use and misuse substances earlier, more often and in greater quantities. Other studies published in 2003[2] confirm high rates of dating violence reported by adolescent girls and that girls who were victims of dating violence were more likely to be involved in other violent behaviours, to report extreme sadness and suicidal actions, to use illicit substances, and to engage in risky sexual behaviour.

Related Conditions

In addition to having a higher chance of being sexually or physically abused, girls are more likely than boys to be depressed and to have eating disorders. All of these factors increase the chances for substance abuse.

The CASA researchers note that schools, professionals and public policy makers have failed to pay sufficient attention to the unique motivations for use and the accelerated consequences of use for this population in one-size-fits-all substance use prevention and treatment programming. Building from the findings of this report, the researchers highlight recommendations for action to a number of groups – including parents, schools, communities, health professionals, clergy, media, policy makers and the research community – so that the issues facing girls and young women can be addressed. The study, known as *The Formative Years Report* can be found online at www.casacolumbia.org

footnotes

1 National Center on Addiction and Substance Abuse at Columbia University. (2003). *The formative years: Pathways to substance abuse among girls and young women ages 8-22.* New York, NY: CASA.

2 Howard, DE & Wang, MQ. (2003). Risk profiles of adolescent girls who were victims of dating violence. *Adolescence, 38*(149), 1-14.

Crystal Meth Psychosis

Ian Martin, BScME, MD, CCFP

Ian is a Vancouver family physician working at Three Bridges Community Health Centre where he attends to the health care needs of those who suffer from mental illness and addiction issues, those who identify with the lesbian/gay/bisexual/transgendered (LGBT) community, and street youth. He has developed a specific interest in the management of crystal meth dependency, and is actively involved in trying to help develop better ways to help those affected by this drug

Abuse of *crystal meth* (CM), a form of methamphetamine, is a growing problem in many different regions of the country, and those who use it come from a variety of different backgrounds. CM is a powerful stimulant which can be injected, snorted, smoked or swallowed. In addition to creating a 'high,' CM artificially stimulates the body's adrenalin system, raising body temperature, heart rate and blood pressure. Immediate dangers of intoxication with CM may include heart attack, stroke, seizures and even death. However, more commonly, psychosis and long-term changes within the brain associated with its use plague the user and place a huge burden on health and addiction resources, which are often ill-equipped to deal with the problem.

Worldwide, amphetamine and methamphetamine are the most widely abused drugs after cannabis (marijuana). According to the World Health Organization, there are 29 million regular users in the world, which is more than for heroin and cocaine combined.[1] In Vancouver, 68% of street youth report having used CM at some point in their lives; 46% report using the drug within the last month; and the prevalence of CM use is most pronounced among the Aboriginal and lesbian/gay/bisexual/transgendered (LGBT) communities.[2] Some people use CM to enhance sexual pleasure. Gay or bisexual men who use CM (via any route) have a much higher risk of HIV than heterosexual intravenous drug users due to unsafe, prolonged, rough sex practices.[3] Because small amounts of the drug can be used to suppress appetite, suppress sleep and enhance concentration, it is used by students and professionals to lose weight and meet deadlines.

Amphetamine psychosis was first described in 1944, by Dr. Clifton Himmelsbach of Kentucky and his team, who provided varying amounts of amphetamine to opiate-addicted prisoners.[4] Today, the drug has changed, but the symptoms are similar. In terms of its chemical makeup, methamphetamine is the basic amphetamine molecule with an extra methyl group, or carbon atom, on its molecular structure. The extra atom allows the drug to impact the dopamine reward centre of the brain (the limbic system). This creates a more intense high than amphetamine and makes it more addictive and toxic to the brain. The term 'crystal' refers to the drug's appearance (see photo on opposite page) which usually looks like clear shards of glass that are then crushed. The form of methamphetamine used today can be crushed up, heated and still have a potent effect on the brain, meaning it can be smoked.

CM users usually experience some degree of psychological problems due to the drug. CM-related psychosis – indistinguishable from the psychotic symp-

toms of paranoid schizophrenia – is often the most troubling. A single dose of the drug can keep the user awake for 24 hours or more, and psychosis most commonly develops with more sustained binges of use which often last three to eight days at a time. Symptoms of psychosis seen with CM use include paranoia, hearing voices, disorganized thinking, and formication (a sensation as though small insects are crawling under the skin). The latter of these may cause the user to seek medical attention for what they believe to be scabies or lice, and which may appear to be severe acne but is due to the individual picking at his or her skin. An additional psychotic symptom often seen is stereotypy, which is meaningless, repetitive activity such as assembling and disassembling bicycles or making intricate drawings for hours at a time. As with many of these symptoms of psychosis, users are aware that the activity is meaningless, but are unable to stop.[5] However, with sustained use, insight into their actions is lost and the CM user becomes increasingly psychotic.

After bingeing, the user will sleep for prolonged periods and often awake with symptoms of confusion and psychosis, along with profound depression leading to suicidal behaviour and potential violence. These users are unable to take medication as prescribed – such as HIV medication, methadone or antibiotics – and are certainly unable to deal with their addiction. After being clean of the drug for several months, about 5-15% of users developing psychosis will fail to recover completely.[6]

It is often quite difficult to determine what came first, the drug or the mental illness, and a lot has yet to be learned about helping people with CM-related psychosis. Often, inpatient detoxification from the drug is unavailable, and detoxification centres are not able to cope with people who are dangerously psychotic. In addition, a seven-day stay in a detox centre, or a 28-day treatment centre – designed for those with cocaine and heroin addiction – is inadequate to deal with the long-term side-effects of CM dependency. Once the user has been medically assessed, there is some evidence that treatment with an antipsychotic is of benefit in decreasing agitation, confusion, paranoia, and can help keep the user safe, assuming they are not in need of hospitalization.[6]

Research shows that by treating patients early, there may be some benefit in preventing the development of long-term psychosis and schizophrenia.[7] We have had good experiences using the atypical antipsychotics (e.g., olanzapine) in managing some patients as outpatients regardless of whether they are clean of the drug.[8] The hope is to decrease the rate of hospitalization, keep patients safe, ensure they are able to keep scheduled appointments, ensure they are able to comply with treatment for other diseases like HIV, and put the user in a position where they can deal with their addiction. However, these are not harmless medications and more research is required to look at the management aspects of methamphetamine addiction and the mental health issues associated with it.

footnotes

1 UN Office for Drug Control and Prevention. (2000). *World drug report.*

2 Martin, I & McGhee, D. (2003). *The methamphetamine study of youth (MASY).* Preliminary, unpublished data presented at the Canadian Society of Addiction Medicine Conference, October.

3 Halkitis, PN, Parsons, JT & Stirratt, MJ. (2000). A double epidemic: Crystal methamphetamine drug use in relation to HIV transmission among gay men. *Journal of Homosexuality, 41*(2),17-35.

4 Caplehorn, RM. (1990). Letter to the editor: Amphetamine psychosis. *British Journal of Addiction, 85,* 1505-06.

5 Murray, JB. (1998). Psychophysiological aspects of amphetamine-methamphetamine abuse. *The Journal of Psychology, 132*(2), 227-237.

6 Srisurapanont, M, Kittiratanapaiboon, P, Jarusuraisin, N. (2002). Treatment for amphetamine psychosis. *Cochrane Database of Systemic Reviews, 4.*

7 Cornblatt, BA, Lencz, T, Obuchowski, M. (2002) The schizophrenia prodrome: Treatment and high-risk perspectives. *Schizophrenia Research, 54,* 177-86.

8 Mirsa, LK, Kofoed, L, Osterheld, JR, & Richards, GA. (2000). Olanzapine treatment of methamphetamine psychosis. *Journal of Clinical Pharmacology, 20*(3), 393-4.

photo: James Callanan

The Skinny on Crystal Meth

Victoria Schuckel

Victoria is on the Visions Editorial Board. She was formerly in the provincial Adult Mental Health Division for 9 years and is currently Manager of Research in the Ministry of Health Planning

In order to better understand why large numbers of young people are using the very popular and very harmful drug *crystal meth*, or methamphetamine, Dr. Doug McGhee undertook a research project and video documentary on crystal meth use by young people in urban BC. McGhee is a doctor who studied inner-city medicine at UBC and now works as a family physician in Victoria.

Background

Crystal Meth Use in British Columbia

As the following statistics suggest, crystal meth is being used more frequently by younger people in BC:

- A 2002 study comparing high school and vulnerable youth (average age 17) found that 18.7% had tried

crystal meth, with an average first use at 14.5 years[1]

- Among homeless youth in Vancouver, more young people (younger than 19) used amphetamines than older youth[2]
- The specialized youth detox in Victoria saw a yearly doubling of admissions for crystal meth from 2001-2003, and continue to see this increase with 67% of admissions now for crystal meth detox[3]
- Preliminary data from MASY (2003)[4], a survey of youth in Vancouver and Victoria comparing high school youth and vulnerable youth, shows that overall:
  - 70% of street involved Vancouver youth have used crystal meth
  - 10% of Victoria high school youth have tried it
  - 19% of lesbian/gay/bisexual/transgendered (LGBT) youth have used it
  - 19% of Aboriginal youth have used it
  - 43% of youth attending the Victoria Youth Empowerment Society drop-ins reported using crystal meth

The Research Project

As part of the research project, McGhee asked six young people who used crystal meth to photo-document, using disposable cameras he provided, anything to do with crystal meth, in any way they chose. The photographs became the central visual images of the video, *Reduce Speed*, and served as catalysts for sharing important stories that were integrated into the video. Other perspectives captured in the video include those of police officers with expert knowledge of designer drugs, health and mental health workers, and youth outreach workers. These voices reflect the broader perspective of the community and professional understanding of crystal meth.

To understand why this is a drug worth paying attention to, Doug McGhee says that just as Hepatitis C was a secondary wave which followed the surge of crack cocaine use, we can expect – and need to mitigate and prepare for – a tremendous number of cognitively-impaired youth following the first wave of widely-used crystal meth.

The Findings

The qualitative findings of McGhee's research resonate with the current literature on crystal meth use. The experiences of the participants of the study:

- reinforced the need for a continuum of services including:
  - targeted preventive/early intervention services – particularly for girls, Aboriginals, street-involved youth and LBGT individuals
  - accessible health services for street-involved youth
- identified the value of peer educators
- confirmed users had experienced feelings of isolation and suicidal thoughts
- indicated some had entered sex work as a consequence
- each knew at least one friend who had become psychotic
- each had found a path away from crystal meth by:
  - leaving the scene
  - tapering
  - switching to other drugs then quitting, or
  - attending detox and treatment

The process of undertaking the research project was ultimately fascinating, concerning and encouraging for McGhee. The insights youth participants shared strengthened his interest in increasing awareness and capacity within local health care services to effectively respond to people who are at risk or are using crystal meth. Towards that end, he provides educational seminars and is currently developing a shared-care program in Victoria, working with other physicians and psychiatrists to develop joint approaches for dealing with crystal meth-induced psychosis. To increase his own knowledge, he now works with a variety of community agencies and experiential youth in Victoria.

footnotes

1 Pacific Community Resources. (2002). www.pcrs.ca

2 McCreary Centre. (2002). *Between the cracks.* See www.mcs.bc.ca/rs_new.htm

3 Victoria Youth Empowerment Society. (2002). Annual Report. For information, contact vyes@ultranet.ca

4 Martin, I & McGhee, D. (2003). *The methamphetamine study of youth (MASY).* Preliminary, unpublished data presented at the Canadian Society of Addiction Medicine Conference, October.

tips for service providers

Symptom management and engagement is all we have at present, therefore it is recommended to:

- provide targeted prevention/early intervention to at-risk populations
- recognize withdrawal is longer than for cocaine, lasting 7–14 days, though difficulties with sadness, irritability, suicide risk and high rates of re-use can last for 4 months or more
- expect paranoia, cognitive impairment and impulsivity
- address immediate needs and engage within 24 hours, whenever possible
- stabilize with harm reduction and engage with motivational interviewing techniques
- focus on client retention since this is the most important predictor of good outcome
- involve families and account for dependent children
- support relapse prevention
- support individuals' reintegration into social groups, workforce/volunteering, school, and manage legal issues

web resources

www.crystalneon.org

www.lifeormeth.org

www.streetdrugtruth.com/drugs/meth.php4

corp.aadac.com/drugs/factsheets/index.asp

www.samhsa.gov/oas/drugs.cfm

www.drugscope.org.uk

www.ccsa.ca/ccendu

Double Trouble

People diagnosed with both a mental illness and an addiction are falling through the cracks of the public health system because of a lack of coordinated services

David Carrigg

Reprinted with permission from the Vancouver Courier, Feb. 2, 2002

Leo Turok hears voices. It started when he was 16 and studying at Lord Byng Elementary. Soon, the paranoia began keeping him in his room at home and away from friends at school.

He quit school before graduating. Every six months or so, when the suicidal urges became too great, he'd admit himself into UBC's emergency ward. He would return to normal quickly, so it wasn't until he was 19 that Turok was diagnosed as having schizophrenia. He spent three months at UBC's psychiatric ward stabilizing and adjusting to his new drug regime. After leaving the hospital, Turok went to a mental health services support home in Kitsilano where he lasted all of three weeks before being forced out for antisocial behaviour.

A friend offered to move into a West End apartment with Turok, but again, anti-social behaviour – mostly paranoia that friends were trying to harm him – drove his friend away. Turok moved into a bachelor suite, still in the West End, and started dabbling in street drugs. The apartment soon became a flophouse for homeless drug users he met on Davie Street and the Downtown Eastside.

Turok was registered with the West End Mental Health Clinic and was still showing up for his bi-weekly medication injection when he began taking more street drugs, mostly speed and crack. A clinic street nurse noticed the pattern and told Turok's mom Olga.

No one was sure what to do about it. Soon Turok stopped going to the clinic. When he couldn't pay his rent, he moved briefly back to his Vancouver home, where he would demand to be locked in his room so no one could harm him. Olga took her son back to UBC hospital. From there, he was sent to Riverview Hospital, where he stayed 13 months before being refused service for repeatedly escaping and using drugs.

From Riverview, Turok had nowhere to go but the Downtown Eastside, to the city's three homeless shelters – The Lookout Emergency Aid Society, 346 Alexander St.; Triage Emergency Services and Care Society, 707 Powell St.; and the Haven, 128 East Cordova St. – where his drug use worsened and the voices in his head increased. Now, when 24-year-old Turok calls his mom, it's to arrange a quick meeting at McDonald's, where she brings him fresh clothes that he changes into in the washroom.

"We went to McDonald's last Sunday," said Olga, her eyes tired, semi-circular rings of worry permanently etched below them. "He looked rundown and as usual, he just stared, but I took him shopping so he could be around me. I'm not sure where he's living."

Turok is one of an estimated 34,000 British Columbians with 'dual diagnosis' [concurrent disorders] – a mental health problem coupled with an addiction. Dual diagnosis patients, many of whom live in the Downtown Eastside, represent about half the total number of people suffering a serious mental health disorder province-wide.

Despite the large and growing numbers, there are only six long-term care beds specifically set aside for those with a dual diagnosis in Vancouver, all of them in a support home in the Downtown Eastside that opened three years ago as a pilot project. The average stay in the six beds available to dual diagnosis sufferers is between six to 18 months, but turnover is high because of behaviour problems.

Advocates for such individuals complain there's little co-operation or cross-training between mental health and addiction services – addiction workers are not trained to deal with mental illness and mental health workers don't know how to deal with addiction.

The solution, say parents like Olga, is more money and service co-ordination to save their sons and daughters from themselves.

On Powell Street, a block east of Oppenheimer Park, there's a nondescript two-story white building owned by the Lookout Society that houses a string of social services. A beggar sits on the ground in front of the building, a metre from the doorway, perhaps targeting the many professional health care workers based in the Downtown Eastside.

Inside the building is the Vancouver Coastal Health Authority's Dual Diagnosis Program. You need to climb two grubby flights of stairs before a purple photocopied sheet of paper taped to the wall tells you the program is located at the end of the hall to the right. The door is locked, and you have to speak through an intercom system on the wall to get in.

Launched in 1996, the Dual Diagnosis Program treated 800 people last year, and survives on $500,000 a year with four full-time staff and one part-timer. Clients are referred from hospitals, detox centres, mental health teams, residential treatment centres, family doctors and psychiatrists.

Treatment lasts between six and 18 months and helps clients identify when they're 'crashing' or spiralling downward through depression, paranoia, substance abuse and other problems. Staff work with clients, most of whom have mood disorders (like manic depression), post-traumatic stress disorder or personality disorders, on preventing relapses and dealing with conflict in their interpersonal relationships, including managing their anger.

> "I could have 10 staff and we'd all still be busy. No one's looking to do miracles, we just try for some positive outcomes for patients. If we can give people hope and give them back some self-esteem and pride, then we've succeeded."

Alcohol is the most common addiction, followed by heroin and crack, although most use a variety of drugs.

Coordinator Pohsuan Zaide says the dual diagnosis team's task is enormous – the wait to get in is between six and eight weeks. "I could have 10 staff and we'd all still be busy. But this is what I have to work with and I'll do what I can. No one's looking to do miracles, we just try for some positive outcomes for patients. If we can give people hope and give them back some self-esteem and pride, then we've succeeded."

Determining whether the addiction or mental illness came first is often a 'chicken-and-egg' issue, she said. "If you've been using alcohol and drugs for 25 years, you'll likely develop depression or an anxiety disorder. Or if you have a mental illness, you are easily abused and introduced to drugs, especially here [in the Downtown Eastside]."

The concept of dual diagnosis arose in 1986 when an acronym – PISA or psychiatric impaired substance abusers – was coined to describe an addiction co-existing with either a personality disorder, chronic mental illness or post-traumatic stress disorder. The usual treatment was to determine which of the two was the 'primary' disorder, then focus on one.

But Ken Minkoff, a Massachusetts-based psychologist, advocated a new approach: treating both disorders simultaneously, then finding out how the two are related for each individual and getting that person to help devise a recovery program.

Minkoff's work spawned the creation of programs like Vancouver's Dual Diagnosis Program, but most sufferers still fall through the divide between mental health and addiction services, often because of multiple relapses.

"The problem is there's no consensus between the two systems. The mental health people say go away and quit your addiction and then we'll treat you. Or the addiction people say we can't treat you when you're on psychiatric meds," said Zaide, who holds a Master's degree in counselling psychology from UBC. "You just can't operate separately any more or pass the buck. They end up costing the health care systems more anyway, because they keep using the emergency rooms and psych ward beds and are likely to try suicide."

Zaide advocates better funding and licensing for recovery houses for addicts, with better-qualified staff to deal with dual diagnosis. Currently, anyone can establish an addiction recovery house, usually based on the Alcoholic Anonymous 12-step program. Residents who also have a mental health problem, however, are often asked to leave because of their behaviour, which is not recognized by untrained staff as being driven by mental illness.

Last month, the office of the Mental Health Advocate of British Columbia closed as part of provincial government cutbacks. Responsibility for listening to the concerns of [people with mental illness] was passed on to Gulzar Cheema, Minister of State for Mental Health and MLA for Surrey-Panorama Ridge.

The day Mental Health Advocate Nancy Hall left her job, she released a stinging report on the state of the province's mental health system, focusing on statistics showing a significantly increased risk of premature death among those with a psychiatric diagnosis, likely from suicide or conditions that stem from addictions.

One of her recommendations was for an Assistant Deputy Minister to focus solely on mental health and addiction issues.

"We need to provide training to community mental health teams, hospitals, Riverview Hospital, Forensic [Psychiatric Institute] and physicians to ensure patients receive concurrent help for the two disabilities," wrote Hall. "Few people with both an addiction and mental illness get effective treatment for either problem. People with dual diagnosis and their family members report difficulty in getting help."

"Even when they are long-stay patients at Riverview Hospital or the Forensic Psychiatric Hospital, there is no routine care provided for their addictions." [Editor's note: Riverview Hospital now has a concurrent disorders program. To read a description of the program, see *Step Softly,* a publication of the Tri-Cities Mental Health Centre, Volume 1, Issue 2, Page 3.]

One Vancouver mom, Heidi Richards, has filed a complaint with the BC Human Rights Commission claiming the Vancouver/Richmond Health Board – now the Vancouver Coastal Health Authority – discriminated against her son Adrian by not treat-

ing his drug problem while he was receiving mental health care, and not providing suitable housing options. Adrian was a former Riverview patient who has schizophrenia and is now a drug addict, living at Triage in the Downtown Eastside. He developed his addiction after being forced out of support homes due to his behaviour and ultimately ended up on the Downtown Eastside, where drug dealers target newcomers.

Roderick Louis, a former Riverview patient who has become a patient advocate, said when he visits the Downtown Eastside, he usually sees at least a dozen former Riverview patients wandering the area. Most are drug addicts. Some are prostitutes.

"A lot of them have grown up in a decent neighbourhood and developed schizophrenia, have been stabilized and then discharged without support and funnelled right downtown to the only emergency shelters in BC," said Louis, brother of Vancouver city counsellor Tim Louis and founder of the Patient Empowerment Society, which pushed for patients' rights at Riverview. "They run out of money and quickly learn to make money either by selling drugs or their body. They are right smack in the middle of the biggest prostitution and drug addiction university in the province. It's ghettoizing the mentally ill."

Louis believes providing the mentally ill with rent subsidies would go a long way toward getting them out of the Downtown Eastside and away from the drug culture.

But Zaide says centralizing mental health and addiction services in the Downtown Eastside is not necessarily bad for clients. "Some clients say where we are located is a good reminder of where they've been and where they don't want to be. Some people's addictions get triggered, but you can get drugs anywhere. You have to take responsibility for your recovery and stop blaming others."

"Sometimes, there's not much you can do if someone is an adult and adamantly refuses to get help."

The Patient Empowerment Society has met with Cheema to suggest he form a multi-ministry mental health group to coordinate mental health, addiction, housing and other government services used by the mentally ill. "You just need someone with gumption in the Premier's office saying 'let's link these things up,'" said Louis, who, along with other advocates, is calling for better funding and staffing for treatment and recovery facilities for dual diagnosis sufferers.

Cheema admits the existing treatment system for dual diagnosis patients is not co-ordinated and that people are "falling through the cracks," but says groups shouldn't expect any new funding.

Cheema argues recent streamlining of the province's health regions into five super-regions, plus the recent transfer of addiction services from the Ministry of Children and Family Development, will help solve the problem by better coordinating addiction and mental health services.

"We've taken the first steps but the issue is complex. I'm working closely with health services to make sure there's a coordination of services and hopefully we'll get results," Cheema said.

Louis is unconvinced, claiming the Ministry of Health Services is one of several ministries [overseeing issues] including social services, housing, [the legal system] and education, that [affect] dual diagnosis sufferers and need to be included in any co-ordination efforts.

"Collapsing 52 health regions into five won't improve services. A [person with schizophrenia] sees a doctor for one hour a month, but for the other 29 days and 23 hours they are having to deal with things like food and rent and transport and trying to get some training," said Louis.

For Olga Turok, her greatest concern is that a focus on dual diagnosis patients will come too late for Leo. "He calls every few days and I think he stays in the Downtown Eastside or with friends somewhere near UBC. Sometimes, he seems to be in control and it looks promising, but every time there is disappointment. It's played a lot on my nerves and I've had my own depression and sleeping problems but it's my priority. Something has to change."

Discovering my Dragon
– and Starting to Tame it

Neil

Neil is a member of the Mood Disorders Association's Vancouver support group

In some ways I've just landed, treading solid ground instead of shifting sands. I'm a landed immigrant, having arrived from the Middle East four years ago. But in a broader sense, I've finally reached some real understanding of the dragon I've been running away from for over twenty years. During those two decades, I've lived in ten different cities, on four different continents – at least 40 addresses – countless temporary, part-time and casual jobs, lengthy periods of unemployment. Add in protracted periods of depression punctuated by manic episodes, plus a heady mix of alcohol and marijuana, and you have a fair idea of the chaos I've been struggling to come to terms with.

Naturally, I've spent quite a bit of energy trying to figure out what I've been trying to escape by all these moves and all this intoxication. My current understanding is that of 'dual diagnosis,' or 'concurrent disorder.' I'd like to tell you the story of how I reached this understanding, and of just how long it took me.

First came the acceptance that I had a real problem with depression. Faced with an anxiety that for the first time in my life had escalated to the point of physical shaking, I sought the assistance of my family doctor. While I was greeted with considerable understanding, I was given a very inappropriate drug, Paxil (paroxetine hydrochloride, one of the SSRI family of antidepressants). I found immediate relief from the anxiety, but after three months, manic symptoms returned. Particularly since I'd managed to quit both alcohol and marijuana, I'm convinced Paxil was responsible for what turned out to be a hypomanic episode, lasting four months. While not as devastating as some of my earlier 'drink-drugs-and-spending' manic sprees, this episode caused a fair bit of damage to my work, academic and personal lives. And when it was over, I was right back where I started – once again, acutely depressed.

The next realization for me was that I had bipolar disorder. It seems ridiculous that I didn't reach this conclusion earlier. How come nobody noticed? The insights I began gaining when I joined a local support group finally helped me to begin to reach my own diagnosis. This process was matched by a series of very unsatisfactory visits to a psychiatrist, who confirmed my suspicions but offered nothing in terms of treatment. I was given a diagnosis of 'bipolar, not otherwise specified.' Unfortunately for me, 'dual diagnosis' or 'concurrent disorder' was also not specified. Again, it was back to the family doctor, who started me on a course of valproic acid (the generic name for Depakene, an anticonvulsant now widely used as a mood stabilizer). I was also given Paxil in the belief that the mood stabilizer would balance things off, and I would not be at risk for another manic episode.

During the next summer, my doses of both Paxil and valproic acid crept up. As well, I began to dabble with marijuana again. By the fall, my abstinence from alcohol had also ended. The stage was set for another mania, this time a full-blown episode. By the time the cycle ended with a return to the familiar winter depression, my marriage was over, I was homeless, and had no bank account or source of income. Out of this, I managed to piece together the final pieces of the puzzle – a jigsaw with the picture of my personal dragon, dual diagnosis, on it.

To deal with my acute depression, I began self-medicating with marijuana, with some measure of success – for a while. However, it became clear that this came at the cost of relationships with 'normal' people, and of not being able to complete my schoolwork. Through a contact at my support group, I made a visit to a dual diagnosis program run by the Vancouver Coastal Health Authority. The idea was that after signing in at ten drop-in sessions, I would graduate to a more formal program. All it took was three sessions. On the third visit, the penny finally dropped. We watched a video about heroin use, the reasons why people take it, and why they can't get off it. All of a sudden, my life was there on the TV screen. I'd prided myself that I'd never taken 'hard' drugs. Yet it was all there: the same issues, the same problems. I quit alcohol and marijuana immediately, and have managed what I'd rate as 99% success with both for over six months now.

And the outcome of all this? I have a new psychiatrist, don't drink, don't smoke, and take a much-reduced dose of valproic acid and Remeron (mirtazapine, a newer tetracylic antidepressant). I've completed my degree, found full-time work and a place I can afford to live in, and resolved most of the really difficult issues with my ex-wife. Things are still not easy, largely, I think, because I have to find ways to replace a lifetime of destructive social and personal habits with productive behaviour patterns. I'm sure that my understanding of what 'bipolar' and 'dual diagnosis' mean is different from anyone else's, but that's fine by me. I've found my dragon, and got a name for him. Now I've just got keep working on new ways to steal his flame.

Reflections from the Field

Debbie Suian, MA, RCC

Debbie is Concurrent Disorders Therapist at the Tri-Cities Mental Health Centre in the Lower Mainland

People with concurrent disorders are first and foremost, people. Although they are frequently people with serious mental and sometimes physical health issues, they are also grandparents, mothers, fathers, brothers, sisters, friends and neighbours. They are – or once were – someone's child, husband, wife, partner or companion. Sometimes people with concurrent disorders are homeless; sometimes they are live in the wealthiest of neighbourhoods. Contrary to what many people believe, people with concurrent disorders are found in every socio-economic group, and across occupations. Anywhere you might find a person, you might find a person with a concurrent disorder.

Over the past several years, I have worked primarily with people who fall into the category of concurrent disorder clients. I have researched the latest best practice guidelines, and reviewed recommendations from leading professionals in the field. It has been validating to discover that while each government body, agency, or individual has their own unique way of saying it, the bottom line invariably includes a caution against losing sight of the person in the service of 'treating' the disorder.

In spite of this, I find myself occasionally sitting in rooms listening to conversations about 'schizophrenics,' 'addicts' and 'alcoholics.' Sometimes this comes from the people suffering from these disorders, sometimes not. Always, I am left wondering what kind of person the 'schizophrenic,' 'addict' or 'alcoholic' was sent into this world to become. Although the label gives me no clue as to the answer, the labeled person when asked, often can.

The explanations that people provide to justify or make sense of their suffering are typically heartwarming and inspiring. I have found a depth of compassion, understanding, empathy and humility in the stories of the people I work with. At times, this is the only bright spot in a work day that revolves around trying to make too little go too far. The people I work with tell me they look forward to helping others, to finding a place for themselves in the world, and to finally feeling a sense of belonging. They also tell me this is sometimes quite a challenge, as labels once applied, are not easily seen past. But for the most part, the people I work with persist. They keep coming to appointments, keep working on the changes they've decided to make, and keep taking the risk of looking to others for support when the burden becomes too great to carry alone.

The people I work with are amazing. They are people who suffer the double stigma of mental illness and addiction. They are also people who have had experiences that would make most 'normal' people shake with fear, and they are people who have moved through those experiences with an inherent desire to survive – and ultimately to live. I have worked with multi-talented people who sometimes have little left to lose, but still much to offer. From these people, I've learned about acceptance, courage and wisdom, and when I'm in their presence, I am inspired to become the best person I can be.

These days, in addition to working with people with concurrent disorders, I am responsible for training others in this work. I am fortunate to spend my days surrounded by colleagues who also see the strength, courage, resilience and wisdom in the people we work with, and who strive to deliver the best possible service in the face of sometimes-daunting odds. Working with concurrent disorders is not a task for the faint of heart, nor is it a task for the easily discouraged. But the people we work with have always known this. To be allowed to travel with them on their journey is a privilege.

tales from the trenches: an expert speaks

Larry

Reprinted with permission from Step Softly, *Volume 1, Issue 2, November 2003.* Step Softly *is a publication on concurrent disorders published by the Tri-Cities Mental Health Centre*

The journey has been a difficult one. I have been suffering from mental illness most of my adult life – it started as a teenager. I was hospitalized for a year in my early 20s, after a crime I committed when I went insane, and put on a lot of drugs that made me terribly tired. I'd had a vision when I was 20 years old after drug use one night, and a few days later I read about it in a book. And I thought I was going to be the world's next greatest saint because of this vision, and I started having laughing and crying fits in my bed thinking that all my dreams would come true. I would laugh because I thought I had it made. I would cry because I thought I was a fool and just imagining things.

I saw my third eye open up one night in bed and I saw the seal of God written on my forehead. After I was in jail, I realized I was hearing voices that I called 'angels.' And I saw Jesus on the cross a number of times. When I was on the sick ward in prison, someone asked me if I was Saint Christopher, and he was supposed to put crosses under my bed. So I put crosses under my bed, and I looked over and saw a cross of light in his hand. ▶

I was hospitalized for a year in a psych ward in Edmonton where I was heavily medicated. I used to lay in bed thinking I would swallow my tongue. After a year I got out, and I tried to work for a living. I held about six jobs in three years. I got born again as a Christian. I took Kung Fu for a year and a half. And I was baptized in the Pentecostal church and received the gift of tongues. When I was training Kung Fu and was supposed to quit, I experienced another body inside myself from the stress of the exercises I was doing. This happened twice.

After three years of trying to hold a job, and quitting about six of them after six weeks, and staying in bed because of depression and tiredness, I said, "Lord, I can't take it anymore. I'm letting myself down and my employer down." I went to Vancouver and hit skid row. I lived on welfare and went to missions and volunteered in the missions for 10 years, making sandwiches and hauling food and clothing, mopping floors and volunteering in any way I could. I got more rewards out of doing volunteer work than working for the almighty dollar. That's when I realized what the gospel really was – when I hit skid row with all the down and out people. I remember sitting in a mission one day and an old hobo asked me if I believed in the word of the Bible. And I hesitated and said, "Yes," but I wasn't too sure of myself. But now I can say, definitely "Yes" to this day.

I had a suicide attempt at one point when I tried to burn myself to death because I didn't like my lifestyle. I was put into Riverview and given shock treatment. I remember coming out of the shock treatment one day and I couldn't remember my own name, and I was never so scared in all my life. I got out of Riverview and spent some more time volunteering until I was hospitalized again after drug abuse. Then I left Riverview one day and committed another crime. I went insane again.

For the last 15 years I've been in and out of Forensic [Psychiatric Institute]. While I was volunteering on skid row, I used to stay in the Regent Hotel. One night I had a dream I was reaching out to grab a woman's kerchief and I couldn't grab it. I wanted to grab it with all my heart, and I couldn't grab it. Then I saw an old rugged shroud and I touched the hem of the shroud and the Holy Spirit touched my heart and it was filled with bliss. And I heard a voice in my heart that said, "My son, hear the instructions of thy father and forsake not the law of thy mother" – that's from Proverbs. My heart filled with so much bliss that I had to say, "Mercy, mercy Lord, I can't bear all Your love." And another night I saw God's hand on my back. I can still remember to this day. It was made of white light and you could even see the hairs on His holy hand. I spent my adult life crying my eyes out because I didn't understand the vision and what God's been trying to show me all these years.

I started going in to recovery two years ago, [after being] on and off drugs since the age of 17. I'm almost 50 years old now, and my life has been in and out of depression, and on and off drugs, and I've virtually slept my adult life away. Recovery means a lot to me because I've met some wonderful people and now I have a support system in place for the next time I get out of Forensic. I've been out in the past and had no one to talk to, and nothing to do, and spent my days depressed and in tears. The last three years I've found a lot of peace, and I spend my time reading scriptures and praying and meditating. I find the journey has been well worth it – although there's been a lot of sadness and heartache. My faith has sustained me, and although I'm not Superman, I'm supergrateful.

It hasn't been the drugs that caused me so much misery as much as the mental illness. The torment and mental anguish has been unbearable some times. I have a great love for people who've been on skid row and in mental hospitals and in prison. I feel a deep affiliation with them. Oswald Chambers once said, "If you can't admit you're worse than the worst criminal, you can't be a saint." He also said, "Unless there's something in your life you wish wasn't there, you can't be a saint. There's always something in your life you wish wasn't there." I recently read that a saint has a past and a sinner has a future, and all the way to heaven is heaven.

My drug and alcohol counselling has taught me how to correct errors in my thinking, and cognitive strategies. I used to think "I don't care" a lot, and that "nobody else cares," but I've realized that I care a great deal sometimes, and that other people do too. Sometimes I think life is hell, especially at night when I suffer from insomnia. But in the morning things clear up, and these days my days are going without too many problems. Most of my illness is in remission. And the peace I feel is a precious gift. I don't suffer from mental anguish or depression, and I have a support system of people that are very precious and I wouldn't change it for the world. I've made my peace with the system. The bible says "If your ways please the Lord, you make even your enemies to be at peace with you." This world can be a terrible, and frustrating place. There are all kinds of suffering people out there from starvation to perversion and the devil has deceived most of society these days. This could be the wickedest world there ever was, and if you believe the Book of Revelations, it will be destroyed by fire.

I think the greatest hope is whether there will be a rapture and resurrection, and that the multitudes in the Valley of Decision will make the right choice. Some believe that we can change society before the end comes and sometimes I'd like to believe that myself. But a lot of people may suffer before paradise returns to earth. i

Lost and Found

Gordon Harper

Gordon is a social activist and an advocate for those who struggle with substance use and mental health issues in Victoria. He is a trainer in the CCISC mental health and addictions integration initiative and serves on a number of regional committees concerned with addictions, mental health and homelessness. (CCISC stands for the Comprehensive, Continuous, Integrated System of Care model, developed by Dr. Ken Minkoff, and described later in this issue)

Some years ago, I found myself driven to my knees by my own addiction. Oh, what to do? Nothing that I tried seemed to make any difference at all. I became paralyzed, mired in guilt, shame and fear. I felt helpless, hopeless and useless. I eventually reached a point where I didn't care whether I lived or died. In fact, dying seemed somehow more attractive than continuing to struggle on as I had been.

A family intervention, miraculous in and of itself, sparked off an intense flurry of activity, which ultimately left me standing on the doorstep of the local detox centre. I was so frightened and ashamed that my legs would barely carry me forward. I fully expected to be met with criticism and scorn. Instead, I was made to feel welcome and was treated without judgement, with great respect and sometimes even a little bit of love. The love seemed to make a difference where nothing else had worked in the past.

In spite of the inspiration created by this warm reception, early recovery was not smooth sailing for me. Frequent and unexpected relapse was crushingly demoralizing. And I was not alone. Fully ten per cent of any population you care to measure will have a problematic relationship with substances in their lifetime. This year across Canada, about 10,000 people will die as a direct result of substance use. Many more will have their quality of life severely compromised by addiction and mental illness. By contrast, during the recent, dramatic and well-documented SARS outbreak, four people died in British Columbia, and another 36 elsewhere in Canada. The point here is not to trivialize the hazard posed by a highly communicable disease, but to draw attention to the fact that the larger community has never given this other epidemic the attention that it deserves.

It's just not possible to travel to the downtown core of many BC communities without being a witness to the little dramas that take place as street-involved people, many of whom have complex mental health and addictions issues, do what they have to do to just get through another day. It's worrisome, but even more distressing to realize that these folks are just the tip of the iceberg, that there are a great many more whose daily struggles are not so public.

It is difficult to know what to do. The world we live in today is fast-paced and complex. Every day we are confronted by scenes on our streets, by news stories, or by situations in our own families that demand an emotional response. The problems faced by many folks today are so overwhelming that many members of the community just don't know what to do. We all seem to suffer from compassion fatigue. For many of us, the only way that we can turn our backs on obvious need is to create some sort of a disconnect in our minds. By concentrating on the differences between 'us' and 'them,' we can, for a few moments at least, pretend that folks in difficulty are somehow different from us, deserve what they have got, and do not warrant our support.

Our conundrum, thus far unresolved, is this: demand for mental health and addiction services throughout British Columbia far exceeds capacity. It seems that additional resources are required across the province. At the same time, the system of care is complex and difficult to access. Many people who would likely benefit from mental health or addiction treatment cannot or will not engage with services. There is something very wrong here.

In retrospect, I see that I was ideally situated in many ways to make dramatic and positive changes in my life. I was white, male, middle-aged, middle class, employed, reasonably well educated, and had no apparent concurrent disorder. I had little difficulty dealing with bureaucracy, so I could easily access the system of care and enjoyed wonderful support from friends and family. And still I struggled. Two sessions of residential treatment, loads of group and individual therapy, and a healthy involvement with the 12-step community all helped. But in spite of all this help, I nearly didn't make it. Today, as I continue my journey, I marvel at the folks I meet. Many of them lack some of the advantages that I had, but continue to make heroic progress, one day at a time.

Ignorance, anger, fear and shame continue to tear our communities apart. Let's work together to change the way that those who struggle with addiction and mental health issues see themselves, and the way they are viewed by others. And a little love wouldn't hurt either.

We all seem to suffer from compassion fatigue, turning our backs on those in need

Vernon's Gemini and Phoenix Programs

From Personal Experience to Practice

Ron Nichol
(with Les Storey)

Ron is the Program Coordinator of Gemini and Phoenix. Les is Facilitator for the program

The Gemini/Phoenix programs are a synthesis, not only of my personal recovery experience, but of the works of a number of researchers and writers, both ancient and contemporary. It was like a breath of fresh air to read the works of Minkoff and to read about the Addictions Counsellor training course, developed at what was formerly known as the Addictions Research Foundation of Ontario (and now part of the Centre for Addiction and Mental Health). Another influence was the concurrent disorder treatment approach developed at the University of Arizona, which is available for viewing on two tapes that can be borrowed from the Riverview library. There is also a wealth of relevant resources for program development and philosophy in the *New Framework for Support* published by the Canadian Mental Health Association (CMHA), National Office, and in the *Peer Resource Manual*, published by the BC Ministry of Health in 2001.

In 1979, after a life of frustration and despair, from either chasing the dragons of addictions, or hiding from the dragons of mental illness, I was fortunate enough to come into contact with a person who helped me to leave the double revolving doors I lived in, in the hopelessness of relapse and recovery, and with the aggravation of bouncing between addiction treatment centres and psychiatric wards. My life had become the proverbial football as I bounced from one service to another, with each disclaiming responsibility for treatment, saying that they could not help unless I first took care of the other problem.

When I became manic and overwhelmed and started drinking, the addictions counsellors and other recovery programs would claim that I was 'not ready yet,' had 'ego problems,' was 'not working the program,' and most often that I was suffering from 'a case of the self-pities.' At times, I would sober up and would become depressed and anxious. The psychiatrist would claim that my problem was drug- and alcohol-induced psychosis, and that all I needed to do was stay sober and the depression and anxiety would pass. When anxiety and depression turned into mania, I would drink to achieve oblivion from the mind-rush and voices; then, the psychiatrists would, with pontifical affirmation, say that I had this drinking problem that needed to be looked after before they could help. As I said, this merry-go-round lasted until 1979 wherein I found myself in desperation: either I sobered up, or I would die.

It was very fortunate for me that at that time, after being sober for a month or so in a long-term residential treatment centre, the staff noticed that I was having a difficult time reading and writing. I was sent for psychological evaluation and it was found that I had brain damage from my misuse and abuse of alcohol and drugs. I look at this occurrence as being fortunate because it brought me into contact with a psychiatrist who looked at both of my problems as one and the same. Our deal was that if I looked after staying sober by whatever means possible, she would help me to look after my mental health issues.

We established a regime of psychoeducation, where I learned to recognize the triggers and symptoms of depression and mania. This positive relationship lasted for almost nine months before the good doctor succumbed to the lure of better research facilities and funding in the States.

However, a dialectic or process of recovery had been established that allowed me to integrate services to meet my needs. As part of my spiritual, mental, intellectual, and social recovery program – which evolved primarily through pragmatism and intuition – I went to the University of Calgary and obtained a BA in Religious Studies and Applied Ethics, with a minor in Psychology. I was admitted to post-graduate studies in the Religious Studies department, but my bipolar illness flared up, and I had to retire from full-time studies. Nevertheless, I continued to do my classroom work on a part-time basis, and managed to raise my minor in Psychology to a major.

During my years at university, and for several years after, I worked as a service provider for the CMHA in Calgary as a residential supervisor, for the John Howard Society as a residential counsellor, and for the Department of Corrections in several capacities with addictions-related programs, both as a full-time employee and a volunteer.

All of this experience and learning has gone into the development of the Gemini Program. Actually, two interlocking projects have evolved: the Gemini Program itself has been in operation for fourteen months; and Phoenix (Phase One) groups will have commenced by January 2004. Phoenix Phase Two groups are somewhere down the road. ▶

Post-Traumatic Stress Disorder, Anxiety Disorders and Substance Use

Nichole Fairbrother, PhD

Nichole is the Community Liaison Officer for the Anxiety Disorders Association of BC and an honorary Research Associate with the Anxiety Disorders Unit in the Department of Psychiatry at the University of British Columbia

Sadly, many people are exposed to traumatic events such as a motor vehicle accident, rape, assault or other violent crimes, or to natural disasters such as hurricanes or earthquakes. Remarkably, many trauma victims recover and cope well with these events without professional assistance. For the small minority of people who do not recover, post-traumatic stress disorder (PTSD) is the most common diagnosis to develop. PTSD is a form of anxiety disorder that occurs in between one and 14% of the population, at some point in their lifetime, and is more common in women than in men. Many PTSD victims also suffer from depression, substance abuse, and from other anxiety problems.

Not infrequently, we hear the term *trauma* used in reference to a particular experience. Mental health experts consider a person to have been exposed to a traumatic event if he or she experienced, witnessed, or was confronted with (i.e., learned about) an event or events that involved actual or threatened death or serious injury or a threat to the physical integrity of oneself or others. One thing all people with PTSD have in common is they felt intense fear, helplessness or horror during the traumatic event.

The remaining symptoms of PTSD fall into three categories: reliving symptoms, avoidance symptoms and symptoms of increased arousal. While some of these symptoms may be experienced to some extent and at some point by many people not suffering from an emotional disorder, PTSD sufferers experience many of the symptoms below, and find them very upsetting.

Reliving symptoms include:

- intrusive memories of the event and flashbacks
- dreams or nightmares about the event
- acting or feeling as if the event is happening again
- intense distress and bodily arousal when reminded of the event

Avoidance symptoms include:

- trying to avoid thoughts, feelings or conversations about the event
- trying to avoid activities, places, or people that ▶

Gemini and Phoenix Program | *continued*

The Gemini Program is an umbrella program for addiction and mental health issues. Our facilitators look after administration, education, research and advocacy. Phoenix groups, on the other hand, are dedicated to the recovery process and are run in partnership with local addictions services. Phase One of the Phoenix program offers participants an opportunity to self-evaluate through education and discussion of addictions issues in a group setting. Phase Two of the Phoenix program is dedicated to ongoing recovery groups.

We cannot say for certain what Gemini and Phoenix will become; they are both projects that will require time and experience. Both Gemini and Phoenix are programs developed for consumers by consumers. We hope that the Phoenix projects will help us identify more consumers in the community who have not only experienced concurrent disorders, but who are coping successfully with them. Gemini and Phoenix are designed to assist in the recovery process, not to confront it – a positive development that is received enthusiastically by mental health and addictions service providers.

Gemini and Phoenix will need to recruit peer facilitators who are willing and able to give back to their community. These facilitators will eventually form a core of peer mentors, who not only have the practical personal experience of recovery from mental illness and addiction, but will also qualify academically through taking courses in addiction counselling and in facilitating recovery groups.

Both projects are integrated with other peer support services offered in the Vernon area. Each of our facilitators is familiar with all support services offered to mental health consumers, and therefore has the ability to refer clients to needed services and, when necessary, to advocate for the consumer. Our goal is to create a mentoring service that is based on both experiential and academic training.

Peer mentors are in a unique position in that they've been there and know first-hand what the frustrations and rewards are in the process of recovery. It is this pragmatic wisdom that we as consumers can share with others dealing with similar issues, and thereby begin a more positive cycle of recovery.

remind one of the event
- difficulty remembering important parts of the trauma
- loss of interest and participation in important activities
- a restricted range of emotions
- a sense of a foreshortened future

Symptoms of increased arousal include:
- difficulty falling or staying asleep
- irritability or outbursts of anger
- difficulty concentrating
- hypervigilance (i.e., keeping a close look out for signs of imminent danger)
- an exaggerated startle response

Post-Traumatic Stress Disorder and Substance Use

Studies examining how PTSD develops have found that a large number of people with PTSD also have problems with substance use. Compared with people who do not suffer from PTSD, people with PTSD are two to four times more likely to suffer from alcohol abuse or dependence, and four to nine times more likely to suffer from drug abuse or dependence.[1] Put another way, five to six out of every ten people with PTSD also suffer from substance use problems that interfere with their daily lives and cause additional suffering.

There are several reasons why PTSD and substance use problems often occur together. First, people who abuse alcohol or drugs are often exposed, by virtue of their substance use, to more dangerous situations than people who do not have substance use problems. As a result, they are at greater risk of experiencing the kinds of traumatic life events that may lead to the development of PTSD. Second, some people who develop PTSD may already have problems coping with stress without using alcohol, drugs or other substances. Third, people with PTSD may be vulnerable to using alcohol and drugs as a way of managing their PTSD symptoms (i.e., they are using alcohol and drugs to self-medicate) even if they didn't have substance use problems before the trauma occurred. For example, a person with PTSD may drink or use drugs to stop the scary memories or lower the uncomfortable body sensations of anxiety. Unfortunately, substance use often makes these symptoms worse in the long run and is not a recommended coping strategy.

Researchers have found that people who develop a substance use problem after a traumatic event often experience unmanageable anxiety. People with PTSD and substance use problems often believe their anxiety symptoms mean they are going 'crazy,' dying or will never be the same person they were before the trauma.[1]

It is very important that people coping with PTSD and substance use problems receive treatment or the symptoms can become chronic and even worsen over time. People who suffer from both substance use problems and PTSD do not respond well to traditional treatment for substance use problems. However there is strong reason for hope, as people who receive a combined PTSD and substance use treatment experience significant decreases in their symptoms.[1] Greater access to treatments that are designed specifically for people coping with both PTSD and substance use problems is needed in BC.

Effective treatments often include learning new ways of coping that do not involve the use of drugs or alcohol. Effective treatments also help the person deal with the traumatic event so that the upsetting memories and associated symptoms no longer get in the way of living a full and rewarding life. It is also important to validate the experiences of people suffering from these two disorders, and to help them understand why these problems are both occurring. This is especially important because many people may be unaware they have both problems. (For more information on approaches to dealing with these issues, please see the article by Nancy Poole on the following page).

Substance Use and Other Anxiety Disorders

While PTSD and substance use are very commonly found together, people with other forms of anxiety disorders also experience problems with substance use. Substance

footnotes

1 Conrod, PJ, & Stewart, SH. (2003). Experimental studies exploring functional relations between post-traumatic stress disorder and substance use disorders. In P. Ouimette & P. Brown (Eds.), *Trauma and substance abuse: Causes, consequences, and treatment of comorbid disorders* (pp. 29-55). Washington, DC: American Psychological Association.

2 DeHaas, RAB, Calamari, JE, & Bair, JP. (2002). Anxiety sensitivity and the situational antecedents to drug and alcohol use: An evaluation of anxiety patients with substance use disorders. *Cognitive Therapy and Research, 26,* 335-353.

3 Stewart, SH, & Kushner, MG. (2001). Introduction to the special issue on 'Anxiety Sensitivity and Addictive Behaviors.' *Addictive Behaviors, 26,* 775-785.

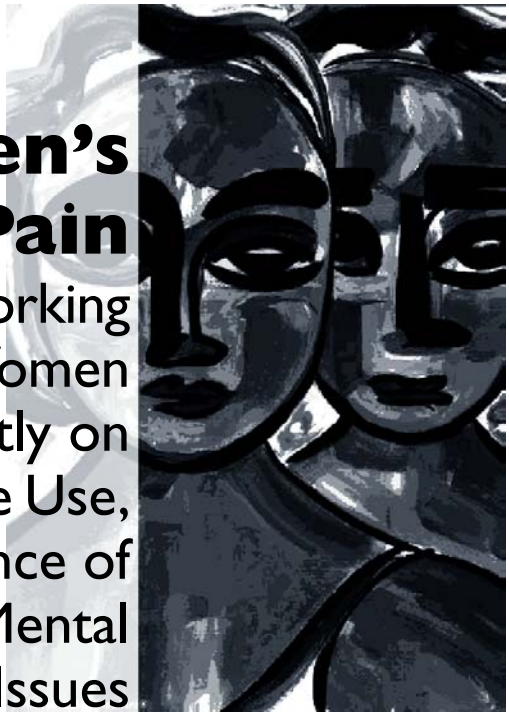
use disorders and several types of anxiety disorders occur together at a very high rate.[2,3] People suffering from an anxiety disorder are more likely to have problems with alcohol use than people without an anxiety disorder.[2] For example, people with generalized anxiety disorder or panic disorder are three times as likely to suffer from a substance use disorder over the course of their lifetime compared to people who do not have an anxiety disorder.[2] Interestingly, there is not a high level of substance use in people who suffer from obsessive-compulsive disorder.[2]

More research is needed for us to better understand why anxiety disorders are associated with a higher rate of substance use disorders. We really don't know if having an anxiety disorder makes a person more vulnerable to abusing substances or if the reverse is true: that having a substance use disorder makes people more vulnerable to developing an anxiety disorder. It may also be that some other issue such as low social support or social isolation makes people vulnerable to both.

We do know that alcohol, at least initially, can help to dampen some of the symptoms of anxiety. However, over the long term, it may actually help to maintain the anxiety problem. Because, in the short run, alcohol consumption helps to reduce feelings of anxiety, substance use is reinforced and people can end up in a vicious circle of anxiety and dependence. We also know that people with anxiety disorders and people with substance use problems both tend to be fearful of the bodily arousal that typically accompanies anxiety (e.g., rapid heart, difficulty breathing, etc.), and believe that these sensations of arousal are dangerous in some way (physically, psychologically or socially). It may be that, compared to people who are not very afraid of the bodily arousal that accompanies anxiety, people who are fearful of these sensations experience a greater reduction in bodily sensations of anxiety when they drink or use certain kinds of drugs.[3] If this is the case, it may help to explain why anxiety problems and substance use problems often occur together.

Many people with an anxiety disorder and a substance use disorder get the best results when they learn new ways of managing both problems. If you have an unmanaged anxiety disorder, it may be very difficult to overcome your problems with substance use (and vice versa). Fortunately there are a growing number of effective treatment approaches that target both anxiety and substance use problems. People with anxiety disorders and substance use problems can overcome these difficulties.

For more information about anxiety disorders, please contact the Anxiety Disorders Association of British Columbia at (604) 681-3400



Women's Pain

Working with Women Concurrently on Substance Use, Experience of Trauma and Mental Health Issues

Nancy Poole

Nancy is a research consultant on women and substance use at BC Women's Hospital and BC Centre of Excellence for Women's Health

In September 2003, the Aurora Centre, BC's provincial treatment centre for women with substance use problems sponsored a ground-breaking national conference on women's treatment issues, to mark their 30th anniversary of service provision. In many areas, the conference addressed the emerging literature and practice on sex and gender role differences in the experience of addiction. The complex connections between women's experience of trauma, their mental health and substance use received particular focus through a pre-conference workshop entitled 'Numbing the Pain: Substance Abuse and Post-traumatic Stress Disorder.'

Research has shown that as many as two-thirds of women with substance misuse problems may have a concurrent mental health problem, such as depression, post-traumatic stress disorder (PTSD), panic disorder and/or an eating disorder.[1] Research also shows that a large proportion of women with substance use problems are victims of domestic violence, incest, rape, sexual assault and child physical abuse.[2] Compared with non-abused clients, women in treatment for problem substance use who have been victimized are more likely to suffer from depression and suicidal ideation, have lower self-esteem, negative psychological adjustment and more post-traumatic stress symptoms.[3,4]

Lisa Najavits, PhD, an Associate Professor in the Department of Psychiatry at Harvard Medical School and an award-winning clinical researcher and practicing psychotherapist, facilitated the 'Numbing the Pain' workshop to lead off the September conference. She shared her evidence-based practice on concurrent work on trauma and substance use as outlined in her 2002 book *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*. The response to the workshop was

lively, with 120 clinicians from across British Columbia and Canada in attendance.

The key principles of the Seeking Safety model are:

1. ***Safety*** as the overarching goal and most urgent clinical need; helping clients attain safety in their relationships, thinking, behaviour and emotions
2. ***Integrated treatment:*** working on both PTSD and substance abuse at the same time rather than sequentially in order to be more successful with clients, as well as more cost-effective and more sensitive to client needs
3. ***A focus on ideals:*** to counteract the often profound demoralization and loss of ideals in both PTSD and substance abuse
4. ***Work in the four content areas of cognitive, behavioural, interpersonal and case management:*** while grounded in the present- and problem-oriented approach of cognitive-behavioural therapy, this programming is strongly focused on relational and planning skills
5. ***Attention to clinician processes:*** helping clinicians build therapeutic alliances and demonstrate compassion, as well as attend to client accountability and self-care.

Building on this workshop and their commitment to integrated and effective treatment for women, several organizations in BC are currently applying the Seeking Safety model in outpatient groups for women affected by trauma and substance misuse. The Pacifica Treatment Centre in Vancouver is currently offering a 12-week group for women needing to work on trauma issues in the aftercare period, entitled 'Continuing the Journey,' funded by the BC Technology Social Venture Partnerships. The Victoria Women's Sexual Assault Centre, with Vancouver Island Health Authority funding support, is offering a 15-week pilot Seeking Safety group in Victoria, with collaboration from Alcohol and Drug Services, BRIDGES, Victoria Native Friendship Centre, PEERS, Victoria Cool Aid Society, Victoria Women's Transition House and the Youth Empowerment Society.

Women's treatment organizations in the US are also making women's treatment services 'trauma informed'[5] in a national project entitled the *Women, Co-occurring Disorders and Violence Study*. It is a five-year initiative jointly supported by the Center for Substance Abuse Treatment, the Center for Mental Health Services, and the Center for Substance Abuse Prevention. Knowledge gained from this study is expected to be useful in advancing national, state and local policy that affects how the various service systems respond to women with histories of substance use, mental health and physical and sexual abuse. (To learn more about this project see www.wcdvs.com).

The application of trauma-informed care is also emerging within the mental health system in BC. An example is the Vulnerable Patients Project undertaken by Riverview Hospital in 2001, where staff education was provided on how trauma is connected to the development and continuation of mental health problems. The program also provided education on re-traumatization prevention skills to be routinely applied by mental health workers in their work, to address the common co-existence of mental health, substance use and trauma histories in patients accessing care from the mental health system.

Many alcohol and drug service providers in BC who attended the 'Numbing the Pain' workshop are also finding ways to incorporate elements of the Seeking Safety approach within outpatient and residential addiction services, even where support for specific and ongoing group work is not currently available. For more information on the Seeking Safety model and on related resources see www.seekingsafety.org.

footnotes

1 Zilberman, ML, Tavares, H, Blume, SB & el-Guebaly, N. (2003). Substance use disorders: Sex differences and psychiatric comorbidities. *Canadian Journal of Psychiatry, 48*(1), 5-13.

2 Ouimette, PC, Kimerling, R, Shaw, J & Moos RH. (2000). Physical and sexual abuse among women and men with substance use disorders. *Alcoholism Treatment Quarterly, 18*(3), 7-17.

3 Kang, SY, Magura, S, Laudet, A & Whitney S. (1999). Adverse effect of child abuse victimization among substance-using women in treatment. *Journal of Interpersonal Violence, 14*(6), 650-57.

4 Najavits, LM, Weiss, RD & Shaw, SR. (1997). The link between substance abuse and posttraumatic stress disorder in women: A research review. *American Journal of Addictions, 6,* 273-83.

5 Harris, M & Fallot, RD. (2001). *New directions for mental health services: Using trauma theory to design service systems.* New York, NY: Jossey-Bass.

first nations women suffer high rates of mental illness and addiction

Researchers at the University of New Mexico School of Medicine have completed what they believe is the first study of urban First Nations women in a primary care setting, looking at current and lifetime mental illness and substance abuse in relation to demographic and social factors. From a subject group of 234 First Nations women, the researchers found consistencies with other research showing that Aboriginal women suffer from higher rates of certain mental disorders, particularly depression and anxiety, compared with non-First Nations women in similar settings.

Lifetime substance use disorder was reported in 62% of the women in the study. The researchers caution that the methods of measuring substance abuse do not put into context certain behaviours found in the study population – many women abstain from alcohol entirely, and binge drinking can distort the findings. Low education, high debt, and self-reported poor health were associated with current mental disorders.

In addition to substance abuse, First Nations women in this study had high rates of anxiety disorders and combined anxiety disorders and depression. The authors say that Aboriginal leaders and Indian Health Service leadership could work together to call for more mental health funding and to set up pathways from primary and urgent care settings to specialized mental health services that are culturally competent. The authors add that mental disorder prevention and treatment must consider concurrent substance use and mental disorders.

Duran, B et al. (2004). Prevalence and correlates of mental disorders among Native American women in primary care. *American Journal of Public Health, 94*(1), 71-77.

Visions Reader Survey

We want your feedback to make this publication better by understanding its strengths and weaknesses and our audience. Please take a few moments to give us your thoughts. Then tear along the dotted line and enclose in the postage-paid envelope.

I am: ❑ < 18 ❑ 18-25 ❑ 26-35 ❑ 36-50 ❑ 51-65 ❑ 65 +

Gender: ❑ Male ❑ Female

To know our audience better, do you read Visions in your capacity as a(n):

❑ Person with experience with mental illness and/or substance use problems
❑ Friend or family member of above
❑ Mental health service provider/professional
  ❑ Front-line service provider ❑ Manager/policy-maker
❑ Addictions service provider/professional
  ❑ Front-line service provider ❑ Manager/policy-maker
❑ Resource centre personnel/librarian
❑ Other:

What topics are you interested in having Visions cover (or did you particularly enjoy if we covered the topic in the past)? Check off as many as you like:

❑ Housing	❑ Systems change	❑ Media	❑ Children
❑ Rehabilitation	❑ Families	❑ Income Support	❑ Youth
❑ Stigma/discrimination	❑ Higher education	❑ Eating disorders	❑ Self-management
❑ Schizophrenia	❑ Legal/criminal justice	❑ Policy	❑ Employment/Workplace
❑ Medications	❑ Psychosis	❑ Alcoholism	❑ Rural/remote issues
❑ Anxiety disorders	❑ Concurrent disorders	❑ Personality disorders	❑ Spirituality
❑ Cross cultural issues	❑ Sexuality/relationships	❑ Seniors	❑ Aboriginal
❑ Mood disorders	❑ Trauma/abuse	❑ Women's Issues	❑ Men's issues
❑ Drug addiction	❑ Psychotherapies	❑ Other topic ideas:	

How often would you like to see Visions produced?
❑ Quarterly (present format) ❑ Less often ❑ More often

Do you like the current length of Visions (averaging about 40-48 pages)?
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Do your read the entire magazine, or just select articles? ❑ Entire magazine ❑ Select articles

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Generally, which sections do you like the best?
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How often do you read the Editor's Message or Guest Editorial as a reference for understanding the theme?
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Are you familiar with the new BC Partners for Mental Health and Addictions Information? ❑ Yes ❑ No

What do you like best about Visions?

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What was your favourite story, section, or aspect of this issue?

Do you have any suggestions for improving Visions?

Thank you! Would you like to be entered into our May 1 draw for a $50 gift certificate to a restaurant in BC of your choice, or a $50 voucher for publications from the BC Partners (this could include a 2 year subscription to Visions for paying subscribers). If you do, please fill out the following fields. If not, thank you for your time answering the survey and helping us improve *Visions*. Please note that your personal information will only be used for the execution of this contest and will not be used for any other purpose.

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Concurrent Mood Disorder, Cluster Symptoms and Substance Abuse

A GP's Approach to the Identification and Treatment of Three Important Symptom Groupings in Conjunction with Substance Abuse

Colin Horricks, BA, MD, CCFP

Colin has a family practice in Vancouver and works sessionally with governmental alcohol and drug programs. He is also a Clinical Assistant Professor in the Department of Family Medicine at the University of British Columbia

The author would like to thank Dr. L Yatham and Dr. Shimi Kang, and also thank Sherry Small and Grace Lutz for their support during the writing of this article

Overview

Concurrent mood disorders and substance use often involve a complex situation in which an individual's depression may have a bipolar component and may also co-exist with symptoms known as Cluster B and C symptoms (defined below). When mood disorder combines with substance abuse and these other groups of symptoms, this leads to a complex medical situation in general practice. Clarification of symptoms of these three states (i.e. depressive symptoms; manic/hypomanic symptoms; and Cluster B and C symptoms) is necessary for effective treatment. Abstinence from drugs of abuse coupled with the use of mood stabilizing medicines, antidepressants, and/or broad-spectrum psychotropic medications are the key first steps to consider in the resolution of this situation.

When the patient is more stable, stress resolution can be attempted. Helpful approaches from a psychological point of view include cognitive therapy (for example using the helpful ideas of David Burns and Albert Ellis). Recommending writing exercises may also be helpful. To a patient who is fragile, this could be too upsetting, but writing could be helpful for people with some sense of stability and those who are able to discuss aspects of their past with the physician or therapist. In selected cases, it can be very interesting and helpful to consider a metaphorical approach for dreams. In my own clinical practice, I've found it very helpful to have a patient 'read' a dream as if it were a poem, describing and providing insights into the individual's own situation. An exercise program is most helpful and is critically important as well for the relief of fatigue. These facets to treatment address both the biological and psychological aspects of our nature.

Assessment

A person's experience of themselves develops over time. Various symptoms can be troubling and eventually unmanageable, prompting the individual to seek help. They may feel that it is 'the situation' and not themselves at all. They may be crying a lot or just 'feeling lousy.' They may be using alcohol, marijuana, cocaine, cigarettes and such to try to feel better. It is a tragic situation, but this dysfunction can continue for 10-15 years before a diagnosis is made. This is the subjective confusion the patient brings to the doctor.

Objective clarity begins by noting the symptoms and determining how long they have been present. This leads to a diagnosis and then suitable treatment. The essential diagnostic categories to search for and identify, if present, include (1) depressive symptoms (2) manic or hypomanic symptoms and (3) Cluster B and C symptoms (defined below).

Ideally, for the patient who is abusing substances, a three to six month period free of drugs of abuse is desirable and necessary before assessment is possible. It should be kept in mind that withdrawal can mimic symptoms of depression, bipolar disorder and Cluster symptoms. Another complication in the assessment picture is, for example, that emotional upset can be caused by bingeing on weekends. Abstinence is a difficult process and there are some strategies to help a person realize this goal so that an accurate assessment can be made. Time is required for social recovery from addiction. Searching for a period of abstinence in the patient's history and finding out what that period of time was like can also be helpful.

Risk for psychiatric illness can be clarified by looking at the personal history and the family history. Two key points in the personal history are the patient's experience of childhood and periods of abstinence. Important family history includes history of alcoholism and any mental health issue.

By helping the patient maintain a period of abstinence and keeping the above guidelines in mind, the risk of overdiagnosis (and overuse of medications) can be minimized.

Depression (and anxiety)

When looking for the presence of depression (with or without co-occurring anxiety) in the general practice setting, the doctor needs to separate the symptoms of anxiety and depression from other physical disorders that may possibly exist. Disturbed sleep, appetite and weight change, depressed mood, irritability, fatigue and diminished sexual interest which appear together and have gradually appeared over time are generally symptoms of depression, rather than a physical health issue.

Similarly, symptoms of anxiety may also include somatic (or bodily) manifestations present in the same time period. These symptoms include muscular pain of any kind including tension headache, blurred vision, ringing in the ears, light-headedness, dry mouth, a sensation of a lump in the throat, shortness of breath, palpitations or racing heartbeat. Gastrointestinal symptoms of anxiety include nausea, vomiting, diarrhea, constipation or change of bowel habit, for example as may be seen in irritable bowel syndrome. A person may experience urinary frequency. There may be aggravation of premenstrual symptoms and neurodermatitis (a psychosomatic skin condition). There may be psychological symptoms of anxiety: for example, claustrophobia or intellectual manifestations that include the inability to concentrate or a sense that memory is being affected. Various stressors may coincide with these symptoms of anxiety and depression. It is also true that obvious stressors cannot always be found.

This typical presentation in the context of the rest of the history allows the doctor to set aside other diagnostic possibilities. These symptoms of anxiety usually clear when the depression resolves with appropriate antidepressant treatment. (In this population of patients, for completeness, the medical screen should include thyroid stimulating hormone, hemoglobin, HIV, and hepatitis status).

Manic or Hypomanic Symptoms

Secondly, the co-existence of symptoms that may be periodically present may suggest the occurrence of manic or hypomanic symptoms. I find DSM criteria cumbersome to work with but the Mood Disorder Questionnaire (online at: www.bipolar.com/mdq.htm) is a most helpful tool in ruling in or ruling out a co-existing bipolar pattern. Hirschfeld states that seven out of ten people with bipolar spectrum disorder are correctly identified by this questionnaire and nine out of ten who do not have bipolar spectrum disorder would be successfully screened out.[1]

Cluster B and C Symptoms

Thirdly, and finally, an important symptom grouping to be considered is the presence of Cluster B and C symptoms, which are commonly present in people who have substance use and depression-related problems. These Cluster B and C symptoms serve as a type of shorthand to the presence of what the DSM-IV would identify as one or more of the personality disorders.

Zarate and Tohen[2] speak to the frequency of co-occurring Axis 1 (primary psychiatric diagnoses) and Axis 2 disorders (in this case, personality disorders or Cluster symptoms) and tell us that these comorbid conditions are common and often difficult to diagnose and treat. They state that the literature provides little guidance for the clinician on how to diagnose and treat these co-occurring conditions. In my experience, I have found the Cluster-based approach a helpful way to assess and deal with these situations.

Cluster B symptoms include excessive emotionality (e.g., when a person is very easily led to tears) and behavioural disruption, in the sense that a person may behave in an overly erratic or overly dramatic manner.

Cluster C symptoms include excessive or inappropriate fear or anxiety. In my practice, I have found that these symptoms occur in people who have been mishandled in their formative years – suffering from the effects of neglect, emotional and physical negativity or abuse, and sexual abuse.

Concurrent Substance Abuse

When a person is experiencing one or more of the constellations or groupings of symptoms described above, alcohol and drug abuse can commonly play a part in the history. For instance, Zarate and Tohen quote a prevalence of comorbid substance use disorder in Bipolar Type I at 60.7% and 48.1% for Bipolar Type II.[2] They also state that the likelihood of an individual with bipolar disorder having a substance use disorder is six times greater than that of the general population and twice as common as an individual with unipolar depression.

In my experience dealing with concurrent depression-related symptoms and Cluster symptoms, substance abuse primarily involves alcohol, marijuana, cocaine and heroin. Later in the article, I'll return to the difficult topic of how these issues can be addressed, focusing specifically on heroin dependence.

Developing a Treatment Plan

Once these patterns of symptoms have been identified, a treatment plan can be formulated and a therapeutic trial of medications established. If the medications seem to satisfy the patient's symptoms, then that medication should be continued. If the medication does not seem to satisfy the situation, then it can be discontinued in favour of another medication. One situation can be guaranteed here: if abstinence from alcohol and drugs of abuse cannot be maintained, the therapeutic trial will fail.

The treatment of depressive symptoms without indication of the presence of a bipolar facet can be managed with conventional antidepressants. Tailoring the medication in a thoughtful way to the patient's needs is helpful. For instance, I choose amitriptyline (Elavil) if the patient has significant insomnia or body pain (*a*

footnotes

1 Hirschfeld et al. (2000). Development and validation of a screening instrument for bipolar spectrum disorder: The Mood Disorder Questionnaire. *American Journal of Psychiatry, 157*(11), 1873-1875.

2 Zarate, Jr., CA & Tohen, MF. (1990). Bipolar disorder and comorbid Axis I disorders: Diagnosis and management. In LN Yatham, V Kusamker & S Kutcher (Eds.), *Bipolar disorder: A clinician's guide to biological treatments* (pp. 115-138). New York: Brumner Routledge.

cautionary note: tricyclic antidepressants have potential danger in that they can be lethal in overdose situations). Fluoxetine (Prozac) is helpful if fatigue is significant. Doxepin (Adepin or Sinequan) is helpful if a person requires an antihistaminic effect (for the presence of allergies or itchy skin). An SSRI medication or clomipramine (Anafranil) is indicated for obsessive-compulsive tendencies. Imipramine (Tofranil) is helpful if there are urinary symptoms, especially nocturia (frequent night-time urination). Bupropion (Wellbutrin) is an ideal antidepressant to select for smokers (smoking is very common among patients who abuse substances and have these three symptom patterns). I preferentially prescribe Bupropion over SSRI medication to avoid sexual dysfunction.

If a person satisfies the criteria for having a bipolar pattern, it's appropriate to select a mood stabilizer. The most commonly used stabilizing medicines include divalproex (Depakene), lithium carbonate and olanzapine (Zyprexa). Forty per cent of patients with bipolar disorder will establish emotional stability with the use of one mood stabilizing agent, but 60% of patients will require two stabilizing agents.

Each of these medicines has their own advantages and side effects. Divalproex is protective against the elevated mood component and with rapid mood cycling. Divalproex can be used in conjunction with an antidepressant to manage the depressive component, if necessary. The best antidepressant for the depressive component of a bipolar pattern is bupropion as this medicine is less likely to stimulate to a high while it effectively manages the depressive aspect. Divalproex can also facilitate withdrawal from alcohol and benzodiazepines and can be used to reduce incidence of relapse to these drugs. In this case, the divalproex can be continued for six months to one year.

Lithium carbonate is protective against highs and lows in the mood cycle. It is inexpensive and can be effective, but approximately 30-50% of patients with bipolar disorder are considered refractory to lithium treatment (that is, lithium stops working for the person after an initial period of effectiveness).[2]

Olanzapine (also used as an antipsychotic) has a mood stabilizing effect protecting against highs and lows. It is also helpful in the treatment of Cluster B and C symptoms. Gabapentin has significant anxiolytic (anti-anxiety) effects. Lomotrigine also has its place in acute bipolar depression, rapid cycling, refractory bipolar patients and bipolar disorder with OCD.[2]

Conventional wisdom suggests that a person with a bipolar pattern should not be given an antidepressant unless they are on a mood-stabilizing agent. Prescribing an antidepressant to a patient with a bipolar pattern without a mood-stabilizing agent, in practice, can precipitate a manic or hypomanic phase and put the patient in danger. Patients with a diagnosis of bipolar disorder will often tell you that they have tried antidepressants and their experience of these antidepressants should serve to inform the doctor that a bipolar pattern is a possibility. The patient will often report that they have been given many different antidepressants and they were of no help at all, or that the antidepressants precipitated a 'weird feeling' or a 'high.' They will often report the same experience with coffee consumption.

Cluster B and C symptoms can be managed with a low dose of psychotropic medicine. These medicines include respiridone (Respirdal), quetiapine (Seroquel) and olanzapine (Zyprexa). If the patient has Cluster symptoms and insomnia, then quetiapine or olanzapine would be a good choice. If insomnia is not a problem, a morning dose of respiridone could be helpful. Doses of these medications can be increased until the symptoms are resolved. Benzodiazapines are almost always contra-indicated and should only be prescribed with considerable discretion, although they are very helpful in facilitating withdrawal from alcohol and opiates. Trazadone is helpful as a sedative.

Further resolution of these Cluster symptoms can be aided by encouraging the patient to write in letter or dialogue form on a daily basis over a period of time.

Dealing with Substance Abuse, including Heroin

The drug abuse and dependency facet of this problem is a daunting issue for the patient who needs to face it, but the problem is also, one way or another, very manageable. A variety of programs can be of immense help for patients trying to establish recovery form substance abuse. 'Daytox' and detox programs as well as residential treatment programs, and one-on-one counselling at alcohol and drug programs are all very helpful. A 12-step program with the help of a sponsor is also helpful. These programs serve to establish structure that protects against relapse; they all facilitate the necessary psychological work.

In my practice, I have a large number of patients dealing with heroin, and when it comes to heroin dependence, the above-mentioned measures may or may not be enough. If a patient has a history of relapsing to narcotics, it may be appropriate to consider the option of a methadone maintenance program. People often have mixed feelings about the use of methadone. However, after considering the advantages of methadone over heroin and the fact that the opiate-dependent person can become free of an opiate dependency perhaps only 20% of the time, with hard work and good medical management, one can see that the options are limited.

The continued use of heroin requires procuring the money for the drug and this is at great cost to society. Heroin is used four times a day and the administration of the heroin is associated with a high risk of contracting HIV and Hepatitis C. The heroin user also gets a powerful high. In contrast, the meth-

related resources

Burns, D. (1999). *The feeling good handbook.* Plume Books.

Horricks, CH. (1985). The psychological profile: A history taking aid. *Canadian Family Physician, 31,* 864-868.

a case study

I think it is instructive to include the following short outline of a patient's experience of himself. I will then present the notes that were taken and the observations that were made at the initial and four subsequent patient visits that took place over a period of five weeks. (Note: this case history may not reflect the outcome that many others could have. Patients with significant psychosocial problems including sexual abuse, substance abuse, time in foster homes or detention centres, as well as a mood disorder for many years, obviously have a difficult prognosis. Another patient may have a poorer outcome despite the best treatment.)

The patient's story

"I am a forty-year-old man who is addicted to drugs and alcohol and I have been this way since age 15. I have made many attempts to try and get my life on track. I have spent time in foster care and in detention centres. I have tried many different types of medication to try to help me with my hot temper and my lack of focus. I have never been able to set goals and attain them because I always seem to get discouraged and give up.

I have been very selfish in my past. I never seem to care about my actions, and I would hurt others. I once stole $1600 from my diabetic sister who was saving to buy a new prosthetic leg. I once took $400 off my stepfather when I found him dead. I never cared about any of my actions – I just never cared, even when I knew the outcome of my actions would be very negative.

I was sexually abused between the ages of 14 and 17. I was expelled from school so many times I was finally told to leave in Grade 8. I have always firmly believed I would only just survive and that I would continue to fail at whatever it was I tried. I have always been afraid to set any real goals because I knew it would only be a matter of time and I would fail again.

I have been on several different medications including Paxil, Wellbutrin, Prozac and a few I cannot recall. They never seem to help me."

Commentary

This man's history underscores the importance of delineating the symptom patterns of depression, bipolar disorder and Cluster B and C symptoms.

His history revealed a pattern of broken sleep and variable appetite. He stated his weight was steady, his mood could be high or it could be low. He stated he was irritable and tired. He had diminished sexual interest. *Therefore, depressive symptoms were present.*

He was a cigarette smoker and had a history of Hepatitis C, bronchitis and asthma. He revealed a history of abusing cocaine, alcohol, marijuana and occasionally heroin. He had also sustained several concussions that occurred during altercations.

He stated that his father, uncle and sister had been diagnosed with bipolar disorder. He had mixed feelings about his experience of his mother and father.

He had spent time in a foster home between the ages of 13 and 17. Between the ages of 14 and 17, he had been sexually abused.

The mood disorder questionnaire elicited nine out of 13 positive responses suggesting a positive screen. *A bipolar pattern was present.*

Lastly, it was noted that on direct questioning, he was able to say that in his life he experienced excessive fear, anxiety and emotionality, and behavioural disruption. *Cluster B and C symptoms were present.* Additionally, he felt paranoid on occasion and he had a history of suicidal ideation.

At the close of the first visit, he was established on olanzapine at 10mg at bedtime and he was to begin Wellbutrin at 150mg in the morning. Seven days later, during visit number two, he reported that his sleep had settled, and he noticed a slight, depressed appetite. He stated that his mood, temperament, energy and sexual interest were alright.

He noticed improvement in his fear level and his anxiety was gone. He noticed that his emotionality and behavioural disruption had improved. His cigarette smoking had diminished. By the end of the first week, we were able to document a good response to the olanzapine and Wellbutrin.

One week later, at visit number three, we were able to review some cognitive therapy points and some writing exercises. Because he had not fully resolved his fear, emotionality and behavioural acting out, we increased his olanzapine to 15mg at bedtime.

On the last visit (five weeks since his first visit) he was taking olanzapine at 15mg at bedtime, and Wellbutrin in one tablet in the morning. He denied depressive symptoms and any symptoms that were reflected on Hirchfeld's Mood Questionnaire. He also denied the presence of Cluster B or C symptoms.

He said that he had never felt this clean or this settled in his life. He was in a much more hopeful situation and he wrote the following: "The medication I am taking seems to have changed how I react to situations which in the past would have led to violence or least a temper tantrum. Today I am able to control my reactions and not go off with a hair trigger.

The 12-step program with NA and AA meetings gives me structure and new-found hope. I honestly feel like I have a new lease on life. I have not felt this hopeful before."

adone patient requires the medicine once per day and does not get the characteristic high. Methadone is relatively inexpensive and greatly reduces the cost of heroin addiction to society. A person who has been stabilized on methadone and who is also emotionally stable (with or without medications described above) can in time perhaps consider withdrawal of the methadone, and if they are careful and determined enough, they may establish freedom from all opiates. Relapse remains the critical problem here, and as a result, methadone maintenance on an ongoing basis may be the best approach.

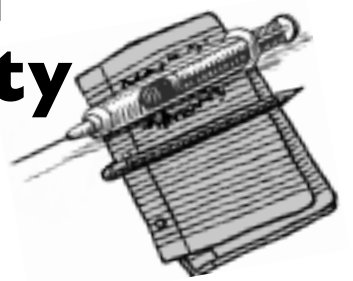
Conclusion

It is challenging for busy family doctors to find twenty minutes for a patient assessment, but taking time can be time-saving. Time must be spent or the patient will never be understood and a complete assessment is worth the effort.

In conclusion, identifying three important symptom groupings can lead to pharmacological treatment of depression, bipolar disorder, and Cluster B and C symptoms, in a general practice setting. With abstinence from drugs of abuse, use of community resources such as NA and AA, and psychological work such as counselling and writing exercises, a happier, healthier, more manageable life is achievable.

Mental Illness, Addiction and the Supervised Injection Facility

New Narratives on the Downtown Eastside



Dan Small, PhD

Dan is a medical anthropologist who has worked in the mental health field for many years and currently works with the Portland Hotel Society in Vancouver

I have been involved in numerous health sectors including Forensic Psychiatric Institute, clubhouses, review panels, the Centre for Excellence in HIV/AIDS, the Vancouver Area Network of Drug Users (VANDU), UBC Medical School, the BC Cancer Agency and the College of Physicians and Surgeons. In my role with the Portland Hotel Society, a community organization serving people in the Downtown Eastside, I have been involved in the set-up, implementation and management of North America's first legal supervised injection facility (SIF). In all these realms, I have found addiction to be one of the most challenging of phenomena for professionals to treat and address.

I believe that problems encountered in treating addiction are more to do with our underlying cultural† understandings of addiction than with any inherent obstacles in the people we try to help to help themselves. This essay examines some of the "cultural scaffolding" surrounding addiction,[1] or the ways we collectively assign meaning to certain people who struggle with both mental illness and/or addiction. It also looks at how the differences in how these meanings are constructed have hindered our approaches to providing help, to the detriment of the people with addiction. Finally, it describes how the new supervised injection site and the values represented by this approach, reflect an emerging set of meanings and approaches that is ultimately more hopeful.

I begin with the assumption that professionals organize their interactions based on narratives. A narrative is similar to a story‡ – and situating ourselves within an understandable story helps make our lives meaningful.[2] Our narratives provide meaning for important events in our lives (they answer the why-did-this-happen question) and construct a sense of plot (the beginning, middle and end) for our experiences.

Medical anthropologists refer to the narratives of professionals as 'therapeutic narratives,' and suggest that these play a vital function in their day-to-day interactions with those they help, and relate to things such as planning treatment schedules, determining which therapies will be undertaken initially, and ascertaining which side effects may be manifested.[2,3] Medical anthropologists take this a step further by suggesting that all interactions between clinicians and patients have a moral and redemptive component.[4] In mental health workers' narratives about people with both mental illness and substance abuse, addiction has traditionally been organized as separate from the mental illness component. I suggest that this separation has not been productive, and that we should instead focus on that which is similiar in these experiences: the quest for personal healing.

Narratives also often reflect upon on the personhood or humanity of those involved in them. By 'personhood,' we refer to aspects having to do with an individual's membership in society. Membership provides dignity, power and privilege in

notes

† By culture, I refer to a shared network of negotiated meanings based on implicit or explicit values

‡ While I will use the terms story and narrative interchangeably, it should be noted that literary theorists make a sharp distinction between the two concepts (see footnote reference #2). The term story refers to a series of events or experiences. In contrast, narrative refers to a specific discussion that describes events or experiences, rather than those events and experiences themselves. Narrative involves a guiding shape, provided by a plot, that structures our experiences and involves a social process, in the sense that the nature of various narratives are negotiated over time within communities. Illness narratives are but a smaller part of the overall life story of an individual

a community or society. The sociologist Goffman in his groundbreaking work on stigma,[5] describes how socially-compromising attributes of personhood such as having an addiction degrade an individual from a full person to a tarnished, diminished one. These individuals are aware of threats to their personhood brought by addiction, and that they occupy a lower social position and are placed at a social distance from others.

Historically, socially-alarming phenomena such as mental illness, criminality, drug addiction, illness, sexuality and death have been segregated or kept at a distance from the wider society.[6] Sometimes, this happens through the establishment of institutions such as hospitals, cancer treatment facilities, or hospices, which allow such issues to be concealed from the wider public. For instance, frightening things such as those living with IV drug addiction are hidden away in facilities such as supervised injection sites, contact centres and life skills centres in the Downtown Eastside, in order to reduce the anxiety these individuals create for members of the public. We have made people living with addiction into the modern-day cultural lepers whom we fear the most.

As suggested above, narratives contain moral components – in other words, they contain implicit or explicit values about what a community or society believes to be right and wrong. Narratives about people with mental illness have historically reflected certain values, represented by the following statements, suggesting that people with mental illness are:[7]

- disordered (versus ordered)
- irrational (versus rational)
- unproductive (versus productive)

Today, these values have been influenced by the process of medicalizing mental illness, which has lead to the establishment (or 'negotiation') of a new set of competing values, reflected by these statements:

- mental illness is a disease that can be treated
- people with mental illness are not to blame for their condition (popular wisdom is increasingly considering it to be a random medical event)
- people with mental illness deserve good medical care and services such as subsidized housing

Common cultural values (and statements) associated with people with addictions reflect some similar values, but others that reflect a harsher judgement. That is, that they are:

- unproductive (versus productive)
- irrational (versus rational)
- disordered (versus ordered)
- dangerous (versus safe)
- deceitful or manipulative (versus honest)
- non-contributors (versus contributors)

And that addicts:

- have made bad choices, choosing to use drugs and therefore are to blame for their condition
- should simply choose not to use drugs or be forced to stop using drugs through detox, medical treatment, drug court or jail
- are fundamentally undeserving of government (taxpayer funded) programs such as housing (Most social housing will not take active addicts as tenants)

Arguably, the newly-established supervised injection facility is a hot spot of 'meaning negotiation' where philosophies that are both disapproving and sympathetic about addiction meet one another. For those who oppose supervised injection facilities, there are a number of key cultural values associated with the SIF, including that the SIF:

- encourages drug use
- promotes addiction
- attracts addicts and social problems
- enables immorality (in the form of addiction)
- represents a surrender in the morally righteous war on drugs

Of interest, when the Portland Hotel Society was about to implement the SIF in partnership with the Vancouver Coastal Health Authority, I was invited to the United States Embassy to meet with Dr. David Murray, consultant to John Walters, US Drug Policy Coordinator (commonly referred to as the US Drug Czar) appointed by President George Bush. At this meeting, Dr. Murray cautioned against the implementation of the SIF based on the values described above. On a number of occasions in the discussion, he implied that the sovereignty of Canada might be jeopardized by the SIF and other harm reduction policies. This speaks to the different cultural values that underpin the drug policies in the United States and Canada.

In opposition to Murray's view, a number of cultural values and assumptions are at the heart of the position of those who support the SIF. These cultural values are summarized as follows:

- no one endorses addiction, but interventions that curb overdoses and the spread of infectious diseases have to be sought
- addiction cannot be stopped forcibly
- saving lives is fundamental (even lives of those making choices we disagree with)
- people need to be alive to seek treatment or withdrawal services
- practical, low-threshold intervention (e.g. provision of clean needles, supervised injection facility) can curb unhealthy injection practice
- reduction of public use of drugs by preventing people from injecting in alleyways is important
- providing services and support for people who continue their active addictions without forcing them to stop their addiction is okay

footnotes

1 Cruikshank, J. (1998). *The social life of narratives: Narrative and knowledge in the Yukon Territory.* Lincoln, Nebraska: University of Nebraska Press. (p. 27).

2 Mattingly, C. (1994). The concept of therapeutic 'emplotment'. *Social Science and Medicine, 38*(6), 811-822.

3 Mattingly, C. (1989). *Thinking with stories: Story and experience in a clinical practice.* Massachusetts Institute of Technology.

4 Good, B. (1996). *Medicine, rationality and experience: An anthropological perspective.* Cambridge: Cambridge UP.

5 Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity.* New York: Simon and Schuster.

6 Giddens, A. (1997). *Modernity and self-identity: Self and society in the late modern age.* Stanford: Stanford UP.

7 Saris, AJ. (1994). *The proper place for lunatics: Asylum, person and history in a rural Irish community.* University of Chicago. (pp. 46-50).

8 This phrase is borrowed from Arthur Frank's (1997) book, beautifully titled: *The wounded storyteller: Body, illness and ethics.* University of Chicago Press.

The mental health field has not been effective in its treatment of people who also suffer from addiction. In my view, this is for a couple of reasons. Firstly, as I've suggested, the mental health field is not served well by separating mental illness and addiction into two distinct universes, based on distinct value systems. The underlying values of society and the corresponding cultural system of most mental health workers scorns people with addiction. This essay has tried to uncover some of these underlying cultural values that shape treatment and services for people living with active addiction.

Additionally, the mental health field's emerging concern on rehabilitation has a strong emphasis on changing people, which is at odds with the rather more basic supports that addicts require first. In contrast with the rehabilitation focus, the harm reduction philosophy underpinning the supervised injection facility is predicated on meeting addicts where they are in their lives right now and trying to support them rather than change them.

Addiction is not so much a struggle with disease as it is an ongoing attempt to heal. Central to the addict's healing journey is a quest for personal agency, hope for the future and a fundamental need for recognition of their value as a person: as a part of our collective humanity. People living with addiction are "wounded storytellers"[8] who have a larger story to tell us not only about themselves, but about ourselves and how we see them.

As professionals, we need to meet these individuals where they are today and not, based on our cultural values, where we want them to be. Attempts to change people (rehabilitation) need to be postponed in favour of more basic connections like providing a clean needle, treating an infection, changing a bandage, providing social housing or maybe just listening to a person's story – their narrative – over a cup of coffee. Putting aside our cultural values based on rehabilitation in favour of a less grandiose intervention is not a lost opportunity, but one that is set aside and saved for another day.

web resource

read more about harm reduction, relapse prevention for addictions, treatments for addictions, supervised injection sites and much more on our website at *www.mentalhealthaddictions.bc.ca*

related resource

Cassel, EJ. (1982). The nature of suffering and the goals of medicine. *New England Journal of Medicine, 306,* 639-645.

Helping People with Concurrent Disorders in the Justice System

The Seattle Mental Health Court Model

The following is excerpted from the proceedings of Vancouver City Hall, and are part of a report prepared by Councillor Jennifer Clarke in October 2001

Background

Like many cities, Seattle, Washington, has a significant group of people who are either homeless, mentally ill, substance abusers – or a combination of some or all of these things – who are repeat offenders of low-level offenses that formerly consumed expensive court and hospital services, with no improvement in their condition or to public order. Seattle officials say that prior to 1999, too many people were inappropriately getting caught in the justice system who should have been diverted out, due to a lack of quick entry routes to proper care. In June 1999, a task force recommended that the city integrate publicly-funded services for mentally ill and drug/alcohol offenders into a single administrative and service delivery authority.

The first point of entry into this system for many patients is either the Mental Health Court (MHC) or the Crisis Triage Unit (CTU) at Seattle's Harborview Medical Center, which link up and implement treatment, housing and case management solutions for the clients they see. Feedback from police, hospitals and court personnel is that these mechanisms have significantly cut down on the time people spend in jails, courts and hospitals. The results are diminished costs, decreased escalation of behaviour due to lack of early intervention, and

strengthened linkages for ongoing care and stabilization for the patients seen.

Key Elements of the Model: What Seattle's MHC and CTU Have Learned

Systems of mental health and substance abuse care need to be integrated. The five ingredients to integration are shared information, shared planning, shared clients, shared resources and shared responsibility. The most difficult to share for the agencies concerned was planning, but their experience was that if only four out of the five ingredients to integration are present, it won't work.

Agency linkage and case management is critical. Database access to re-link a client with his or her case manager and treatment provider when he or she falls off the plan is critical to keeping the client out of detention in hospital or jail, and out of trouble in the community. *Having clients who fall off the treatment plan is to be expected.*

For a treatment plan to work it needs the three ingredients of housing, treatment and case management. If any one element is missing, it won't work.

All housing is not equal. Housing for people without case management and supervision will not work. Housing without appropriate support will end up being a haven for drugs, weapons and crime in short order. As a transition to stable and secure housing, the county has contracted with several shelters to provide 'respite beds' for the homeless. These are designated beds visited by a community health nurse who gives out medications and treats low-level health complaints and injuries for individuals who don't require hospitalization, but do require some level of extended follow up and care.

For a MHC to work, it needs a good clinician for diagnosis and a good case manager to integrate systems. The court team must be dedicated, trusting, stable and willing to meet on an ongoing basis to develop a knowledge of the clients, as well as expertise in mental health, substance abuse and criminal law issues.

MHC Evaluation

A phase-one evaluation has been conducted on the King County MHC program by the University of Washington, describing the results from the first two years of operation. The study compared clients who opted-in versus those that opted-out of the MHC route and indicated that:

- MHC was more successful in linking opt-in defendants to treatment services and increasing the amount of treatment received
- MHC was more successful in establishing engagement with treatment regimens
- MHC opt-in patients experienced significant improvements in adaptive functioning
- MHC resulted in fewer problems with the criminal justice system for defendants seen
- MHC opt-in defendants, on average, spent fewer days in detention
- MHC opt-in participants had a significantly lower rate of new bookings after contact as opposed to the rate for those who chose not to participate

Financial Implications

King County believes it is spending less on dealing with mentally ill clients, and getting better results than it was before it set up the Mental Health Court, if all costs including police, court, jail, hospital, community-based treatment and housing are taken into consideration.

Housing, Mental Illness and Substance Misuse

John Russell

John Russell was the Director of Greater Vancouver Mental Health Services. He now works as a consultant and was recently the Chair of the BC Mental Health Monitoring Coalition

This article originally appeared in the Spring 2000 issue of Visions. We are re-running it because of its relevance to the topic of housing in supporting people with concurrent disorders

Housing is an essential factor in the stability and recovery of individuals who have a mental illness. This is even more true for individuals who have both a mental illness and a problem with substance misuse.

Unfortunately, substance misuse is one of the factors that contributes to people losing their housing, as well as their access to other recovery services. Once housing is lost, the only alternative left is either a shelter or a single-room occupancy hotel. In Vancouver, this means the downtown core, where drug and alcohol use are rampant. In an environment where drugs are readily available, it is even less likely that the person will be able to get control over either their illness or substance misuse.

This scenario is all the more serious given that:

- for people who have schizophrenia, almost half are likely to have a substance use problem

- for people who have a diagnosis of depression or bipolar disorder, the likelihood of concurrent substance misuse goes up to 60%
- conversely, for people who have a substance misuse problem, a high proportion will also have a mental illness, especially depression

In other words, the co-occurrence of mental illness and substance misuse is the norm, not the exception. Living with both of these disorders exposes the person to greater risks, of which homelessness is just one. Others include a greater risk of contracting serious communicable disease associated with drug misuse, greater risk of suicide, greater risk of committing violent acts and a greater risk of being incarcerated for a criminal offence.

What is the role of housing in the solution?

Clearly, mental health housing programs must recognize that the co-occurrence of mental illness and substance misuse is common. While individuals with drug problems can be disruptive and pose some risk to other program participants, eviction only exposes the individual to much greater risks. Housing programs need to have the capacity to provide a more effective response to someone who is missing drugs and alcohol. They also need to be less restrictive in accepting individuals who have had substance problems in the past or are even actively involved in substance misuse.

Current research indicates that the most effective intervention for mental illness and a co-occurring substance misuse problem is an assertive community treatment model. In the model, staff have the expertise to provide treatment for both mental illness and substance misuse in a comprehensive, integrated program. One of the keys to these programs is to overcome initial resistance to treatment by being very client-centred and starting with the needs that the client identifies. One of those needs is likely to be safe and stable housing, preferably not in an area where drugs are easily accessed. Another key is to be able to work with the inevitable and recurrent relapses that individuals will experience as they gradually gain control over both their substance misuse and their mental illness.

There are apparently contradictory findings on the role of specialized residential treatment programs for people who have co-occurring disorders. In a review of the literature, Drake et al.[1] found very poor outcomes associated with residential treatment programs modeled on the intensive residential treatment programs that are common in the alcohol and drug dependence field. These programs had very high non-compliance rates associated with clients dropping out or being evicted from the program. The conclusion is that the expectations of these programs simply do not work for people who have a mental illness.

On the other hand, many people in the field believe that a supervised residential facility is needed for those individuals who are unable to make a start on recovery while living independently in the community. Such facilities provide structure and support rather than intensive treatment. Successful treatment seems to involve only one to two short group sessions a week, frequent repetition of program content and, most importantly, a supportive and creative approach to relapse.

In summary, current policies with respect to substance misuse in many housing and residential programs are an ineffective response to substance misuse. The common response of eviction only compounds the problem and exposes the person to much greater risks. Safe, supportive housing is part of the solution, within the context of a carefully-paced program of recovery that accepts and works with inevitable relapse. Such a program can be provided by an assertive community treatment team with supported independent living units or, for some, a more structured residential setting.

In time, relapses will become less frequent and of shorter duration and, for many people, two years in such a program can lead to effective control of both substance misuse and the symptoms of mental illness.

footnote

1 Drake, RE, Mercer-McFadden, C, Mueser, KT, McHugo, GJ, & Bond, GR. (1998). Review of integrated mental health and substance abuse treatment for patients with dual disorders. *Schizophrenia Bulletin, 24*(4), 589-608.

related resource

Dual Diagnosis Residential Home: For more information, contact Roberta Chapman at the Mental Patients' Association at (604) 738-2811

more on housing in the field of addictions

Many of the issues identified for people with mental disorders also apply to persons with addictions and concurrent mental health and substance use problems. However there are some unique factors relative to housing in the field of addictions.

Often housing options like supportive recovery or even crisis shelters require abstinence in order to accept clients. This requirement does not parallel the mental health system, since supported housing does not require that clients be free of the symptoms of their mental disorder. The result is that many addicted persons fail to qualify for entry into these facilities, and remain on the streets or in environments that are not conducive to addressing their substance use problems.

This situation suggests the potential viability of 'wet' or 'damp' housing options [that is, 'dry' would be substance-use-free] that provide a safe environment for stabilization to clients who are unable to maintain abstinence. The need for transitional housing has frequently been recognized within the addictions service system, and is provided through emergency shelters and supportive recovery facilities. These solutions however are short-term. This creates challenges since people coming out of treatment or supportive recovery may be left with no place to live, a situation which can put their recovery in jeopardy.

Stable housing also gives people an environment in which they are better able to deal with their substance use problems. A Vancouver study found that a group of homeless or formerly homeless people were almost all involved with drugs or alcohol, and that they were more likely to address their addiction if they were housed. When people are secure and happy in their living environment, their chances of maintaining their mental health increase dramatically.

Source: The Primer: Fact Sheets on Mental Health and Addictions Issues. Available at www.mentalhealthaddictions.bc.ca

Uncovering the Elements of Success

Working with Co-occurring Disorders in Residential Support Programs

Gary Beaulieu, MS, LADC, LPC, CCS

Thomas Flanders, BA, DNAD

Gary is the Director of Mental Health Services for the Saint Vincent DePaul Society of Waterbury, Connecticut and has worked in the addictions and mental health field for more than 14 years

Thomas heads a co-occurring disorders support team for the Center for Human Development in the Waterbury, Connecticut area and also facilitates a co-occurring disorders support program for the Saint Vincent DePaul Society

The following article was excerpted from: Beaulieu, G & Flanders, T. (2000). Uncovering the elements of success: Working with co-occurring disorders in residential support programs. International Journal of Psychosocial Rehabilitation, 5, *11-17. To download the full article and model description, see www.psychosocial.com/volume5.html*

Client access to appropriate support and treatment [may be] limited to the few programs and support groups that are staffed with trained professionals and designed to provide services to individuals with co-occurring disorders. Desperate clients who have been deinstitutionalized and living in the community, where ready access to drugs and alcohol has become more and more prolific, often turn to those individuals with whom they have the most contact – their 'residential support' counselors, who may be present in a number of housing settings.

Although the services of these programs may vary in intensity depending on the individual's level of need, they often include supervision; counseling; life skills training; medication monitoring and education; transportation; housing assistance; health and safety education; prevocational, social and communications skills training; and coordination with all other necessary psychiatric and support services. Actively engaged in caring for these clients on a daily basis, these counselors are left with the overwhelming task of finding solutions to the complex needs of the clients they serve in an environment that often seems stacked against them. Despite the political and economic factors that hinder their ability to take action, they have nonetheless been compelled to find new and low-cost approaches that have proven successful for their clients struggling with co-occurring substance-related and mental disorders.

One such approach that has proven to be successful for residential providers has been weekly psychoeducational groups, in which clients can learn about and discuss issues related to their co-existing disorders. At the St. Vincent DePaul Society of Waterbury's mental health division, a community-based mental health residential support program, they have integrated these groups into their model of care and have found them particularly effective in helping individuals with co-occurring disorders maintain their sobriety. After years of experience in facilitating such groups, they consider certain elements to be the key ingredients of their success including active listening, celebrating success, being flexible and non-judgmental and emphasizing a psychoeducation and relapse prevention approach. What follows focuses on the last two key elements of support.

clients may feel more relaxed and receptive to services when they are in familiar territory – a home court advantage

Emphasize psychoeducation

It is essential that clients understand the link between their psychiatric treatment and their sobriety as well as their mental illness and their substance abuse. Education and support can help clients understand these fundamental concepts, which are so important in preventing relapse. Fortunately, residential counselors are often in the unique position to reinforce these connections on an almost daily basis. Clients with co-occurring disorders must recognize that their substance abuse may be an attempt to cope with their psychiatric symptoms, and that if they continue to drink or use drugs, they will have even less control over their psychiatric problems; for example, alcohol can worsen depression, and opiates or stimulants can increase auditory hallucinations, paranoia and delusional thinking.

Additionally, clients must understand that continued alcohol or drug abuse often results in medication non-compliance, which only exacerbates their psychiatric symptoms and that without medication they are more likely to spiral out of control. Part of educating

clients about both problems must include the message that they deserve a better life, and that sobriety is the foundation or the best path they can take towards the improvement they deserve. After all, clients have been attempting to feel good without first being able to feel good about themselves. The 'double-whammy' of substance abuse and psychosis has greatly diminished their sense of control and ability to make sound decisions. Ultimately, the harmful choices they have made have introduced even more chaos into their lives, and alienated them from many of the resources they could use to restore their independence and control. Through ongoing support and psychoeducation, clients are more likely to make the connections they require in order to improve their decision-making abilities, remain abstinent and maintain their medication regimen and psychiatric treatment compliance.

Incorporate relapse prevention in everyday activities

Professionals such as residential counselors who work with clients with co-occurring disorders on a day-to-day basis, can often help them identify potential triggers or develop the coping mechanisms they require to avoid relapse. By identifying potentially stressful situations before they become critical, counselors can help clients either avoid stressors or cope with them on a daily basis. These relapse prevention plans should include not only the development of individualized strategies, but also hobbies, games, meditation and relaxation techniques, social events, the development of support networks, as well as diet and exercise routines which often have an immediate effect on the clients' clarity of thought and decision-making abilities. Such self-directed activities help clients resist temptation, boost self-esteem, and develop the kind of associations that decrease the opportunities and the desire to drink or use drugs.

Overall, the techniques suggested throughout this article may not be appropriate for all providers or client populations. Ultimately, it is important to design a program that works – one that not only meets the needs of the clients, but also the structure of the organization. It is equally important to recognize that clients may feel more relaxed and receptive to services when they are in familiar territory or on their own 'home turf.' This is often the case for clients in mental health community-based residential programs, where services are available to them within the same apartment complex or group home in which they reside. As a result, clients do not feel obliged to 'fit in' to an artificial programmatic role, and providers find it easier to develop rapport, and work with those clients that are more prone to bouts of paranoia. Perhaps this 'home court' advantage should be considered when allocating funds to providers who serve this ever taxing and growing population.

Providing Services to Clients with Concurrent Disorders

Deb Solk

Deb is a researcher at the Kaiser Foundation, a BC addictions charity. For more information, see kaiserfoundation.ca

Providing services for clients with concurrent disorders has historically been laden with challenges originating from a divided treatment system that is ill-prepared to meet client needs. Clients accessing mental health services may not receive the attention required to address their drug or alcohol use issues. In the addictions field, eligibility thresholds for treatment programs are sufficiently high to exclude many clients presenting with mental health disorders. This has often resulted in treatment that is provided either sequentially, (first one issue, then the other) or in parallel form (in which two treatment providers at separate locations use separate treatment plans to treat each condition separately but at the same time). In both versions of this scenario, it has been largely up to the client to navigate through the two streams of services themselves.

In North America, we are starting to acknowledge and address these issues. Both Canada, through *Best Practices: Concurrent Mental Health and Substance Use Disorders*, and the United States, through *TIP 9: Assessment and Treatment of Patients with Co-existing Mental Illness and Alcohol or Other Drug Abuse*, have recently developed standards for the best evidence-based practice in treating clients with concurrent disorders.† Based on best practice research, these two documents address needs, issues, interventions and approaches determined to be most effective in treating clients with concurrent disorders. Three key elements – integrated services, ongoing support and case management – are essential to effective treatment and are discussed below.

Integrated Services

Today we know through research that integrated treatment for co-occurring disorders is far more effective

note

† see footnote citations #1 and #3 on page 9 for these documents

rather than waiting for a person to reach their lowest point of functioning before finding them 'ready for treatment,' we instead need to meet the client at their current level of functioning

than treating these disorders separately, particularly for those with severe mental illness. The merging of services, philosophies and therapeutic approaches allows the strengths of what were two distinct streams of treatment to collectively provide clients with the most comprehensive treatment possible: this is the first of the three key concepts in the treatment of concurrent disorders. This blending process, however, involves systemic changes as well as philosophical ones which have been slow to materialize in our current service system. The wide range of services, breadth of issues addressed and diverse range of practitioners in BC's mental health and addictions service system make this an important challenge.

Integrating treatment for co-occurring disorders challenges some of the more traditional streams of thought in the world of addictions treatment. For instance, there are many clients for whom total abstinence is inappropriate or unachievable, and 'hitting rock bottom' may be dangerous. This is particularly the case when working with persons with concurrent disorders. Rather than waiting for a person to reach their lowest point of functioning before finding them 'ready for treatment,' we instead need to meet the client at their current level of functioning, selecting from a range of supportive services that encourages their movement towards increased stability and life improvement goals. Pharmacological interventions are likely a necessary part of ongoing health, and should be considered as a standard part of an individual's treatment plan.

Ongoing Support

The issue of what are the best kinds of therapeutic interventions for persons with concurrent disorders is presently an active topic of research and debate. Traditional addictions treatment approaches have proven consistently ineffective when used with persons who have concurrent disorders. Rather than being time-limited, therapeutic support for persons with concurrent disorders is now consistently recognized as requiring an ongoing process. This recognition – that the challenges of concurrent disorders are lifelong processes, with varying rates of healthiness and relapse – is the second key therapeutic concept. Removing the time-constrained approach to intervention allows greater creativity in exploring ways to meet the lifestyle goals of our clients. Many different treatment interventions may be required, and the appropriateness of specific interventions may vary over time. Interventions should respond to client needs, recognizing that these are not static, but fluctuate with the cycling of an individual's substance use, mental illness severity, and life experiences.

Case Management

The concept of case management, which originated in the mental health field, is the third key concept of a successful intervention process. Case management provides engagement, support, assessment and linkage for a client on an ongoing basis throughout the treatment process. While the setting in which a client receives specific services may change over time, the case manager ultimately coordinates this process, providing the client with the continuity necessary for ongoing personal growth. With the complexity of the mental health and addictions system and the variety of interventions available, the case manager supports the client in navigating through the system. This ongoing relationship and monitoring also facilitates identifying signs of trouble as early as possible, allowing earlier intervention and minimizing the chances of relapse.

Opportunities for intervention can come from a variety of resources and in a multitude of settings. Primary health providers, who often are the first source of contact, have the opportunity to direct clients to other parts of the service system. The greater their level of knowledge regarding concurrent disorders, the more easily they are able to catch signs and symptoms and refer clients to appropriate agencies for ongoing support.

It is critical that services designed to specifically address the needs of clients with concurrent disorders are broadened significantly, creating a whole continuum of supports and services. Programming must be implemented in ways consistent with best practice research as outlined above. In the meantime, it is imperative that all service providers in the myriad of agencies serving these clients receive training and information regarding the multifaceted issues of concurrent disorders. Additionally, we must communicate both individually between service providers and collectively between agencies to ensure that clients using various services are able to do so in the most effective and supportive manner possible. It is through this collective approach that we can continue building a service system truly designed to meet the needs of the clients that we serve.

The Comprehensive, Continuous, Integrated System of Care Model

Kenneth Minkoff, MD

Ken is the originator of the CCISC model. He and Dr. Christine Kline are currently consulting with the Vancouver Island Health Authority to implement the model

The following article has been edited for length and includes the key points of the model. To download the full version of the article, including references, and for access to a preview of the CCISC Implementation Toolkit, *see www.kenminkoff.com/ccisc.html*

The Comprehensive, Continuous, Integrated System of Care (CCISC) model for organizing services for individuals with co-occurring psychiatric and substance disorders (COPSD) is designed to improve treatment capacity for these individuals in systems of any size and complexity, ranging from entire states or provinces, to regions or counties, networks of agencies, individual complex agencies, or even programs within agencies. The model has the following four basic characteristics:

1 **System level change:** The CCISC model is designed for implementation throughout an entire system of care, not just for implementation of individual program or training initiatives.

2 **Efficient use of existing resources:** The CCISC model is designed for implementation within the context of current service resources, however scarce, and emphasizes strategies to improve services to individuals with COPSD within the context of each funding stream, program contract, or service code, rather than requiring blending or braiding of funding streams or duplication of services.

3 **Incorporation of best practices:** The CCISC model is recognized as a best practice for systems implementation for treatment of persons with COPSD. An important aspect of CCISC implementation is the incorporation of evidence-based and clinical consensus-based best practices for the treatment of all types of people with COPSD throughout the service system.

4 **Integrated treatment philosophy:** The CCISC model is based on implementation of principles of successful treatment intervention that are derived from available research and incorporated into an integrated treatment philosophy that utilizes a common language that makes sense from the perspective of both mental health and substance disorder providers.

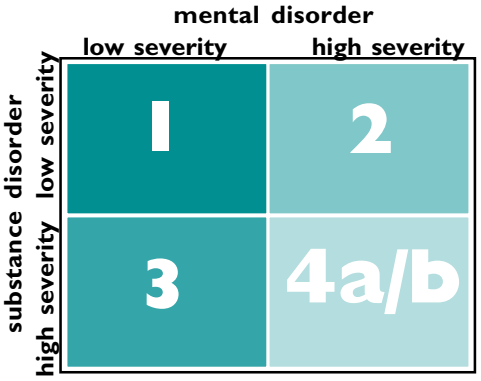
The eight research-derived and consensus-derived principles that guide the implementation of the CCISC are as follows:

- Dual diagnosis is an expectation, not an exception
- All people with COPSD are not the same; the national consensus four-quadrant model for categorizing co-occurring disorders[1] can be used as a guide for service planning on the system level (see box below)
- Empathic, hopeful, integrated treatment relationships are one of the most important contributors to treatment success in any setting
- Case management and care must be balanced with empathic detachment, expectation, 'contracting,' consequences, and 'contingent learning' for each client, and in each service setting. (*Contingent learning* involves specifying consequences for desired or un-desired behaviours for which the client has responsibility; *contracting* is a means for coming to an agreement for these, as a way to increase the chances for success)

four-quadrant model

In this model, people with COPSD can be divided according to high and low severity for each disorder, whether mental health or substance use-related. Group definitions are:

- **Quadrant 1** (*Low-low*): usually seen in outpatient services in either mental health or substance use settings
- **Quadrant 2** (*High-low*): serious and persistent mental illness (SPMI) and substance abuse. Usually followed in mental health settings designed to treat SPMI
- **Quadrant 3** (*Low-high*): substance dependence plus less severe mental illness. Continuing care in addiction settings
- **Quadrant 4a** (*High-high*): SPMI plus substance dependence. Usually followed in mental health settings designed to treat SPMI, but may have episodes of modified addiction treatment
- **Quadrant 4b** (*High-high*): severe substance dependence and behavioural disturbance, but not known to be SPMI. May be followed in either mental health or addiction settings, with enhanced integrated services



- When psychiatric and substance disorders coexist, both disorders should be considered primary, and integrated dual (or multiple) primary diagnosis-specific treatment is recommended.
- Both mental illness and addiction can be treated within the philosophical framework of a 'disease and recovery model' with parallel phases of recovery (acute stabilization, motivational enhancement [helping a person reach the stage where they are ready to make change], active treatment, relapse prevention, and rehabilitation/recovery), in which interventions are not only diagnosis-specific, but also specific to phase of recovery and stage of change.
- There is no single correct intervention for individuals with COPSD; each individual intervention must be individualized according to quadrant, diagnoses, level of functioning, external constraints or supports, phase of recovery and stage of change.
- Clinical outcomes for clients with COPSD must also be individualized.

Implementation of the CCISC requires utilization of system change strategies (e.g., continuous quality improvement), in the context of an organized process of strategic planning, to develop the specific elements of the CCISC. The '12-step Program for Implementation of a CCISC' defines this process sequentially, and, in collaboration with Cline, Minkoff has organized a CCISC *Implementation Toolkit* that promotes the successful accomplishment of many of the specific steps. Implementation of the CCISC occurs incrementally in complex systems, over a period of years, and is characterized by establishment of the following 12 elements:

Integrated system planning process

Implementation of the CCISC requires a system-wide, integrated, strategic planning process that can address the need to create change at every level of the system, ranging from system philosophy, regulations and funding, to program standards and design, to clinical practice and treatment interventions, to clinician competencies and training.

Formal consensus on CCISC model

The system must develop a clear mechanism for articulating the CCISC model, including the principles of treatment and the goals of implementation, developing a formal process for obtaining consensus from all stakeholders, identifying barriers to implementation and an implementation plan, and disseminating this consensus to all providers and consumers within the system.

Formal consensus on funding the model

CCISC implementation involves a formal commitment that each funder will promote integrated treatment within the full range of services provided through its own funding stream.

Identification of priority populations and locus of responsibility for each

Using the four-quadrant model, the system must develop a written plan for identifying priority populations within each quadrant, and locus of responsibility within the service system for welcoming access, assessment, stabilization and integrated continuing care.

Development and implementation of program standards

A crucial element of the CCISC model is the expectation that all programs in the service system must meet basic standards for dual diagnosis *capability*, whether in the mental health system or the addiction system. In addition, within each system of care, for each program category or level of care, there need to written standards for dual diagnosis *enhanced* programs.

Structures for intersystem and interprogram care coordination

CCISC implementation involves creating routine structures and mechanisms for addiction programs and providers and mental health programs and providers, as well as representatives from other systems that may participate in this initiative (e.g., corrections) to participate in shared clinical planning for complex cases whose needs cross traditional system boundaries.

Development and implementation of practice guidelines

CCISC implementation requires system-wide transformation of clinical practice in accordance with the principles of the model. Obtaining input from and building consensus with clinicians prior to final dissemination is highly recommended.

Facilitation of identification, welcoming and accessibility

This requires several specific steps: (1) modification of database capability to facilitate identification, reporting and tracking of clients with COPSD; (2) development of 'no-wrong-door' policies that mandate a welcoming approach to people with COPSD; and (3) establishing policies and procedures for universal screening for co-occurring disorders at initial contact throughout the system.

Implementation of continuous integrated treatment

Integrated treatment relationships are a vital component of the CCISC. Implementation requires developing the expectation that primary clinicians in every treatment setting are responsible for developing and implementing an integrated treatment plan in which the client is assisted to follow diagnosis-specific and stage-specific recommendations for each disorder simultaneously.

▶ continued on page 50

footnote

1 National Association of State Mental Health Program Directors and the National Association of State Alcohol and Drug Abuse Directors. (1998). *The new conceptual framework for co-occurring mental health and substance use disorders.* Washington, DC: NASMHPD.

A Scan Around BC

Reconfiguring Mental Health and Addiction Services in the Health Authorities

Mykle Ludvigsen

Mykle is a Communications Officer at the Canadian Mental Health Association's BC Division

Imagine you are a person with a mental illness. Now imagine you are also a person with an addiction, and that this concurrent disorder (mental disorder plus addiction) interferes with your ability to live a normal, productive and healthy life. Even further, imagine that even though your addiction and mental illness are affecting each other, neither a service from the mental health system or the drug and alcohol addictions system is fully able, or even willing, to help. You are turned away by the mental health system, you are told, because you have an addiction and need to treat that first, only to be told by an addictions service that what you really need to do is go treat your mental illness first.

Unfortunately, that routine was more common than one would hope, but with the recent paradigm shift that has put addictions and mental health in the same sphere, services are being improved to ensure that all mental health and addictions services work together better to put the person dealing with both a mental illness and an addiction at the centre of the health system's focus. Over the last two years, the provincial government has initiated a series of reforms that have amalgamated several smaller health regions to larger health authorities. With this amalgamation came a series of changes to mental health and addictions services – transferred to the health authorities to manage in their communities at that level – with the mandate to ensure that those services are best tailored to serve their region in the most effective way. What follows is a rundown of some of the highlights in each health authority.

Vancouver Island Health Authority

The Vancouver Island Health Authority (VIHA) has what many consider to be one of the most cutting-edge programs available to enact system change. While all the health authorities have a comprehensive system in various stages of development, VIHA has contracted with Dr. Ken Minkoff (see the preceding article) to develop a concurrent disorders plan that reflects the needs and capabilities of the people on Vancouver Island.

This plan was designed with an eye to changing the mental health and addictions system to ensure that it was accessible to all and that any contact a consumer with both a mental illness and an addiction makes creates a pathway to the appropriate service.

In January 2002, a consensus conference among stakeholders on Vancouver Island agreed to create a system of care where people with concurrent disorders would be welcomed. In the process started on Vancouver Island, everyone in both the addictions and mental health field is introduced to each other's fields and educated in the proper response to dealing with someone who may come to them with a co-occurring disorder. These individuals then fan out across the health authority, training others in how to deal with someone coming to them with a concurrent disorder, passing down the information from professional to professional all the way down the line.

"It's going to take some time," says Alan Campbell, Manager of Policy Transition for the Vancouver Island Health Authority, explaining that the program lets staff and other providers learn not only how to treat people with a concurrent disorder, but also how to identify them, and to treat them with appropriate care. "Within three years, we can lock in these types of changes and have them as part of our regular quality of care."

In this system, everybody is involved. People fully versed in the plan developed by Dr. Minkoff train others who will essentially act as trainers to others contracted to provide service to consumers and people with substance use problems by VIHA. Curriculum resource binders are provided and a full day of training, followed by site visits. The progress is documented with self-assessment action plans that are reviewed every six months in an attempt to move forward. The plan is also tailored to specific audiences as required – a nurse's experience may be different than that of a case worker's – and, according to Campbell, this seems to be effective. "We look at the competencies we expect people to have," he says.

These individuals then fan out across the health authority, training others in how to deal with someone coming to them with a concurrent disorder, passing down the information from professional to professional all the way down the line

Special attention has been made in reaching harder-to-target groups such as physicians and those who work in 24-hour settings, but slowly but surely, the VIHA program is progressing on schedule.

This plan will ensure that every person who is the point of contact with the system for someone with a co-occurring disorder will have adequate training in both the addictions and mental health areas – whether that be the local mental health centre, the hospital emergency room, or any other service that is available. The admission policies for hospitals have been adjusted to permanently entrench that philosophy throughout the system.

Campbell says future directions include expanding the program to over 200 agencies within the Vancouver Island Health Authority, and to connect with Aboriginal agencies and the local colleges and universities to train people as they are coming into the system, so that the values presented in Dr. Minkoff's plan are connected to the curriculum. He notes that while this could take a while, it is the ultimate goal of the health authority.

Other health authorities throughout the province are watching Vancouver Island very closely to see what they can learn from their example, and in many cases have implemented changes in their own regions.

Northern Health Authority

The Northern Health Authority has trained two key staff on the Minkoff plan, and according to Elizabeth Tovey, Mental Health Manager for the Authority, VIHA has been very helpful and open to partner with this region, which serves a very unique audience. Trainers are currently meeting all mental health and addictions staff and having them agree on some core principles – including the key welcoming criteria that the Minkoff plan finds so important, that is, ensuring that no one is turned away from a mental health or addictions service just because they have a co-ocurring disorder.

Fraser Health Authority

Fraser Health has also implemented a unique system by creating 11 new concurrent disorders therapist positions at the various mental health centres throughout Fraser Health's service delivery area. Debbie Suian, the Concurrent Disorders Therapist in the Tri-Cities (Coquitlam, Port Moody, Port Coquitlam) Mental Health Centre explains her role as a trainer/consultant, rather than a direct service worker, although she does admit to occasionally working with clients with more complex issues. She sees the job as a bridge between the mental health and addictions worlds, and tries to ensure that what she describes as the 'ping-pong effect' – where people go between each system to try and get help – doesn't occur. Only into the job a few months, she has organized monthly training events and a peer support group for staff at the mental health centre, in addition to providing ongoing consultation to colleagues. She co-facilitates a weekly concurrent disorders support group with Cheryl Worfolk, manager of New View Clubhouse, and has recently launched 'networking' meetings, where people from various agencies, whether they be non-profit, government or health, with interests in the field, are able to meet at a local restaurant to share information and to make their services available. Information-sharing is a key element in integrating the system, as people working in the field need to know what's out there. She is a member of the regional training subcommittee, and has also created a monthly newsletter for people interested in mental health and addiction, and is available for consulting to anyone in the Tri-Cities area.

Interior Health Authority

Interior Health is also beginning its mental health and addictions concurrent disorders training for professionals in the field and according to Carmen Lenihan, Coordinator of Concurrent Disorders Services at the Okanagan Independent Living Society, there has been a greater awareness that concurrent disorders may be more of a rule than an exception in regards to consumers in the system (see more on the opposite page).

While it's clear that integrating the two systems has not been easy, most people tend to agree that it is a worthwhile effort. Behind the scenes, programs are evolving rapidly and there is general enthusiasm for the project. Only time will tell how effective it turns out to be.

Vancouver Coastal Health Authority

For information on the Vancouver Coastal Health Authority, please see the article on page 52.

regional health authority contacts

- **Vancouver Island Health Authority**
  1-877-370-8699 or (250) 370-8699
  www.viha.ca
- **Northern Health Authority**
  1-866-565-2999 or (250) 565-2649
  www.northernhealth.ca
- **Fraser Health Authority**
  1-877-935-5669 or (604) 587-4600
  www.fraserhealth.ca
- **Interior Health Authority**
  (250) 862-4200
  www.interiorhealth.ca
- **Vancouver Coastal Health Authority**
  1-866-884-0888 or (604) 736-2033
  www.vch.ca

Concurrent Disorders in the Okanagan Valley

Sketching out Potential Service Options

Carmen Lenihan

Carmen is the Coordinator of Concurrent Disorders Services at the Okanagan Independent Living Society. She has a background in social work and not-for-profit management

Concurrent disorders, substance abuse coupled with another major mental illness, are a much discussed topic in the Okanagan Valley these days. Statistics vary depending on a number of factors, but it is estimated that as many as 50% of individuals seeking help for a mental health concern also have issues around substance use.[1] These high numbers warrant finding an effective way to treat this population's unique needs. Addiction services alone are not enough, nor are treatments for a mental health concern that don't address the other issue.

As the Coordinator of Concurrent Disorders Services at the Okanagan Independent Living Society, I have spent the past three months researching this topic further, with the goal of developing a program specific to the treatment of concurrent disorders. The following is a brief synopsis of what I have discovered.

Existing Services

Currently, few services specific to concurrent disorders exist in the Kelowna area. Many government and non-government agencies recognize the need to better serve this population, but currently lack the specialization. Although some drug and alcohol treatment facilities do not exclude individuals who are diagnosed with a major mental illness, current programs may not adequately address the complex needs of these clients. On the flip-side, mental health services are structured to treat many mental disorders, but not substance abuse, which gets referred back to the alcohol and drug rehabilitation centres.

Services Needed

Further interviews with professionals and clients revealed the following needs:

- ***Cross training:*** professionals working in the addiction field could benefit from more education on other major mental illnesses, while mental health workers could benefit from additional training on how drugs and alcohol affect someone with a mental illness. The complexity of concurrent disorders should be the primary focus of this training. Adding drugs and alcohol to a major mental illness can produce a number of impacts that may be difficult to separate. If someone has been abusing drugs and alcohol for years, it may be difficult to determine whether or not a major mental illness separate from the substance abuse even exists. Drugs and alcohol can mimic or mask a mental illness, while a mental illness can mimic or mask substance abuse.
- ***Specialization:*** services need to be developed where both the substance abuse and other mental illness can be addressed concurrently. Aside from detoxification and the management of initial withdrawal symptoms, recovery needs to include addressing both disorders.
- ***Client-centred treatment:*** harm reduction models are teaching us that we cannot use the same approach for everyone.[2] This is especially true for concurrent disorders. Services need to be client-centred and recovery plans need to be individualized.

How the Community is Responding

Local mental health and addiction services are beginning to work more closely together, especially with the amalgamation of mental health and addiction services under one management structure. The Interior Health Authority is providing education around concurrent disorders, and there is talk of specialized services. Our largest addiction recovery centre is blending in a harm reduction model. Generally, there is greater awareness, and professionals are recognizing that concurrent disorders may be more of a rule than an exception. A lot of individuals who misuse drugs and alcohol, for example, also suffer from some degree of anxiety or depression. According to a University of British Columbia study, early onset of a major depression or an anxiety disorder doubles the risk for later drug use.[3]

How the Okanagan Independent Living Society is Responding

We felt it was important to gain a clear understanding of our local community's issues and plans around concurrent disorders. Armed with this information, we are now sketching out potential service options, which would:

- facilitate a continuum of care focusing on the potential for permanent change, rather than band-aid solutions
- provide flexibility in service delivery through individualized recovery plans

footnotes

1 BC Partners for Mental Health and Addiction Information. (2003). *The primer: Fact sheets on mental health and addictions issues.*

2 Donald MacPherson. (2001). A framework for action: A four-pillar approach to drug problems in Vancouver. City of Vancouver. See www.city.vancouver.bc.ca/fourpillars

3 Mental Health Evaluation and Community Consultation Unit, University of BC. (2001). Concurrent disorders: Substance use disorders and other mental disorders - Dimensions of policy and practice. *Mheccu Bulletin, 2.*

4 Addictions Task Group Report and Kaiser Youth Foundation. (2001). *Weaving threads together: A new approach to address addictions in BC.* See healthservices.gov.bc.ca/addictions

new concurrent disorders program in the north okanagan

The Concurrent Disorders Program is new to the North Okanagan region of the Interior Health Authority. It was started because there was a recognition that some clients were falling through the cracks because of the complex nature of their addiction and mental health issues.

To access the program, you must approach one of the professionals that is currently working with you. This may be a mental health worker or an addictions worker. This person may then request additional help from the program.

Help will be time limited and will be designed to help advocate for you, reduce the barriers you may be encountering and help you become healthier as soon as possible. The Concurrent Disorders Program is designed to help clients and professionals throughout the North Okanagan. You can access the program in the Salmon Arm or Vernon areas by calling (250) 549-5737. In the Revelstoke area, call (250) 837-6601.

Source: January 2004 issue of Consumer Voices, *a publication of CMHA Vernon and District branch. Article by Betty Kedding.*

- provide breadth in service to accommodate individuals at different stages of recovery
- track success rates and provide aftercare services and relapse prevention
- stress personal responsibility, resilience and re-integration into the community.

These goals tie in well with the latest research around harm reduction and new approaches. For example, one addiction task group report[4] sketches out an intervention continuum showing a progression from saving lives, through stabilization, healing and eventual reintegration. This would be accomplished by providing services at the pre-contemplation and contemplation stages – stages where the consumer is either starting to consider or actively considering change – of recovery planning, through to maintenance and aftercare. We are not proposing to provide services along the entire continuum, but through collaboration and partnerships, we hope to provide a few links in the chain of recovery.

The CCISC Model | *continued from page 46*

Development of basic dual diagnosis capable competencies for all clinicians

Creating the expectation of universal competency, including attitudes and values, as well as knowledge and skill, is a significant characteristic of the CCISC model. Competency assessment tools (e.g., CODECAT) can be utilized to facilitate this process. For more information about these tools, see the full text of the CCISC model, and scroll down to find the *Implementation Toolkit* link.

Implementation of a system-wide training plan

In the CCISC model, training must be ongoing, and tied to achievable competencies in the context of actual job performance. This requires an organized training plan to bring training and supervision to clinicians on site. The most common components of such training plans involve curriculum development and dissemination, mechanisms for training and deploying trainers, career ladders for advanced certification and opportunities for experiential learning.

Development of a plan for a comprehensive program array

For more information on the CCISC implementation activities within the Vancouver Island Health Authority and elsewhere, see the article by Mykle Ludvigsen on p. 47 of Visions.

The CCISC model requires development of a plan in which each existing program is assigned a specific role or area of competency with regard to provision of dual diagnosis *capable* or dual diagnosis *enhanced* service for people with co-occurring disorders, primarily within the context of available resources. Four important areas that must be addressed in each CCISC are:

- ***Evidence-based best practice:*** There needs to be a specific plan for initiating at least one *continuous treatment team* (or similar service) for the most seriously impaired individuals with SPMI and substance disorder. This can occur by building dual diagnosis enhancement into an existing intensive case management team.
- ***Peer dual recovery supports:*** The system must identify at least one dual recovery self-help program (e.g., Dual Recovery Anonymous, Double Trouble in Recovery) and establish a plan to facilitate the creation of these groups throughout the system.
- ***Residential supports and services:*** The system should begin to plan for a comprehensive range of programs that addresses a variety of residential needs, building initially upon the availability of existing resources through redesigning those services to be more explicitly focused on individuals with COPSD. This range of programs should include:
  - dual diagnosis capable/enhanced addiction residential treatment (e.g., modified therapeutic community programs)
  - abstinence-mandated ('dry') supported housing for individuals with psychiatric disabilities
  - abstinence-encouraged ('damp') supported housing for individuals with psychiatric disabilities
  - consumer-choice ('wet') supported housing for individuals with psychiatric disabilities at risk of homelessness
- ***Continuum of levels of care:*** All categories of service for those with COPSD should be available in a range of levels of care, including outpatient services of various levels of intensity, intensive outpatient or day treatment, residential treatment and hospitalization.

CCISC implementation requires a plan that includes attention to each of these areas in a comprehensive service array.

BC Partners for Mental Health and Addictions Information

EMPOWERMENT THROUGH INFORMATION

- *Anxiety Disorders Association of BC*
- *Awareness and Networking Around Disordered Eating*
- *British Columbia Schizophrenia Society*
- *Canadian Mental Health Association's BC Division*
- *FORCE Society for Kids' Mental Health Care*
- *Kaiser Foundation*
- *Mood Disorders Association of BC*

Funding is provided by the BC Ministry of Health Services and the BC Ministry of Children and Family Development

We want your opinion

New educational resources for concurrent disorders

The BC Partners for Mental Health and Addictions Information are embarking on the creation of another self-management resource. In the past year, we created a generic self-management toolkit for mental disorders. We also produced self-management toolkits for anxiety disorders, depression and for addictions.

Given the importance of addressing mental health and addictions together, the BC Partners have decided to embark on a project to develop resources to help people gain vital information about concurrent disorders and begin to build skills for managing co-occurring mental health and substance use problems in their day-to-day lives.

The BC Partners decided during the initial phases of the project that an important first step would be to canvass the views of people who are dealing with concurrent disorders themselves such as consumers, family members and front-line service providers. A suggestion came forward to use *Visions* as a way to gather insights, ideas and suggestions as to how to proceed with the project. So, for *Visions* readers who fall into any of those groups, or for people who just want to share their ideas, please take a few moments, consider the following questions, and send us your thoughts.

What kinds of resources are most necessary? Let us know what your top priority would be among the items listed below:

- ❑ basic information about concurrent disorders such as pamphlets, booklets, etc.?
- ❑ Information about available services and how to access them?
- ❑ Workbooks or worksheets on relapse prevention?
- ❑ Stories of recovery?
- ❑ Adapting existing resources for concurrent disorders?
- ❑ All of the above?

What self-management resources (information, fact sheets, workbooks, guides to existing services, self-help groups, websites, etc.) already exist that we should know about? In your Health Authority or region? In the province of BC or elsewhere?

Do you have any other ideas about self-management of concurrent disorders you would like to share?

Please send your responses to **feedback@mentalhealthaddictions.bc.ca,** fax it to **604-688-3236** to the attention of Visions Editor, or mail it in with your completed *Visions* survey (see page 31/32) in the envelope provided. Once we've collected all the feedback, we'll bring them forward so that they can guide us when we're developing resources on this important area. Thank you in advance for your input.

Vancouver Coastal Health

Redesign of Addictions Services and Concurrent Disorders

Susann Richter

Susann is with Vancouver Coastal Health Authority's Addictions Services, Community Engagement. For information, contact susann_richter @vrhb.bc.ca

Background and Current Challenges

People suffering concurrent disorders (also called dual diagnosis) have both a diagnosable addiction and a psychiatric disorder. It is widely accepted that there is a strong relationship between addiction and psychiatric disorders, and that either condition can lead to, or affect the other.[1] Dr. Kenneth Minkoff goes so far as to state that "dual diagnosis is an expectation, not an exception."[2]

Providing services to people with concurrent disorders has historically been challenging. In British Columbia, addictions, mental health and primary care services were for many years delivered as separate systems under different ministries, with little opportunity for coordination. With the recent regionalization of health services, addictions, mental health and primary care services are now co-located under the health authorities (since 2002). This opens the door to the possibility of better integration and planning.

The need for a seamless system of services is important for concurrent disorder consumers. These individuals are among the most challenged in any health care system. Unless proper screening and assessments can be done by both mental health and addictions providers, many people will be treated for only one disorder. Even when both disorders have been identified, treatment is difficult since traditionally, the two systems have differed in philosophy and approach.[2] The consumer might receive different treatment for the same symptoms from each provider. This can lead to confusion, reductions in medication compliance and a loss of overall health. The complex symptoms of these clients can also cause them to refuse treatment, even when offered and available.

There are many inherent barriers to accessing services for people with co-occurring disorders as they are often unable to make significant contact with others. They tend to be among the most marginalized and isolated members of society. In addition, consumers with mental health issues may be reluctant to reveal addictions concerns to mental health service providers and social assistance workers because of the stigma attached. There is an urgent need for education, common language and common clinical standards among the various agencies involved in services for concurrent disorder consumers. A lack of such coordination can be disastrous. For example, there is currently a perception among consumers and service providers that disability assistance in British Columbia may be terminated if a person admits to substance misuse. The belief is that, if the mental health symptoms are attributed to substance misuse, the person may lose their classification for social assistance purposes, resulting in a significant or total loss of income.[3]

Another issue that decreases access and reduces effectiveness of services is the debate over the root cause of concurrent disorders. Some models are based on the belief that the addiction is caused by an effort to self-medicate for mental health symptoms; others state that the psychiatric disorders are caused by substance misuse. Still other models identify common factors such as genetic loading or personality disorders as risks, while a bi-directional model proposes that either disorder can make people vulnerable to the other.[4] This debate can result in a complete lack of service. For example, consumers state that they will often be refused treatment at emergency wards when they present with psychosis because the psychosis will be attributed to drug use and, therefore, be considered not worth treating.[3]

In an integrated system, how and where a person enters care would not matter, as treatment follows regardless. In the above example, the consumer in emergency would be treated episodically but would then be referred to appropriate concurrent disorder specialists. The model of treatment would allow enough time and assessment for the symptoms to lead to a treatment plan, without the need to determine too quickly the origin of the symptoms. Health Canada describes program and system integration in its *Best Practices* document:

Program integration means: mental health treatments and substance abuse treatments are brought together by the same clinicians/support workers or team of clinicians/support workers, in the same program, to ensure that the individual receives a consistent explanation of illness/problems and a coherent prescription for treatment rather than a contradictory set of messages from different providers.

System integration means: the development of enduring linkages between service providers or treatment units within a system, or

footnotes

1 Drake, R. (2003). *Dual diagnosis and integrated treatment of mental illness and substance abuse.* See: www.nami.org/Content/ContentGroups/Helpline1/Dual_Diagnosis_and_Integrated_Treatment_of_Mental_Illness_and_Substance_Abuse_Disorder.htm

2 Minkoff, K. (2001). *Dual diagnosis: An integrated model for the treatment of people with co-occurring psychiatric and substance disorders in managed care systems.* Presentation.

3 Based on discussions with addictions service providers and consumers in the Vancouver community

4 Hodgins, D. (2000). Meeting the challenge of concurrent disorders. *Developments, 20*(2). See: corp.aadac.com/programsservices/developments/vol20_issue2.asp

5 Centre for Addiction and Mental Health. (2002). *Best practices: Concurrent mental health and substance use disorders.* Ottawa: Health Canada. See www.cds-sca.com

across multiple systems, to facilitate the provision of service to individuals at the local level. Mental health treatment and substance abuse treatment are, therefore, brought together by two or more clinicians/support workers working for different treatment units or service providers. Various coordination and collaborative arrangements are used to develop and implement an integrated treatment plan.[5]

Addictions Redesign in Vancouver

Currently in the community of Vancouver, the Vancouver Coastal Health Authority is in the process of redesigning addiction and mental health to integrate into primary care services. Over a five-year time period, community health centres are being redesigned with the goal of increasing access and services to high-risk and hard-to-reach clients. One of the overarching principles of the collective redesigns is that client care must be integrated and seamless, with many points of entry into a unified system. With respect to addictions, services are being redesigned over a three-year timeframe. Addictions teams and services are being implemented in all of the community health centres across Vancouver (to be completed by June 2004) and will provide:

- needle exchange
- methadone maintenance therapy
- home detox
- counseling
- prevention services

The new model of care for addictions is based on best practice research and includes the following eight principles:

- Sees addiction as a public health issue
- Recognizes the relationship between addiction and mental health
- Supports both abstinence and substance use reduction as goals
- Integrates with primary care
- Has multiple entry points
- Uses evidence-based research
- Provides treatment on demand
- Involves the client in all aspects of treatment planning

Standardized education and clinical practice guidelines are being implemented for all addiction services. When a client comes into the system, regardless of their presenting symptoms, they will be assessed and will access whatever services they are seeking at the time. The assessment tools include mental health assessment, so that over time, the client may be directed to mental health services (either on-site or with external mental health teams) if that is part of their symptomology. Education is extended to all of the staff at the community health centres, including reception staff. This ensures that all staff interacting with the client have knowledge related to addictions.

Individual mental health workers are being added to the teams at the sites, and greater links with existing mental health teams are being formed. This opens the door to coordinated education and clinical standards development between disciplines.

Existing Resources for Dual Diagnosis

An excellent existing dual diagnosis program (that covers Vancouver) is part of the network of services that will be supplemented by having better-educated and coordinated service providers at community health centres. The dual diagnosis team provides a model of care for people with concurrent disorders and has specialized staff including a physician who is an 'addictionologist.' This team is available to do education with staff at other sites and currently attends at Vancouver Detox on a weekly basis to assist with dual diagnosis clients who are detoxing and considering a treatment plan. The dual diagnosis program provides group therapies including rational emotive therapy, relapse prevention, anger management and family support, among others. This programming will be more accessible to clients as primary care teams learn how to assess and connect people with what they need.

A community engagement and education process is being undertaken to promote collaboration, increase understanding of addictions and concurrent disorders and to receive input from consumers of services and their families.

While the effort to integrate services is in an early stage of development, there are increasing opportunities and an understanding of where and how health care delivery systems need to improve to better serve hard-to-reach clients such as those with concurrent disorders.

On the Street

Mental Illness and Addiction on the Downtown Eastside

Cynthia Row and Mykle Ludvigsen

Cynthia is Editorial Assistant for Visions. She lives in Vancouver, is a mental health consumer, and has a background in freelance writing and broadcasting

Mykle is a Communications Officer at the Canadian Mental Health Association's BC Division

Vancouver's Downtown Eastside is known as one of the grittiest places in North America to live. It is a community that is faced with serious economic, social and health problems that seem out of place in a wealthy society such as Canada. Thankfully, both the public at large and those charged with making sure our community is healthy have taken a keen interest in this neighbourhood, with the desire to make it a better place.

Concurrent mental illnesses and addictions are found in all walks of life, but the devastating impact of this condition on both individuals and society can best be seen starkly on the streets of this neighbourhood. Every day, while the needs of the most needy fall through the cracks, service providers work closely with these people to help them rebuild their lives and recover from their mental illness, addiction or both. This grassroots reality is far different than the world of endless reports from various levels of government or the minutiae in the restructuring of various services.

Addiction services tend to be the most available on the Downtown Eastside, but there is acknowledgment and awareness by those who work in these services that a high percentage of people using their facilities and expertise indeed have a co-occurring mental illness. The Portland Hotel Society (which operates the controversial new supervised injection site in Vancouver, known as InSite), the VANDU unsanctioned injection site nearby, and the Triage and other emergency shelters are doing the best they can to incorporate the reality of concurrent disorders into their operations, considering the resources they have to work with. The people here have key knowledge into what would make a difference in the lives of those with a concurrent disorder in the Downtown Eastside.

Recently, Vancouver opened its first legal, supervised injection site. Under the authority of Health Canada and the Vancouver Coastal Health Authority, the site is run by the Portland Hotel Society, a recognized community leader in the Downtown Eastside. Because the needs of their clients are so complex, yet sometimes quite basic (a coat here, or a blanket there), and because their clients' lives are in crisis, staff at every level – from the front door operator to health workers – tend to be advocates for their clients on all issues, all the time, on an individual basis.

The functional goals of the Portland Hotel Society (PHS) are to "establish relationships where (clients) slowly get to know and trust us, and get them to the place where they can access support and services," according to Liz Evans, Executive Director of PHS. 'The Portland' has always held the philosophy that housing is a first step in stabilizing the addiction, which in turn is acknowledged as an important first step in treatment. This strong belief in the value of housing is shared by other service providers, and is also something that PHS provides for people with addiction problems.

The PHS currently has also enlisted the services of a drop-in counsellor at the Portland Hotel, or a "listening lady," as Evans calls her. PHS subscribes to the view of "continuity and acceptance, based on the therapeutic family model," according to Evans. Only time will tell how successful it is.

While Evans admits that services in the Downtown Eastside generally are progressing towards the 1998 recommendations for treating and managing addictions – that included the 'four pillars' recommendations, leading to the establishment of Vancouver's supervised injection site – service providers are still under-serving their clientele: the homeless, the drug and alcohol-addicted, many of whom have serious mental disorders.

According to Mary Marlow, Manager of Withdrawal Services for Vancouver Detox, potential clients for their agency are screened by their automated telephone sys-

the injection room, with individual stalls, at Vancouver's supervised injection site, InSite, in the Downtown Eastside

photo: Joshua Berson

tem which, while gathering pertinent information, asks whether or not a client has a psychiatric condition, whether or not that person is under the treatment of a mental health professional, or whether that person is on any medication. If the person is indeed under treatment, then generally, according to Marlow, they would be treated in the mental health system. But anyone with an apparent undiagnosed psychiatric condition who is in the detox facility would be assessed by a mental health worker who comes into Detox regularly to do assessments. Again, these services are just trying to keep up with the demand, thanks to dedicated to staff with a keen sense of being on a mission to help those who want to clean themselves up.

Over at the Triage Emergency Shelter at 707 Powell Street, clients (over 19 years of age), are referred by health care workers, Ministry of Human Resources employment assistance workers, hospital staff, or come in of their own accord. People are not screened at intake and while many have health issues such as HIV, they may not have an official psychiatric diagnosis when they come to Triage. Triage provides short-term emergency housing to people with addictions and operates Windchimes, a transition shelter. Triage has 28 crisis beds and access to 46 transitional beds.

Lesley Remund, Triage Emergency Shelter Manager, is emphatic about what would make the critical difference in the life of anyone on the street with an addiction, including people with mental illness: "The most important need for these people is housing and a continuum of care with minimal barriers to access," she says. She points out that currently there is no housing for women with a concurrent disorder in the Lower Mainland. There is one 39-bed facility planning to open in 2005; but, as Remund points out, "transitional housing is a stop-gap measure." Remund also thinks that there needs to be a clear pathway, and a continuum of care for the dually diagnosed. "After here, where do they go?" she asks. "People go from here to Detox and back to here." She also stresses that services for the dually diagnosed should be available in one location, similar to what has been recommended in the Minkoff plan.

Concurrent disorders as a health issue is gaining recognition in the health community, but there is a long way to go before mental health and addictions issues receive the attention and resources given to other health conditions, such as heart disease or diabetes. In a faltering health care system, competing for recognition is even more of an uphill battle – a battle being fought by service workers on the Downtown Eastside and throughout our communities.

In the meantime, large numbers of people with concurrent disorders go without adequate management of their condition, as they struggle just to survive. Workers on the Downtown Eastside try to help them with their most basic needs – food, shelter and clothing – while a full-blown health crisis rages around them on the streets. A first step towards a real solution is to acknowledge that a large number of street addicts have serious untreated mental health issues. And policy makers would do well to listen closely to those who have daily contact with them at PHS, Triage and detox facilities.

However this is achieved, stable and retainable housing must be available for people with addictions and mental health problems before proper treatment or self-management can truly take hold. People who struggle with these conditions need to be met where they are at – namely by a continuum and circle of care in their own communities.

photo: Joshua Berson

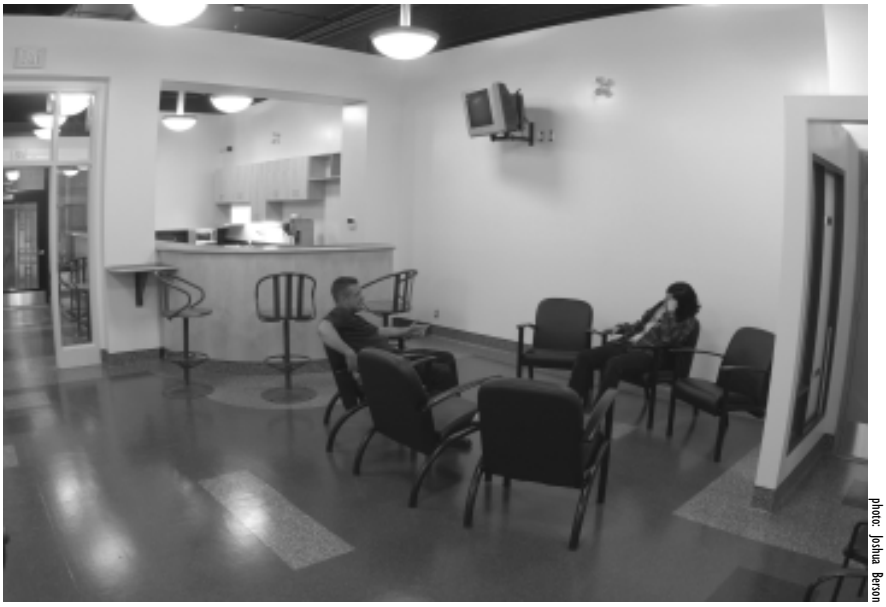


photo: Joshua Berson

above: the 'chill room' at the injection site, essentially a waiting room and social space

top: an injection kit at the site

related resources

Downtown Eastside Community Resources website: www.dtes.ca

BC Partners for Mental Health and Addictions Information. (2003). *Supervised injection sites.* See www.mentalhealthaddictions.bc.ca

What's so 'Special' about Special Populations?

New Programs for Women and Youth with Concurrent Disorders

The following article is a result of an 'e-interview' that *Visions* carried out with Dr. Shimi Kang, who told us about her work at the Children's and Women's Health Centre of British Columbia, establishing new programs for women and youth with concurrent disorders...

Dr. Kang, BSc, MD, FRCPC, completed psychiatry training at the University of British Columbia and a Fellowship in Addiction Psychiatry at Harvard University in Boston, USA. She also gained front-line experience with substance use problems while working as a family physician in Greater Vancouver prior to completing specialty training in psychiatry and addiction psychiatry. She has a special interest in youth, women, trauma and the cross cultural aspects of addictions and mental health. Along with her role as consulting psychiatrist to BC Children's and Women's Health Centre, Dr. Kang is affiliated with the Orchard Recovery Centre and is a Research Associate with the Mental Health Evaluation and Community Consultation Unit (Mheccu), within UBC's Department of Psychiatry. As a result of her endeavours, Dr. Kang has received five national awards in the United States in the field of addictions and mental health, including the American Academy of Addiction Psychiatry Research Award.

For the first time, mental health and addictions services are being merged in BC and there is an opportunity to develop integrated services that address the specific and complex needs of people with concurrent disorders.

Dr. Shimi Kang is an addiction psychiatrist who hopes to develop a unique treatment model for women and youth with concurrent disorders. She is a consulting psychiatrist to both BC Children's and Women's Hospitals, where she has established BC's first Youth Addiction Psychiatry Clinic, and has been specially contracted to develop a concurrent disorders program for women.

Both programs are supported in partnership with the respective hospitals and the Provincial Health Services Authority (PHSA) under the direction of Leslie Arnold, President of Mental Health for the PHSA. Through these programs, Dr. Kang hopes to provide women and youth specific diagnostic assessment, management and treatment recommendations which reflect the highly entangled relationship between substance use problems and mental health issues.

"It is clear that concurrent disorders require a specific management approach. Not only is there significant overlap between substance use and mental health problems, they affect each other's development, course, and prognosis. Concurrent disorders increase the risk of misdiagnosis, treatment delay and result in the inefficient use of already-scarce services," states Dr. Kang.

Youth Addiction Psychiatry Clinic

In response to this need, the Youth Addiction Psychiatry Clinic at Children's Hospital offers outpatient consultation for adolescents (age 12-17) with problems of substance use who may have additional co-occurring mental health issues. Specifically, services include a comprehensive psychiatry consultation with special attention to the role of substances in the diagnostic assessment, education regarding the acute and long-term medical and psychiatric effects of problem substance use, and liaison work with family, school and community resources.

"One of our goals is to increase the connection between the teen and his or her community. Studies show that youth who feel connected with home, school, sports or with community or religious groups are less likely to use substances, especially illicit drugs," says Kang.

Youth addiction is a very real problem in BC, with the average age of first use being 12 for alcohol, 13 for marijuana, and 15 for ecstasy, methamphetamine and cocaine. Treatment requires a unique approach. As Dr. Kang explains, "Management of concurrent disorders in youth must include consideration of the negative impact of drugs on brain development, the binge pattern of use, and the increased involvement in high-risk behaviors such as driving, physical fights, and unsafe sex. The ideal clinic referral would be a youth with some period of abstinence who is willing to connect with primary drug and alcohol therapy in their community. Of course, this is difficult at times given the unpredictable nature of addictive behaviour; however, we hope to provide the maximum benefit to a highly underserved and large population." ▶

Mental Disorders and Addictions in a School Setting

Jo Ann Green

Jo Ann is a Prevention Counsellor at Templeton High School in Vancouver

Secondary school communities provide youth with a microcosm of their community at large. High school provides a venue not only for academic achievement, but also for learning skills with which to navigate life. Schools partner with other community agencies to educate and raise awareness around many issues. Mental health and substance misuse are two priorities addressed, often by the school counselling department, through career and personal planning curriculum and through external partnerships. This article describes some local initiatives and resources that are available to address mental issues, including concurrent disorders, in young people.

Community Initiatives and Resources

One important initiative started in April 2000, when Vancouver Community Mental Health Services, BC's Children's Hospital, Vancouver/Richmond Health Board, Vancouver School Board and Ministry for Children and Families laid out the *Protocol for Managing Child and Adolescent Psychiatric Emergencies in Vancouver*, a copy of which can be obtained through Vancouver Community Mental Health Services.

Other resources come through community agencies, such as the Canadian Mental Health Association, which provides excellent handouts and information useful in educating school personnel and/or for use in classroom education. The Early Psychosis Identification and Intervention (EPI) project was a province-wide initiative that produced excellent material for youth-oriented awareness-raising through posters and pamphlets as well as written material. Contact Canadian Mental Health Association across BC at 1-800-555-8222 or check out the Info Centre at www.cmha.ca. Also, see the website of the British Columbia Schizophrenia Society at www.bcss.org. Another related website which includes information on child and youth mental health issues, including early psychosis, is provided by the Mental Health Evaluation and Community Consultation Unit at UBC, which coordinated the EPI project. It can be found at www.mheccu.ubc.ca

When it comes to raising awareness, theatre presentations can provide an interesting interactive way to impart information. Currently a one-woman show called Spiralling Within is touring BC and Canada. The production is written and acted by a talented and courageous young woman (Siobhan McCarthy) who portrays the journey of self discovery initiated by her mental illness, the confusion of finding the right medication, and the struggle of self-medication with club drugs. The play ends with the hope of recovery through the balance of medication and holistic self-care. It's possible to arrange a production for your school. See whoareyoucallingcrazy.com. In Vancouver, Youth Net, a youth organization funded to provide mental health awareness-raising is helping coordinate the talk back that follows the play.

School-Based Resources

A great number of resources exist within the schools themselves. For example, many school districts have alcohol and drug prevention counsellors or addiction youth counsellors, either in the school or available ▶

What's so Special | *continued*

Developing a Program for Women

At Women's Hospital, Dr. Kang has joined the Reproductive Mental Health Program where she works with women who are pregnant or post-partum and experiencing concurrent disorders. "Gender specific factors are seen in the entire range of issues related to problem substance use and addictive behaviours. Women differ from men in prevalence rates, drug of choice and the influence of trauma. Mental illness, infectious disease, victimization, and issues such as child care and the guilt, shame and societal stigmatization of addicted mothers and pregnant women are all gender specific features."

Although many are greatly affected by the ravages of drugs and alcohol, each population presents unique and explicit considerations and challenges for the prevention, assessment and management of their problem. It is only by recognizing and responding to these considerations, that a system of care can be equipped to provide optimal support and treatment. Programs being established at BC Children's and Women's Health Centres are leading the way.

through a community agency, for consultation, education and/or early intervention. Vancouver Coastal Health Authority also employs a youth counsellor for concurrent disorder clients; contact information may be accessed through www.kaiserfoundation.ca.

Safety and trust are important qualities to foster in a school environment – trust that the environment is one in which it is safe to seek help and where there is a willingness find youth-appropriate support and referral. General education around mental health, as well as alcohol and drug information help raise awareness, and encourage students to self-refer or to alert staff about concerns for a friend. In Vancouver, CART – the Children and Adolescent Response Team run out of Vancouver Community Mental Health Services at (604) 874-2300 – provides excellent assessment and referral services if a dual diagnosis issue seems apparent. Early interventions in mental health and/or alcohol and drug issues will hopefully ensure those issues have less severe impact and prevent long-term effects.

If a school creates educated, healthy, helpful, socially responsible school communities, then youth will carry that learning experience to the community at large. Teaching our youth to seek help and network with others is a skill invaluable in all aspects of life.

web resources

- www.search-institute.org/assets
- www.preventionsource.bc.ca
- www.youthnetvancouver.org
- www.kidshealth.org
- www.crisiscentre.bc.ca
- www.aadac.com
- www.mcs.bc.ca
- www.freevibe.com
- www.firstcallbc.org
- www.cmha.ca
- www.mheccu.ubc.ca
- www.kaiserfoundation.ca
- www.youthinbc.com
- www.psychosissucks.ca
- www.hopevancouver.com

some reasons why teenagers take drugs

physical
- attempting to feel relaxed
- blocking pain
- reducing sensations
- getting a buzz – new sensations
- increasing energy

social
- gaining recognition of friends
- being 'one of the gang'
- overcoming shyness
- escaping loneliness
- aiding communication

emotional
- attempting to increase self-esteem
- escape from emotional upset
- reduce anxiety
- avoid making decisions
- asserting independence

intellectual
- reducing boredom
- attempting to understand self better
- satisfying curiosity
- wanting to see the world a new way

environmental
- popular acceptance of alcohol and other drug use
- difficult family situation
- pressure to mature early
- role models

Source: Drug Programs Bureau, New South Wales Department of Health. See www.health.nsw.gov.au/public-health/dpb/publications/parents_talking_teenagers.html

Promoting Holistic Wellness in Mental Health and Addictions

A Research Theme of the BC Aboriginal Capacity and Research Development Environment

Background

The new BC ACADRE is situated within the Institute for Aboriginal Health, a partnership between the First Nations House of Learning and the College of Health Disciplines at the University of British Columbia. This initiative is provincial in scope and is focusing on increasing capacity related to Aboriginal health research through the development of partnerships and collaboration between post-secondary institutions, Aboriginal organizations and First Nations communities in BC.

The BC ACADRE joins a unique network of ACADRE initiatives across Canada, which aims to improve the health of Aboriginal peoples through the facilitation and development of Aboriginal capacity in health research.

The ACADRE objectives include:

1. Supporting community determined research
2. Promoting health research training for Aboriginal people
3. Supporting the development of community health assessments and ethical research practices inclusive of Aboriginal traditional knowledge
4. Promoting holistic wellness in mental health and addictions

Each of these objectives represents a research theme. The focus of the present article is on the fourth theme, mental health and addictions, and on a tool that is being piloted that will help to promote research capacity in the area of promoting holistic wellness in mental health and addictions.

Promoting Holistic Wellness

Researchers in the field of intercultural mental health recognize that some therapeutic approaches might be ineffective or even harmful when applied without regard to the cultural background of the client. Aboriginal people tend not to utilize the mental health services provided by the majority culture. Of those Aboriginal people who do use such services, approximately half drop out after the first therapy session.

In an effort to address this problem, researchers in Aboriginal mental health have stressed the need for mental health theorists and practitioners to become familiar with mental health healing processes that might be more appropriate for Aboriginal people. As there is little research on culturally sensitive mental health and addictions services, it is vital that Aboriginal people be provided with a mechanism to identify the practices that best facilitates healing for them.

The mental health and addictions research program will have several important dimensions. Feasibility studies and pilot projects will be supported to explore what facilitates healing in various areas of mental health and addictions, including but not limited to the problems of suicide, trauma, and physical and sexual abuse. It is expected that the results of these pilot studies will contribute to the success of ACADRE investigators accessing Canadian Institutes of Health Research operating grants in the future.

One particular need that has been identified is the need to create opportunities for those who work in Aboriginal community health to articulate and legitimate "their unique cultural perspectives on wellness," and to further examine the concepts of "self-help resources" (recommended by First Nations) and "self-care resources" (recommended by the biosocial medical model).

The Community Healing Resources Inventory, led by Dr. Rod McCormick, and funded by the National Aboriginal Health Organization is one tool that is currently being studied as a means of identifying Aboriginal health strengths, including within the area of mental health and addictions. As part of this ACADRE program, Aboriginal health students and community workers will be trained to use the inventory to ascertain what healing resources exist within their respective communities.

The BC ACADRE program has recently completed a series of pilots of the healing inventory in eight communities, and is currently looking at the results, and at their implications for addressing mental health and addictions in a holistic fashion. The BC ACADRE is in the early stages of consulting with Aboriginal communities in the province and hopes that in the years to come it will be able to facilitate respectful and relevant research to improve the overall health of Aboriginal people.

This article was adapted from the website of BC Aboriginal Capacity and Health Research Development Environment (ACADRE), with assistance from Kim Brooks, Manager of BC ACADRE, and from Dr. Rod McCormick, Associate Professor of Counselling Psychology, UBC, Mental Health and Addictions Theme Leader. For more information about the program and its other research themes, see www.health-sciences.ubc.ca/iah/acadre or contact Kim Brooks by email at kcbrooks@interchange.ubc.ca or (604) 827-5464

resources

Background Articles

- RCT of motivational interviewing, CBT and family intervention for people with comorbid schizophrenia and substance abuse disorders. Barrowclough, C, Haddock, G, Tarrier, N, Lewis, S, et al. (2001). *American Journal of Psychiatry, 158* (10), 1706-1713.
- Implementing dual diagnosis services for clients with severe mental illness. Drake, RE, Essock, SM, et al. (2001). *Psychiatric Services, 52*(4), 469-476.
- In search of how people change: Applications to addictive behaviors. Prochaska, JO, DiClemente, CC & Norcross, JC. (1992). *American Psychologist, 47,* 1102-14.
- Removing barriers: Dual diagnosis and motivational interviewing. Sciacca, K. (1997). *Professional Counselor, 12*(1), 41-6. Available online at: www.treatment.org/Topics/pdf/SciaccaRemovingBarriers.pdf
- Pathways to housing: Supported housing for street dwelling homeless individuals with psychiatric disabilities. Tsemberis, S & Eisenberg, RF. (2000). *Psychiatric Services, 51*(4),487-95.

Consumer and Family Oriented Resources

- BC Partners for Mental Health and Addictions Information. For fact sheets, brochures and toolkits related to mental disorders, addictions and concurrent disorders. See www.mentalhealthaddictions.bc.ca
- Dual Diagnosis Pamphlet, Video and Workbook Series. Features material on understanding all the major mental illnesses and their relationship to addiction. Also includes the Preventing Relapse Workbook. See dualdiagnosis.org/store/dd-booklets/dd-bw_pg1.html
- Dr. Minkoff's Website. For a host of concurrent disorder videos and other materials, see kenminkoff.com
- The Coping Kit: Dealing with Drug Addiction in Your Family. For this and other addictions-related tools and resources, see www.kaiserfoundation.ca
- UCAN2: A Co-Occurring Disorders Workbook. The result of a collaborative effort of individuals at Peace Arch Hospital, White Rock, BC.
- How to Start and Run a Double Trouble in Recovery Group. See www.doubletroubleinrecovery.org
- Toolbox for Change. Includes self-management tools for misuse of alcohol, drugs, food, gambling and other issues, available online from the Addictions Alternatives website at www.aa2.org/tools/

System Change Resources

- Evidence-Based Practices Project on Dual Disorders. US-based. Includes background information and resources for implementing system change. See www.mentalhealthpractices.org/dd.html
- WELL Project for Trauma-Informed Care for Women with Concurrent Disorders. Practitioner curriculum and consumer recovery guide available to order. See www.healthrecovery.org/prod/prod.html
- National GAINS Center for People with Co-occurring Disorders in the Justice System. A US-based centre providing resources and technical assistance. See www.gainsctr.com
- Sciacca Comprehensive Service Development and Curriculum for Mental Illness, Drug Addiction and Alcoholism. See www.pobox.com/~dualdiagnosis or email Kathleen Sciacca at Ksciacca@pobox.com

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