

# crosscurrents

AUTUMN 2009  
VOL 13 NO 1

The Journal of Addiction and Mental Health



## EMPLOYMENT

Making it work

### **SUPPORTED EMPLOYMENT**

Helping clients find work – and stay there

### **CHOOSING THEIR OWN PATH**

Unique program fosters entrepreneurship

### **YOUTH WORK**

Preparing young people for a promising future

### **GIVING FOR A LIVING**

Peer support provides meaningful work

### **Innovative primary care**

Nurse-led clinics increase access to quality care

### **The food connection**

Nutrition plays growing role in mental health treatment



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

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*Wood Gathering*, Jeff Bergen, acrylic on wood, 9" x 9"

Jeff is a support worker in Peterborough, Ontario. He plans to illustrate a three-volume manuscript about the Children's Crusade of 1212. His art can be found at [www.jeffbergen.ca](http://www.jeffbergen.ca)

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Centre de toxicomanie et de santé mentale

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It's age-old wisdom that work is key to community connection, self-confidence and independence. The ancient Roman physician Galen declared that "Employment is nature's best physician and is essential to human happiness." That was 172 AD. Fast forward to July 2009, where Canadian unemployment rates reached almost nine per cent, part of a global trend in unemployment resulting from the economic slump.

This is a worrisome trend for mental health and addiction services because unemployment and financial uncertainty are linked to the development of mental health issues, ranging from depression and anxiety to psychosis. Unemployment in people with mental health problems varies by country and diagnosis, but generally ranges from 20 to 90 per cent. These are alarming figures, given the fact that research shows that the vast majority of people with mental health and addiction issues can work and that work is a key factor in recovery.

From a general population perspective, the Mental Health Commission of Canada has been making headway, deeming workplace mental health a priority because of the inordinate costs of mental illness to the Canadian workplace and because of the centrality of employment and income to the quality of life of people with mental illness and addiction.

From a clinical perspective, the question now being asked by mental health and addiction professionals is not "Can clients work?" but rather, "What supports do they need to succeed at work?" Many of the stories in this issue of *CrossCurrents* try to answer this question. Anne Ptasznik writes about her experience meeting with staff and clients of the Employment and Support Development team at the Centre for Addiction and Mental Health. Helen Buttery introduces us to two entrepreneurs and the program that helped them find a perfect fit in self-employment. Astrid Van Den Broek examines how unique employment services are targeting the needs of youth with mental health and addiction issues. The Q&A discusses return to work for people recovering from addiction.

We also meet a young man to whom we assigned the task of keeping a journal about his job search upon finishing a redirection through education program. And we share the inspiring story of Paulette Walker, Canada's first drug court program peer support worker.

We wrap up the issue with the Last Word column, where Ruth-Anne Craig, executive director of the Manitoba division of the Canadian Mental Health Association, responds to Dr. Richard Warner's column in

the summer issue, which argues that disability programs are a disincentive to employment.

Please check out *CrossCurrents* on the web. We are launching an interactive online edition, alongside CAMH's new knowledge exchange portal for mental health and addiction professionals. We will be rolling out the sites in the coming months. Please visit us at [www.camhcrosscurrents.net](http://www.camhcrosscurrents.net) and <http://knowledgex.camh.net>. We encourage you to contribute to the sites and send us your ideas about how we can make them better.

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## a view from CAMH

Some argue that during these pressured economic times focusing on employment for people with mental illness is unrealistic. Classically, during a recession, women, minority groups, older people and people with disabilities are disproportionately affected by economic downturns. Employers have an ever-growing pool of people desperate for jobs. Unemployment among those with a diagnosis of mental illness would be expected to increase.

Clinicians at CAMH have taken a different position, which is that employment schemes are even more needed during a recession, where jobs are scarce and less available to people

at the fringes of the employment market. This position is in tune with the welcome focus on health equity being pioneered by local health planners in Toronto and is based on increasing evidence of the effectiveness of employment schemes. For instance, in a recent study, individual placement and support, a model that has been developed for the first episode psychosis program at CAMH, was compared to standard rehabilitation and vocational support programs geared towards improving work skills. Both approaches improved levels of employment, but in this international randomized controlled trial, individual placement and support was better for people with severe mental health issues.

The impact of employment in promoting recovery and keeping people with mental health challenges out of hospital, off social assistance as economically productive members of society compares well with most biological interventions. In a recession we should be thinking more than ever about the importance of employment for people with mental health and addiction issues.

**Kwame McKenzie, MD, MRCPSYCH (UK)**

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## Nurse-led clinics increase access to quality care

LESLEY YOUUNG

The day the Sudbury District Nurse Practitioner Clinic (SDNPC) opened its doors, hopeful patients lined up as early as 7 a.m. Founder and clinic director Marilyn Butcher says she didn't anticipate the demand, given the one small advertisement they put in the community newspaper announcing the opening of the nurse practitioner-run clinic in the summer of 2007.

Still, the turnout made perfect sense, says Butcher. An estimated 25,000 people in northern Ontario's Sudbury region are "orphan" patients, receiving sporadic medical care at overcrowded walk-in clinics and emergency departments. They are not alone. Statistics Canada estimates that four million to five million Canadians are without a primary care physician. The SDNPC represents an innovative model of health care in Ontario – indeed, a first-of-its-kind clinic run by nurse practitioners (NPs) in Canada – aimed at helping to fill the need.

Given long wait times that often impede timely and adequate mental health and addiction care (estimated in Ontario to be six months for a psychiatrist), Butcher says that NP-led clinics could benefit this vulnerable group of people. According to the Ontario Ministry of Health and Long-Term Care (MOHLTC), NP-led clinics are not only a great way to provide better care; they are also well positioned to educate patients about disease prevention and health promotion and to help them navigate the system. Over the next two years, the MOHLTC plans to open 25 NP-led clinics (three were recently announced for the remote areas of Belle River, Sault Ste. Marie and Thunder Bay), according to MOHLTC spokesperson David Jensen.

"I've wondered whether there isn't an overrepresentation of orphan patients with mental health issues," says Butcher. She suspects that people with mental health problems are more likely to fall through the one-patient-one-problem policy at many primary care facilities. "Someone with schizophrenia and diabetes is hard to treat in a five-minute appointment," she says. (The average appointment at SDNPC lasts 15 to 30 minutes.)

Wendy Fucile, president of the Registered Nurses' Association of Ontario in Toronto, says that mental health patients are often marginalized. "People with mental illness are often the ones who find it most difficult to access care," she says. "NP-led clinics are another option, an avenue of entry into the system." In the past decade, most provinces and territories have implemented legislation that allows NPs to operate within their full scope, which includes diagnosis and management of many illnesses and diseases, including mental health conditions, but exclusively within a primary care setting. Ontario is the only province that currently funds NP-led clinics.

At SDNPC, nurse practitioners complete intakes and physical assessments and send patients for diagnostic testing. They diagnose and prescribe medication (although the ability to do so varies from province to province) and monitor stable chronic illness. Many patients will only need to see their nurse practitioner, says Butcher; however, physicians are available for patient and NP consultation when necessary. Because nurse practitioners are not a substitute for physicians, they consult with physicians associated with the clinic for complex diagnoses. SDNPC also makes referrals to its many commu-

nity partners. When the clinic opens a site in the town of Lively, a mental health worker will be hired. For now, nurse practitioners diagnose, treat and refer mental health and addictions cases accordingly.

To date, the SDNPC has taken 2,500 patients, with a goal to reach 4,500. "It takes time," explains Butcher. "These people have been without care for many years. They are diagnosed with multiple chronic diseases, often with a mental health component. For example, the rate of depression is high among people with diabetes, so these patients need a number of visits to sort out their issues." Butcher says that the benefit is a holistic, comprehensive approach to patient management. The trade-off is seeing fewer patients than those ushered through primary care facilities.

Much of the mainstream medical establishment is critical of NP-led clinics, citing concerns about funding and professional qualifications. According to Dr. Sarah Kredentser, a family physician in Winnipeg, Manitoba, and president of the College of Family Physicians of Canada, "Our College fully supports the enhanced role of other health care professions and we respect their skills as members of a team, but we see them working collaboratively within a patient-centred care team."

Although the SDNPC has faced such criticism, the doctors who collaborate with the SDNPC are nothing but supportive, says Butcher. "Individual physicians realize we are in crisis here, that there are tens of thousands of patients without access to care. Besides, we are a drop in the bucket of the funding that goes for primary care in this province." ■

### INNOVATIONS IN NURSE-LED PERINATAL MENTAL HEALTH

The SDNPC model inspired the RN-run Early Intervention Perinatal Mental Health Program at Sudbury Regional Hospital. RN Jacquelyn Moffatt developed the program, the brainchild of psychiatrist Dr. Beena Mathew. The program, which opened in May 2008, has treated more than 60 women with perinatal mental health conditions. It is a valuable program, since the wait to see a psychiatrist in Ontario can be up to six months. Once patients are referred (or self-referred) to the perinatal program, Moffatt conducts an assessment and patients are booked to see Mathew within two weeks for the four-month program. Moffatt looks after their basic needs and does community consultation and education. Patients are connected to community support programs before discharge (there are plans to send orphan patients to the SDNPC). "Mental health conditions like depression in pregnancy need to be treated in a timely manner," says Moffatt. "The sooner we can work with them, the better the results."

# Working out myths about supported employment

WILLIAM A. ANTHONY

In the Winter 2005/06 issue of *CrossCurrents*, William A. Anthony, executive director of the Center for Psychiatric Rehabilitation at Boston University, challenged the following six myths that for decades impeded the development of the psychiatric vocational rehabilitation field.

1. People with psychiatric disabilities really do not wish to work.
2. People with psychiatric disabilities do not wish further education.
3. Psychiatric symptomatology and psychiatric diagnoses predict capacity to work.
4. Intelligence, aptitude and personality tests are a good predictor of future work performance.
5. Vocational performance in the community can be predicted from performance in other settings.
6. People with psychiatric disabilities lose their jobs because of their inability to perform the job tasks.

Four years later, *CrossCurrents* asked Anthony to tell us what has changed and what hasn't. Here is what he told us:

Research developments in the field of psychiatric vocational rehabilitation have relegated these six myths to history. The evidence base that has accrued around the field of supported employment has contributed to their demise. However, new myths have developed about how best to practice supported employment. Have some of the myths below crept into your thinking and your agency's use of supported employment practices?

**Myth: Supported employment as presently practiced is for everyone.**

**Fact:** In a recent issue of the *Psychiatric Rehabilitation Journal*, Robert Drake and Gary Bond report that many people do not wish to enter supported employment program for a variety of reasons, and still others (about one third) who enter supported employment do not become competitively employed. There is still much creative work that needs to be done to improve supported employment services.

**Myth: Professionals can predict a person's readiness to engage in and profit from supported employment services.**

**Fact:** Just as professionals cannot predict very well who can and cannot work, they also are poor at predicting who should receive supported employment services. Rather than attempting to predict vocational rehabilitation readiness, Marianne Farkas has developed a rehabilitation readiness technology that practitioners can use to help people determine their own rehabilitation readiness and also helps them to get ready for rehabilitation. According to Farkas, readiness assessment helps individuals "judge for themselves" whether or not it makes sense to them to engage in vocational rehabilitation services. Readiness for rehabilitation is an indication of people's self-determined commitment and interest in rehabilitation, not an assessment of their capacity to achieve rehabilitation success. People differ in their vocational rehabilitation readiness just as they vary in terms of their readiness for any possible change, such as college, marriage, a vacation or a physical exercise program. Like all types of people, they can be helped to improve their readiness.

**Myth: Supported employment practices require rapid job placement without much attention to people's job preferences.**

**Fact:** A hallmark of psychiatric vocational rehabilitation is that service recipients exercise their preference with respect to an employment position. I was a co-investigator in one of the first successful randomized clinical trials of supported employment and personally interviewed each of the supported employment practitioners. All of these practitioners indicated that they helped people receiving supported employment services explore their vocational goals. The focus on rapid job search counteracts the previous misconception that people needed such interventions as sheltered workshops to get ready for work. Supported employment practices begin the job search process more quickly, but the actual job placement should be based on people's preferences.

**Myth: The particular supports used in supported employment are well known.**

**Fact:** The particular supports helpful in supported employment practices vary from individual to individual. The use of supports must be identified based on the individuals' employment goals. While it may be possible to categorize various supports, such as supportive people (a family member to drive), places (a location to store medication), things (a bus pass) and activities (a workplace exercise group), there are as many variations of supportive people, places, things and activities as there are individuals. The practitioner must pay as much attention to the kind of support as to engaging the individual in exploring goals. Furthermore, I have stressed to practitioners that supported employment provides the *opportunity* for ongoing support, not the *provision* of ongoing support. What individuals need to know is that support is accessible, but will not be provided intrusively when the individual neither needs nor wants it. Support in supported employment is available but not intrusive.

Clearly, the evidence base that has developed around supported employment is impressive. As I pointed out in a recent issue of the *Psychiatric Rehabilitation Journal*, there is significant similarity between the principles underlying the entire psychiatric rehabilitation field and the practice of supported employment. Common to psychiatric rehabilitation and supported employment are principles focusing on competitive employment as a rehabilitation goal, consumer preference with respect to choice of service and choice of employment position, and opportunities for support for as long as needed. So while the principles of supported employment are familiar and perhaps comforting to practitioners of psychiatric rehabilitation, new myths specific to supported employment have emerged. As noted above, misconceptions exist about the universal application of supported employment, the meaning of rapid job search, the value of trying to predict supported employment readiness and the nature of employment support. Similar to the six vocational rehabilitation myths I wrote about four years ago, these current supported employment myths must be rejected for the practice of supported employment to remain effective and innovative. ■

## Nutrition plays growing role in mental health treatment

KIM GOGGINS

When Michael Alzamora's psychiatrist told him the results of his fasting blood test in February 2008, he knew he had to take immediate action. His triglyceride level was high, and he knew that as someone with schizophrenia taking one of the newer antipsychotic medications, he was at risk for substantial weight gain, high cholesterol and diabetes.

Alzamora immediately started doing some research and took steps to live healthier. "My first six weeks of changing my diet were 'do or die,'" he recalls. "I noticed that I was highly addicted to sugar, as well as fatty foods. I used to sit for many hours watching television, drinking a litre of cola with sweet pastries. Other times, I would eat enormous amounts of ice cream, also while watching television. For breakfast and lunch, I would have coffee with a lot of sugar and donuts."

Alzamora enlisted the help of a registered dietitian who counselled him on nutrition and provided moral support. She was able to direct him to the right path and help him stay the course – and it worked. During the first two months, he dropped nine pounds and two waist sizes. "I looked and felt healthier. Mentally, I felt strong and confident, and I lost a lot of fat in my abdomen," says Alzamora, who also began to exercise regularly and take nutritional supplements.

Seven months after Alzamora began to

make healthy changes with the help of his dietitian, his blood levels were within normal range and he was running 10 km, three days a week. In May, he completed a half-marathon, running on behalf of the Schizophrenia Society of Ontario. "Physical fitness in combination with good nutrition is crucial to a healthy lifestyle," he says. "I chose running because it makes me physically fit and the long training runs make me mentally strong."

Through nutritional advice and counselling, nutritional screening and assessment, health promotion and disease prevention strategies, dietitians play an important role at psychiatric facilities and on primary health care teams, which are seeing a growing number of people with mental health issues.

When clients embrace the healthy changes she suggests, registered dietitian Monique Sonier (not Alzamora's dietitian) says it's very rewarding. At the Restigouche Hospital Care Center in Campbellton, New Brunswick, she helps clients by encouraging the use of a pedometer to tally physical activity and to make healthier food choices as part of the psychiatric hospital's 12-week NutriAction Program. "We are very proud of our clients. It's very rewarding to see their motivation," she says. "Even if some of them don't lose weight immediately, we hope they will be more motivated to do

some activities and take care of their health. In the long run, they will lose weight and have good eating habits."

Advocacy for clients with medical conditions to receive more social assistance funding to purchase healthy food is also an important role of the dietitian. "They might be able to get a little more funding than if they just completed the required form through their family physician because dietitians may be able to go through the form more thoroughly than a GP could, because of time constraints," says Elke Sengmueller, a clinical dietitian at the Centre for Addiction and Mental Health (CAMH) in Toronto. "Often clients aren't aware that the funding exists so I'm in a position to let them know and to get that form."

To highlight this important role and provide guidance to dietitians, Dietitians of Canada has created a toolkit, in conjunction with the Canadian Collaborative Mental Health Initiative (CCMHI), to be used by dietitians who work with mental health clients in a general practice setting. *The Role of Dietitians in Collaborative Primary Health Care Mental Health Programs* is also a resource for other members of the primary health care team to help them understand the importance of dietitians to the care of clients with mental illness.

"Dietitians now working in primary health care settings, as well as family physicians, are starting to identify more patients who may have mental health issues," explains Linda Dietrich, executive director with Dietitians of Canada for central and southern Ontario. "This toolkit is a resource they can use to see the kinds of nutritional issues that may come up, and they can even go further in the therapies they might provide as part of the team."

Since the toolkit was released in 2006, the number of dietitians in primary health care settings across Canada has grown, especially in Ontario where there has been a move to the family health team model, notes Dietrich. "Most family health teams in

### HANDY EATING TIPS FOR YOUR CLIENTS

Not all mental health care teams have access to a dietitian, but that shouldn't prevent mental health professionals from helping clients strive towards a healthier lifestyle. Dietitians Jan Palmer and Elke Sengmueller suggest ways you can help your clients eat better:

- Take care of your own health to be a good role model.
- Refer clients to Canada's Food Guide to Healthy Eating.
- Take clients to grocery stores to show them how to choose healthy items and prepare them.
- Talk to clients about proper food storage and handling.
- Encourage breakfast and regular nutritious food intake.
- Talk about budgeting for nutritious groceries.
- Visit [www.dietitians.ca](http://www.dietitians.ca), [www.hc-sc.gc.ca](http://www.hc-sc.gc.ca), [www.ccmhi.ca](http://www.ccmhi.ca) and [www.mind.org.uk/foodandmood/](http://www.mind.org.uk/foodandmood/)



Ontario employ a dietitian, but it's based on community needs. It's not a given that every family health team will have a dietitian, but if the community requires that kind of counselling and prevention, very often dietitians are employed."

However, lack of health care funding and a shortage of registered dietitians make it difficult for dietitians to spend the time needed with clients. Many areas face waiting lists and accessibility issues. "It would be ideal if every community mental health team had access to a dietitian on site," says Jan Palmer, a clinical dietitian who says there is only a 1.5 full-time equivalent registered dietitian position for the entire Capital District Health Authority in Nova Scotia, which includes several facilities that provide mental health programs. "Right now, due to the lack of resources, the community health teams in our district refer clients to us. So accessibility can be an issue because travel is a barrier for many clients. It would be great for community teams to have a dietitian on site to be more accessible for clients. We're working towards that."

It's a goal shared by the Dietitians of Canada, which has become more involved in mental health issues. Along with its collaboration on the CCMHI toolkit, the association has developed the Addiction, Mental Health and Eating Disorder Network (AMHED) as a way for member dietitians to share information and resources. The Dietitians of Canada also contributes to the field of nutrition in mental health through speakers, seminars and literature. "We would have always done those things, but as a result of the CCMHI project it's become an important issue for the association," says Dietrich. "We have directed funding to make sure we have representation at national meetings and to ensure we contribute to the Mental Health Commission of Canada." ■

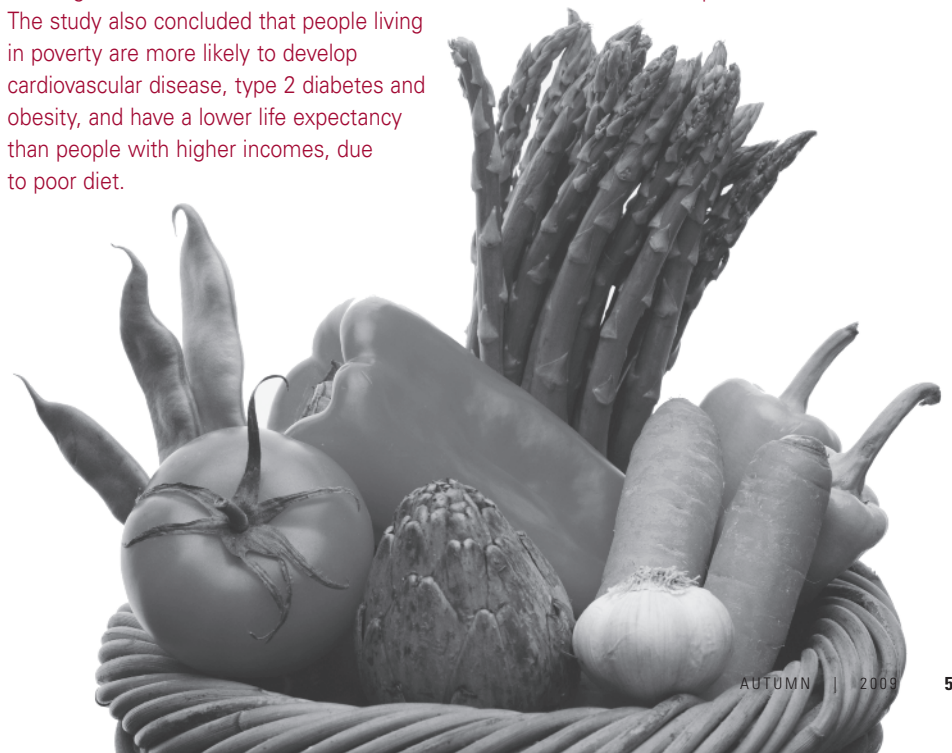
## FOOD FOR THOUGHT

It's no secret that eating nutritious food benefits physical health, but in recent years, there has been more discussion about the link between nutrition and mental health, and even about how nutritional deprivation may contribute to psychiatric disorders, the realm of orthomolecular psychiatry (whose pioneer, Canadian psychiatrist Dr. Abram Hofferer, died this summer). Although many health care professionals dismiss this belief as radical, what is becoming more recognized in mainstream psychiatry is the role of nutrition in treatment.

Research shows that people with mental illness such as schizophrenia and bipolar disorder are at a higher risk of nutritional deficiencies and chronic health issues such as diabetes, heart disease, infections, obesity and malnutrition. Medications to treat mental illness such as antipsychotics, antidepressants and mood stabilizers can also have detrimental side-effects, ranging from gastrointestinal disorders to increased risk of obesity and obesity-related disorders. These side-effects and disorders can be further exacerbated by food refusal, irregular eating patterns and diets high in fat, sodium and refined carbohydrates.

Positive changes in diet can improve energy levels and response to treatment, as well as ease symptoms, says Elke Sengmueller, a clinical dietitian at the Centre for Addiction and Mental Health in Toronto. "Food can definitely affect mood. We know that weight fluctuations, interest and appetite, or lack thereof, are actually one of the criteria for depression. Helping clients improve their appetite and eat more nutritious food can help with increased energy. It may even affect brain chemistry and the neurotransmitter level, getting adequate serotonin and dopamine in the brain."

People with severe mental illness are also more prone to live in social isolation and poverty, which can seriously affect their ability to shop in public or afford healthy choices. A 2009 national poll by the Heart and Stroke Foundation of Canada showed that 47 per cent of Canadians occasionally go without fresh fruit, vegetables, dairy products, whole grain foods and lean meat or fish because these items are too expensive. The study also concluded that people living in poverty are more likely to develop cardiovascular disease, type 2 diabetes and obesity, and have a lower life expectancy than people with higher incomes, due to poor diet.





### Social phobia affects interpretation of social cues

People with generalized social phobia tend to rate happy faces as less approachable than do people without the phobia, according to a new study from the University of Manitoba in Winnipeg. The study involved 12 individuals with generalized social phobia and 28 participants without the phobia. Participants were asked to view 24 emotional faces on a laptop computer and label their expressions as happy, disgusted or angry. They were then asked how likely they would be to approach the person depicted and engage them in a social interaction. Both groups rated happy faces as more approachable than disgusted or angry faces. However, participants with social phobia rated the happy faces as less approachable than did the controls. Depression scores did not affect an individual's rating of the approachability of happy faces, so it could not be argued that depressive symptoms were responsible for the tendency among those with social phobia to see happy faces as less approachable. These results are consistent with the idea that people with social phobia lack the positive interpretation bias found among individuals without phobia. Instead, they show a more negative interpretation bias that may result from their interpreting happy faces as reflecting mockery, social dominance or raised social expectations. The study's authors indicate that their results point to the need for treatment that addresses interpretational biases toward positive social signals in people with social phobia, not just biases towards negative social signals.

*Depression and Anxiety*, May 2009, v. 26: 419–424. D.W. Campbell et al., Department of Psychiatry, University of Manitoba, Winnipeg, Manitoba.

### Shared vulnerability to opioid abuse and psychiatric disorders

According to a new study from Johns Hopkins Bloomberg School of Public Health in Baltimore, Maryland, people with psychiatric disorders are more likely to engage in non-medical opioid use and, conversely, those who use opioids for non-medical purposes are more likely to develop psychiatric disorders. Opioids are drugs with morphine-like effects that are primarily used as painkillers. Researchers looked at data about 43,093 participants from the National Epidemiologic Survey on Alcohol and Related Conditions. There were 1,815 individuals in this sample who had used opioids for non-medical purposes in their lifetimes, and 131 of these were considered opioid dependent. Those who had pre-existing psychiatric disorders (including mood disorders, major depressive disorder, bipolar I disorder, anxiety disorders, panic disorder and generalized anxiety disorder) were more likely than healthy individuals to use opioids for non-medical purposes, with hazard ratios ranging from 2.2 times as likely in the presence of an anxiety disorder to 3.1 times as likely in the presence of bipolar I disorder. Pre-existing psychiatric disorders also made the development of dependence more likely among nonmedical opioid users, particularly in the presence of generalized anxiety disorder (hazard ratio of 10.8) and bipolar I disorder (hazard ratio of 9.7). On the other hand, those who were non-medical opioid users increased their risk of developing subsequent psychiatric disorders relative to non-users, with hazard ratios ranging from 2.8 for generalized anxiety disorder to 3.6 for bipolar I disorder. Those opioid users who could be considered dependent had an even higher risk of developing psychiatric disorders, with hazard ratios ranging from 4.9 for mood disorders to 8.5 for panic disorder. The researchers see these results as pointing to an underlying general vulnerability to opioid use and mood and anxiety disorders, as well as providing support for the idea that some opioid users are self-medicating pre-existing psychiatric disorders.

*Drug and Alcohol Dependence*, July 2009, 103: 16–24. Silvia S. Martins et al., Department of Mental Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland.

### Stigma resistance helps consumers lead fulfilling lives

Research from the Medical University of Vienna indicates that developing the ability to counteract the stigma of mental illness, known as stigma resistance, can help people with mental illness recover and lead fulfilling lives. Researchers asked 157 individuals with a diagnosis of either schizophrenia or schizoaffective disorder to fill out questionnaires rating their subjective experience of stigma on the Internalized Stigma of Mental Illness (ISMI) Scale. The ISMI measures stigma resistance as well as four measures of stigma itself: alienation, stereotype endorsement, discrimination experience and social withdrawal. Almost two thirds of participants showed high levels of stigma resistance: 44 per cent for alienation, 38 per cent for discrimination, 34 per cent for social withdrawal and 15 per cent for stereotype endorsement. Stigma resistance correlated positively with self-esteem, empowerment and quality of life. It was negatively correlated with depression and all measures of stigma except discrimination experience. Higher levels of stigma resistance were seen in those who had social networks with a sufficient number of friends, those who were single or married rather than separated, and among those who received outpatient treatment rather than inpatient treatment or treatment in a clinic. The researchers suggest that therapy might be more successful in reducing the effects of stigma if it were to focus on the development of stigma resistance and only secondarily on fighting the stigmatizing beliefs themselves.

*Schizophrenia Bulletin*, June 1, 2009, doi: 10.1093/schbul/sbp048. Ingrid Sibitz et al., Department of Psychiatry and Psychotherapy, Medical University of Vienna, Vienna, Austria.



### Low response to alcohol increases risk of alcohol problems

People who have relatively little reaction to alcohol are more likely to develop alcohol use disorders (AUDs) later in life, according to research from the University of California, San Diego. Researchers studied 297 males from the San Diego Prospective Study who drank but who were not alcohol dependent when they were recruited. All participants were given an alcohol challenge at the time of recruitment to determine their responsiveness to alcohol. The men were between age 18 and 25 at time of recruitment and were followed for 25 years. One third developed AUDs by the 25-year follow-up. Low responses to alcohol increased the likelihood of developing AUDs throughout adulthood. This result held up even when researchers controlled for other risk factors for developing AUDs, such as family history, age of drinking onset and drinking levels at recruitment. A family history of AUDs did not have a comparable effect, except among participants who were heavy drinkers when first recruited. Participants who were heavy drinkers at recruitment had a higher risk of developing AUDs throughout adulthood. The researchers conclude that their results provide evidence that a low response to alcohol “is a unique risk factor for AUDs across adulthood, and not simply a reflection of a broader range of risk factors.”

*Alcoholism: Clinical and Experimental Research*, September 2009, v. 33 (9): 1–9. Ryan S. Trim et al., Department of Psychiatry, University of California-San Diego, San Diego, California.

### Suicide and self-harm linked to nicotine dependence in girls

New research from Oulu University Hospital in Oulu, Finland, has found that nicotine dependence is associated with an increased risk of suicide attempts and self-mutilation in adolescent girls. Researchers collected data from 508 individuals aged 12 to 17 (300 girls and 208 boys) who received inpatient psychiatric treatment at the hospital. Participants were interviewed using the Schedule for Affective Disorder and Schizophrenia for School-Age Children. Fifty-five participants (35 girls and 20 boys) had attempted suicide, 95 (74 girls and 21 boys) had engaged in self-mutilation, and 49 (43 girls and 6 boys) reported both suicide attempts and self-mutilation. Girls who had high levels of nicotine dependence were four times as likely as those who did not smoke to have attempted suicide, and almost five times as likely to have engaged in self-mutilation. While the risk for suicide attempts was increased only by high levels of nicotine dependence, risk for self-mutilation was elevated even among girls with mild nicotine dependence. Nicotine dependence had no effect on suicide attempts or self-mutilation among males. Given that this is the first study to report an association between nicotine dependence and suicide attempts and self-mutilation among adolescent girls but not adolescent boys, the authors call for further sex-specific studies. They also recommend that nicotine dependence be taken into account when assessing suicide risk among adolescents.

*Comprehensive Psychiatry*, July/August 2009, v. 50: 293–298. Kaisa Riala et al., Department of Psychiatry, Oulu University Hospital, Oulu, Finland.



### Poor outcomes found for treatment-resistant depression

New research from King’s College London has found high rates of relapse for treatment-resistant depression. Using databases such as MEDLINE and PsycINFO, researchers identified nine outcome studies that focused on treatment-resistant depression. These studies included a total of 1,279 participants, most of whom were recruited from secondary and tertiary mental health services. Overall, rates of relapse (readmission or premature death) ranged from 28 per cent to 68 per cent. However, rates of relapse within a year of achieving remission were as high as 80 per cent for those requiring multiple treatments. Those whose illness was more protracted had an approximately 40 per cent likelihood of recovering within 10 years. Three studies reported on mortality and found rates that are comparable to those for depression in general. Treatment-resistant depression was also found to be associated with poorer quality of life. The predictors of outcome identified in these studies were similar to those for depression in general, indicating that treatment-resistant depression is “part of the continuum of depressive disorders rather than a separate or distinct illness.” Given that the available studies show considerable variability in recruitment procedures, definitions and outcome assessments, the authors recommend further study to improve understanding of treatment-resistant depression and to plan effective treatment interventions.

*Journal of Affective Disorders*, July 2009, v. 116: 4–11. Abebaw Fekadu et al., Institute of Psychiatry, King’s College London, London, United Kingdom.

### Child abuse linked to future revictimization

Adolescent mothers have high rates of previous childhood physical abuse, subsequent revictimization as adults and impaired psychosocial functioning. Now, research from the University of Washington in Seattle has clarified the causal pathways linking these events, showing that the experience of childhood physical abuse first impairs psychosocial functioning, leading to revictimization (interpersonal violence) in adult life, which maintains or worsens the existing psychosocial impairment. Researchers recruited 229 unmarried pregnant adolescents who were periodically interviewed over the next 9.5 to 11.5 years. More than half had experienced at least one incident of childhood physical abuse. Between age 21 and 22, almost half of participants reported experiencing some form of interpersonal violence, and 10 per cent reported experiencing a sexual assault during that year. Rates of depression and anxiety for the entire sample did not differ from those in the general population. Alcohol use also reflected that in the general population, but participants had higher rates of marijuana use. Childhood physical abuse had an effect on levels of psychological distress in adolescence that was maintained into early adulthood, and it also influenced adult psychological distress and substance use through two mediated pathways: one through psychological distress and subsequent interpersonal violence and another directly through interpersonal violence. Childhood physical abuse did not significantly affect levels of substance use, and although marijuana use did affect interpersonal violence in adult life, the pathways leading through substance use were not as important as psychological distress in adult outcomes. The researchers conclude that their findings point to the need for “early intervention with adolescent mothers who come from abusive families and who display higher levels of psychological distress.”

*American Journal of Orthopsychiatry*, April 2009, v. 79: 181–190. Taryn Lindhorst et al., School of Social Work, University of Washington, Seattle, Washington.

# Supported employment

Helping clients return to work – and stay there

BY ANNE PTASZNIK



HELENE MAY, A CASE WORKER WITH THE EMPLOYMENT SUPPORT and Development (ESD) team at the Centre for Addiction and Mental health (CAMH) in Toronto, looks a little unsettled when I arrive for our meeting in the coffee shop of a downtown office building. The plan was to meet with Jeremy Scott\*, one of her clients, and George Petroff, his supervisor. Scott, who underwent substance use treatment at CAMH, has been successfully employed painting and doing other chores for more than a year in the building. May tells me that I just missed a frustrated Petroff, who had been discussing with May strategies to help Scott stay at work because in the past few months he has not been completing his hours or showing up on time and has developed a poor attitude on the job. Scott, who hasn't yet shown up for our appointment, had been telling May that everything is fine.

But everything isn't fine for many people with mental health and addiction issues when it comes to work. Unemployment rates can be as high as 90 per cent, according to the Canadian Mental Health Association, and the barriers to successful employment are many, including workplace discrimination, gaps in work history, limited employment experience, rigid income support and benefit programs, lack of confidence and fear and anxiety. Add to that the cyclical nature of these illnesses, and the need for supportive employment programs, which help clients deal with these barriers in real work settings and provide ongoing support, becomes clear. What's also clear is that people with mental health and addiction issues want to work – about 70 per cent, according to the US Substance Abuse and Mental Health Services Administration.

In the past, CAMH's employment programs, like many others

across Canada and the United States, focused on providing pre-employment support and finding volunteer placements to ease clients back into the workforce, but not enough people were getting jobs. Today, the emphasis is on getting clients' resumes updated, focusing on their strengths and helping them find work as quickly as possible and providing ongoing support, says intake co-ordinator

*Barriers to successful employment are many, including workplace discrimination, gaps in work history, limited employment experience, rigid income support and benefit programs, lack of confidence and fear and anxiety.*

Diana Musson. This individualized program and support (IPS) model, considered to be the best practices approach with this population, focuses on facilitating client choice of competitive employment and rapid job search.

A 2001 Cochrane literature review found that people in supported employment were more likely to have competitive employment than those who underwent pre-vocational training. A 2008 study in the *Psychiatric Rehabilitation Journal* found that 61 per cent of IPS participants had competitive employment compared to 23 per cent of those involved with other vocational programs.

However, IPS does not meet the needs of all clients, so Wendy Nailor, who manages ESD, says the program is exploring modifications for particular populations, including people with addiction, who may need more time to re-establish themselves in new careers away from old triggers. The program, in partnership with the Law and Mental Health Program, is also considering on-site social enterprises for clients of this program, whose ability to work off-site may be restricted.

## HOW TO HELP CLIENTS FIND MEANINGFUL WORK

*Making It Work*, a guide published by the Canadian Mental Health Association, provides return-to-work strategies for mental health providers and other professionals who help clients find and keep work. See the guide at [www.cmha.ca](http://www.cmha.ca) for tips, including these:

### Focus on the individual.

- Adopt a participant-centred approach.
  - Consider previous employment, volunteer and educational experiences.
  - Explore attitudes, motivation, self-esteem, skills and abilities.
  - Recognize client's uniqueness.
  - Develop a flexible, individualized job-search process.
  - Provide the level of support appropriate to the client's needs, considering cyclical nature of illness.
- Adopt a holistic approach.
  - Consider how employment will affect pensions, drug benefits, etc.
  - Assess client's level of housing, income and medication stability and their impact on finding and keeping work.
  - Determine whether client will require support after finding work, including help managing finances, finding child care and accessing transportation.

### Connect with the community.

- Build strong partnerships with other agencies, e.g. those that offer specific training.
- Establish partnerships with local businesses.
  - Become aware of local labour market trends and types of jobs available in your community.
  - Gain an understanding of employers' current attitudes towards consumers/survivors and past experiences working with them.
  - Be prepared to educate employers about mental illness and the value of hiring workers with disabilities.

### Advocate for systemic changes.

- Support educational efforts to reduce stigma.
- Advocate for legislative changes to reduce financial disincentives.

Today, while May and I sit in the coffee shop, waiting to see whether Scott will appear, she tells me about the varying levels of supervision that clients in the Law and Mental Health Program require. Petroff stops by again and I get the chance to ask him what the challenges are when hiring someone with a mental health or addiction problem. "The big thing is patience, and I've been a very patient person," he says. Petroff shares with us that he overcame his own alcohol addiction 10 years ago but that he does not understand why Scott cannot do the same. May explains that unless Scott chooses

to disclose more about his illness and treatment to Petroff, she is unable to discuss details that might help him to understand Scott's situation better.

Whether or not to disclose their illnesses and how much to disclose is a decision that the ESD counsellors often help clients wrestle with. Musson says that they generally advise clients not to disclose unless they require accommodation, but that the decision is always left to the client.

A need for accommodation was the reason Margarita Spence chose to disclose to her current employer that she has mental health issues. Spence, an artist, who attributes the seven years it took her to finish art college to her illness, was originally teaching children part-time in an arts school, until she found it required too much energy. She was worried about disclosing because she thought there may be concerns about someone with a mental health problem working with children. When she recently found work as a graphic designer, she decided to disclose to her employer because she wanted him to understand why she sometimes took longer than other designers to finish projects. He arranged for Spence to work freelance part-time and told her to concentrate on her health. "So far, he is trying to be understanding and confidential, and he appreciates that I have abilities despite the fact that I have some difficulties," she says. "I'm very grateful that there is support for going back to work and not just treatment of the illness."

Marion Day has chosen to listen to Musson's advice about not disclosing, for now. Day quit teaching about four years ago when she was using alcohol daily to cope with work stress. She had also been diagnosed with bipolar disorder many years earlier, but did not realize the significant impact the illness had on her until she sought help from CAMH for her alcohol problem. Day had actually ruled out returning to teaching, partly because she did not think she could handle the stress and partly due to shame that everyone knew about her difficulties. She credits Musson, her counsellor, for helping her to not only realize that teaching was her calling, but also for being the first person to encourage her to put her credentials to work.

Musson also helped Day to see that since she had been offered a raise and a renewed contract offer the last time she taught, it was unlikely that her employers knew about her substance use. Now, having successfully applied for a teaching job, she will begin in September. She is considering disclosing her illness after the three-month probation period, partially to help break the stigma for others.

The challenge of finding employment for people with fragmented work records and few full-time work references, which Day had emphasized as one of her constant worries, makes the effort that May at ESD has put into finding supportive employers that much more important. As we finish up our conversation with Petroff in the coffee shop, his demeanour changes, almost as if he were a social worker reframing a negative experience for a client. "We've got to figure out what to do, be positive about it, see if Scott really wants to work," he says. He asks May not to tell Scott that he was frustrated. "Let's take it more like 'George was kind of hoping you could do more.'" When I ask Petroff why he doesn't want Scott to know he is frustrated, he says, "I don't want him to leave." He agrees to have a meeting with the three of them and Scott's social worker, adding, "It's my own failure if he quits because there's always a way around."

While Petroff might be a rare find as an employer, May has successfully developed other supportive employment opportunities, including one with FoodShare, which provides access to healthy food, including delivering fresh produce boxes to people throughout Toronto. May and I meet at their industrial warehouse where she introduces me to Joe Winston, who has been working at FoodShare for three years as a box washer, one of a team of four CAMH clients who are now paid staff. At first, Winston was unsure whether he could handle the work after being out of the regular workforce for years, but he has since changed his mind about his one-day per week job: “I need the money and it’s work I can do. People are friendly; it’s a good atmosphere to work in.” The work has also helped him to be responsible, in keeping with his commitment to recovery from substance abuse.

Zahra Parvinian, FoodShare’s director of social enterprise, says that employers do not need to create a different working environment, as long as it’s a supportive one. She generally treats staff with disabilities the same as her other employees. However, there may be times when someone requires accommodation, for example, if they are adjusting to a new medication. She says it is helpful to have a liaison like May if difficulties arise. One regular challenge arises on pay day, when workers repeatedly ask for reassurance that they will get their cheques.

May explains that clients become anxious about their cheques, particularly because they have a time window within which they must submit their pay stubs, or they could receive notice from ODSP, the Ontario Disability Support Program, which could lead to a delay in them receiving their monthly cheque. Since their illnesses can cause some clients to forget to report, ESD staff help them with this task.

Over the years, there have been significant improvements in ODSP, including an extra monthly \$100 work incentive. ODSP recipients are now also allowed to maintain their health care benefits for life or until an employer begins to pay for them. But social assistance can still present work disincentives for people with disabilities, say Nailor and Musson (also see p. 20). ODSP recipients used to only be able to keep \$160 before additional earnings were clawed back; now they can keep 50 per cent of their earnings, but Nailor says she would like to see people be allowed to retain more of what they earn. The Canadian Pension Plan Disability program, which at one point did not even permit recipients to volunteer, now allows people to receive \$4,700 without reporting that they are working. But a lot of fear remains about relapse. Although both the provincial and federal programs have instituted rapid reinstatement, clients do not trust that this will happen.

Considering mistrust and lack of work experience, deciding whether to go off ODSP is a big decision for people like Winston. While his current position with FoodShare is working out and his supervisor has even recommended a more responsible position, he is uncertain about his future work prospects. “I don’t have any knowledge to do with work. I’m so unsure of myself; I don’t know how to do anything,” he says. “If I got into a training course, I’m 47. By the time I’m 50 or 51, I’m trained to do a serious job. Then how many years can I work at that job, or if I get a job, will they keep me on? Will they fire me? Will the company still exist years after that?”

Since even applying for work can cause anxiety, Lada Banfield, an ESD counsellor, takes an approach to job development that addresses the anxiety that even the act of applying for work can cause.

## RESOURCES FOR HELPING CLIENTS WORK

Canadian Association for Supported Employment  
[www.supportedemployment.ca](http://www.supportedemployment.ca)

Canadian Council on Rehabilitation and Work  
[www.ccrw.org](http://www.ccrw.org)

Dartmouth Psychiatric Research Center  
<http://dms.dartmouth.edu/prc/>

EQOLISE Individual Placement and Support Study  
[www.eqolise.sgul.ac.uk](http://www.eqolise.sgul.ac.uk)

Routes to Work: Canadian Mental Health Association  
 Visit [www.cmha.ca](http://www.cmha.ca) and do a keyword search, or e-mail Julie Flatt, project manager, at [jflatt@cmha.ca](mailto:jflatt@cmha.ca)

SAMHSA’s Evidence-Based Practices: Supported Employment  
 Visit <http://mentalhealth.samhsa.gov> and do a keyword search.

Vocational Rehabilitation Association of Canada  
<http://vra.ca>

She walks with clients in a mall or along city streets discussing the different environments and people the client might like to work with, while looking for stores that are hiring. Sometimes she makes the introductions to hiring managers on behalf of clients, but if the clients feel comfortable, they will approach managers themselves. Banfield sometimes discretely observes the interaction and then discusses the experience with the client and helps them develop responses to questions they may have a hard time answering. It appears to be an approach that works: One day recently, she and a client visited 36 businesses, six or seven of which called up to arrange interviews. Banfield’s client is now awaiting the outcome.

As for Scott, he couldn’t make it to the coffee shop, but when I do meet him a few days later, he tells me what people with mental health and addiction issues need from employers: “Try to understand where we’re coming from – our lives are a little bit tougher, we have more rules, we might slip up – but don’t fire us right away.” Scott tells me that he is not experiencing problems with his work or substance use, which he also tells his social worker, Petroff and May when they meet to discuss Petroff’s concerns. They decide to give Scott another chance to work for the next two weekends, after which May will meet with him. She realizes that Scott likely should have received feedback about Petroff’s concerns sooner, and that he may need more supervision, or a different environment, and that she will need to consult more with his clinical team. “At the bottom of it, personally, I never give up on anyone; I still want to help,” she says. ■

\*All names, except those of ESD and FoodShare staff, have been changed.

# Choosing their own path

## Innovative supports foster entrepreneurship

BY HELEN BUTTERY

**T**HINKING BACK ABOUT 10 YEARS, WHEN BRIAN TILBURY PUSHED A co-worker during an aggressive exchange, he now realizes he gave his employer at the lumber mill the ammunition they needed to fire him. “They were looking for an excuse to get rid of me, and I gave it to them,” says the now 33-year-old millwright and entrepreneur. Tilbury has developed many insights since that time, including how anger and depression hampered his career. He has also discovered that self-employment is what makes him happiest and most productive.

Thanks to the South Fraser Self-Employment Program in Abbotsford, British Columbia, Tilbury has turned this recognition into reality. He now owns and operates Tilbury Industrial Services, providing companies in the Fraser Valley with solutions to mechanical issues and improving production-line efficiency.

This self-employment initiative is part of the Entrepreneurs with Disabilities Program, which targets people with barriers to traditional employment, including mental health and addiction issues, in western Canada, particularly in rural and northern communities, where unemployment rates are high and job opportunities are few. These initiatives are run through Community Futures, a network established by the federal government in 1986 in response to the severe economic and labour market changes faced by rural Canadian communities.

To be considered for the South Fraser program, clients must be unemployed and eligible for employment insurance and must be experiencing multiple barriers to finding employment. The program includes one-on-one counselling with business and financial advisors, start-up training on topics such as marketing, stress management and self-care and extensive business planning support. Most clients complete the program in 40 weeks, during which time they prepare and present their business plan to a review panel, consult frequently with a business advisor and marketing advisor. Within this time frame 85 per cent become self-sustaining.

“We take the fantasy out of Fantasy Island and put the reality in by doing the market research to make sure the business concept is viable,” explains Suzanne Blakley-Oaks, business advisor with Community Futures South Fraser. This year, 25 per cent of her clients have a mental health or addiction issue, or both. She sees the many challenges faced by people with addiction and mental health issues in the mainstream workforce, ranging from psychological and social barriers like stigma to practical hurdles, like the rigidity of the nine-to-five workday. Self-employment can bypass these hurdles, for example, by providing flexible work hours to reflect the person’s needs.

That’s what Victoria Maxwell, who has bipolar disorder, did. She can only work four to seven hours a day and factors rest days into her schedule. “I know what my limits are,” she says. “I have grown to respect them and know that I can’t violate them, because if I do, I’m in big trouble.”

Maxwell, an educator and speaker, went through the Community Futures Sunshine Coast Abilities 2 Business program in 2005. Combining her past acting career with a passion for raising awareness

about the reality of mental illness, her public speaking includes her one-woman show “Crazy for Life,” “Funny ... You Don’t Look Crazy,” and “LAID: Putting to Bed the Myths of Mental Illness and Dating.” Still, it took Maxwell five years before she accepted her diagnosis, during which she spiralled into depression and psychotic episodes.

Once she hit rock bottom, it took another five years to build herself back up, manage her symptoms and regain her self-esteem. In this process, Maxwell realized that the financial unpredictability of acting and the constant judgment and rejection associated with the profession were not for her if she wanted to stay well.

Now, Maxwell has a plan that takes into account both her career and her wellness. That’s because the Community Futures programs do more than just focus on developing a business plan. “We do a wellness assessment,” explains Diane Hill, co-ordinator of Abilities 2 Business in Sechelt, British Columbia. The assessment examines the client’s disability (32 per cent of clients to date have mental health and/or addictions issues), the signs of becoming unwell and the nature of the disability in relation to the effect it may have on business. This way, checks and balances are incorporated into the business plan to address clients’ health needs. However, it turns out that not everyone is cut out to run their own business, for example, if clients realize that stress related to running a business may trigger a relapse in substance use, or that isolation, like that of working from a home office, may contribute to depression.

“Yet often the people we see are more sensible than the general population in understanding their limits and putting wellness measures in place because they have already experienced setbacks,” says Hill. “They already tend to be more considerate of their health.” This may account for the reversal of fortunes for Community Futures entrepreneurs on the Sunshine Coast. While on average 80 per cent of new Canadian businesses fail, those that have been established through Hill’s program are more likely to succeed, with 84 per cent of clients still in business after their year of training.

The hard work and planning is paying off for entrepreneurs like Tilbury. “One of the reasons why I went into business for myself is that as an employee I wanted to have my opinions or suggestions taken seriously, but that wasn’t happening. With my own business it feels great to have people respect me and want to hear what I have to offer. I wouldn’t be where I am today if it wasn’t for the program.” And exactly where he is today is preparing for three months of work booked solid and more projects on the way. ■



Victoria Maxwell earns a living raising awareness about mental illness.

# Job search

## Reflections on the transition to work

BY BYRON CLARKE



Byron Clarke recently completed the Redirection Through Education (RTE) program at George Brown College in Toronto. RTE is a supported education and work entry program for people with mental health or addiction issues. *CrossCurrents* asked Byron to keep a journal over the course of three months about his job search, expressing his hopes and fears as someone with a mental illness.

### Getting ready to work

Work ... I haven't worked since I was 14, stocking shelves at a local grocery store. When I experienced my first psychotic break at 16, I thought I might never work again, the prognosis being pretty dismal for something like schizophrenia. That, coupled with the "let's wait and see" attitude of my doctors, left me not very confident in my chances for recovery.

My feelings about the process of getting a job are definitely a stew. I'm afraid of failing, of not being able to perform to the level required of me. I'm hopeful, cautiously optimistic that it will work. I'm resolved and motivated; I believe I'm ready for work. In a general sense I feel extremely proud and relieved that at age 24 I've made it to this stage in my recovery.

So I guess overall I have mostly positive feelings. I'm still in the process of finishing RTE. I have a few assignments pending, but what I've gained from the program was integral to getting to where I am now. In many ways it's like going back to high school, only mixed in with the academics are practical courses designed to increase your social skills, confidence and workplace readiness. Thanks to the program I've got a great resume, insight into the interview process, experience working in groups, knowledge of my rights and

responsibilities as a worker, and a ton more confidence that this is something I can do.

Now it's time to step out of the wading pool and plunge into the deep end.

### Developing a strategy

I've encountered a problem. I was spending the day with my girlfriend when she started reading my first journal entry. After a brief pause she said: "You haven't worked since you were 14?! How are you going to explain the gap between then and now?" How indeed ... Do I lie to the employer, give false information about my work history and risk them finding out? Or do I reveal the real reason and risk being labelled and dismissed? It's a catch-22.

I thought it over and decided to take the ancient Chinese military strategist Sun Tzu's advice and turn my weakness into my strength. Tell them that yes, I had a psychotic break and was diagnosed with schizophrenia; yes, I spent the last five or six years getting my life and head back in order, but I'm now not only ready; I'm chomping at the bit to show the world what I can do. These might sound like empty words, but I'm confident and sincere, because I'll finish the RTE program with straight A's within the month and I've

made great impressions in my volunteer and work placements. I'll also tell potential employers that if they hire me, they won't just be giving me a job; they'll be giving me the opportunity to fulfill a goal I've had for many years to become self-sufficient, and that my gratitude will motivate me to be the best worker I could possibly be.

So, the next steps in my work search are to finish RTE with straight A's, get reference letters from my work placement supervisor and teachers and write an inspiring cover letter explaining my situation and work ambitions.

What strikes me is the amount of work I'll have to do just to remain on even ground with my peers. I feel a bit like a woman might have felt in the work world of the 1950s, trying to compete with men. Yes, I have found a solution that will likely work, but why is building a sort of comeback tale necessary?

Recovery from any serious mental illness can take years. For many of us, this breakdown happens at just the time we would start getting work experience. We have a legal right not to disclose illness to employers, but then how do we explain this large gap in our work history? And how do we explain to potential employers our participation in work-readiness programs like RTE, designed for people with mental health or addiction issues, without giving away our diagnoses? Showing potential employers my transcript from the program, even if it features straight A's, amounts to telling them I have a mental illness. I'm afraid that this might stand in the way of finding a job.

### Pounding the pavement

I've picked up my reference letter from George Brown. I've written my cover letter and my resume. Now it's time to start pounding the pavement.

I'm a bit scared. I'm not sure how I'll be able to handle the pressures and stresses of a job, even if it's part time. RTE had similar hours, but it was designed for people like me. I had a counsellor to help me and received a lot of support and advice; the staff and teachers understood when I had difficulties and needed to hand in an assignment late, and missing classes due to a bad day was never frowned upon. But I realize there will be a big difference between this kind of program and the "real" world of work. I'll essentially be on my own. I won't have a choice whether or not to show up. I'll just have to suck it up and be consistent. But I'm not certain I can pull it off. Still, what choice do I have? I have to work; it's the next step in my recovery.

I've been handing out resumes this past week everywhere I can – McDonalds, Pizza Pizza, Starbucks and a few others. It was fun in a way. Another step taken into the adult world. My fingers are crossed.

### A promising opportunity

It's funny how things work out. Every day I go to a clubhouse for people with mental illness called Progress Place. I was there today, printing off a bunch of resumes and cover letters, when one of the workers approached and asked what I was up to. When I told him I was looking for a job, he asked whether I had heard of their transitional employment program (TEP). I was immediately interested – another possible avenue to work.

Through the program, Progress Place has work placement arrangements with large companies like Aramark, Winners, The Royal Bank and the *Globe & Mail*. The placements last from four to

eight months, and range between two hours a day to four hours, five days a week. It's generally entry-level work – maintenance and cleaning, bussing, clerical and mail room work, stocking shelves. Through the program, a support worker would accompany me during the training phase and act as a support and supervisor. In fact, if I were having a really bad day and couldn't work, my support worker would actually cover for me. It's perfect, I thought. I'd be getting the work experience I need, another reference letter and a support system to help me transition to work. My ambition says go for a real job, but my head knows that starting small is a safer and more realistic plan. Going from no work to full-time or part-time work would probably be too stressful. I might be setting myself up for failure.

The transitional employment program seems to be the perfect idea, so I told them at Progress Place that I'd like to join. I talked with my family about it and they all think it's a great way to start. I'll be able to ease into the work world, have support as I do it, gain job experience for my resume and bolster my confidence.

In one sense I'm a little disappointed in myself. I had planned to jump straight into a part-time job like anyone else looking for work might do. Essentially, I'd be as capable as any person without a mental disorder. I think that would have given me a great sense of pride. However, the transitional program seems perfect for what it is. An opportunity to get my feet wet before I dive.

**A step in the right direction**

Great news! I was called in by my TEP liaison today and she told me with a smile that I got the job I'd applied for! I start next week. I still don't have all of the details, but it'll be maintenance work at the *Globe & Mail*. It's 15 hours a week. It's not about the job itself so much as it is about gaining confidence and working on my employability skills. I'll also have a nice reference and some job experience at the end of it. I'm worried, but it's the kind of worry that comes with any new and important step. Still, I'm excited because this is definitely something I can do. The perfect middle ground. And who knows – this might be the place to get a few writing contacts.

Well, it turns out the road hasn't been as simple as getting from point A to point B, but I guess life and vocational growth don't happen that simply. I'm optimistic about the future. I'm happy to know that I've made another step in the right direction. Seems Progress Place has lived up to its name. ■



For Byron Clarke, work is the next big step in his recovery.

# Youth work

## Preparing young people for a promising future

BY ASTRID VAN DEN BROEK



SEARCHING FOR YOUR FIRST JOB IS NOT ONE OF LIFE'S EASIER TASKS. Being young and struggling with mental health issues complicates this milestone task that much more. Perhaps your client left school early, so she struggles with literacy and socializing in institutional settings. Perhaps the basic etiquette that students learn in school – being punctual, clean and well-presented, calling in if you're going to miss a day – are foreign concepts to her. Perhaps she has to work extra hard to get up in the morning because of the side-effects of medication.

It is during youth that individuals often transition into roles they maintain long into the future. This transition can involve completing school, securing full-time employment and becoming financially independent. But to successfully accomplish these, youth must develop good interpersonal skills, sound judgment and a sense of personal responsibility and purpose, in addition to academic and work skills. Mental illness in youth presents the double difficulty of looking for work with a mental illness and lacking skills due to interrupted education.

Supporting these youth in finding work is important in order to veer them off a path of poverty and dejection. Unfortunately, it can be a common path, given that about 20 per cent of youth aged 4 to 16 experience a mental health issue, according to the Canadian Psychiatric Association.

Despite the high need among youth with mental health issues, most youth employment programs are not prepared to address the specific needs of these youth. "We need much more support for young people with mental health concerns getting into employment," says Tarina Dueck, manager of disability services at Prospect, a non-profit organization in Calgary, Alberta, that connects underrepresented populations, such as youth with mental illness, to their communities, be it through employment, recreational support or other means. Prospect is one of the few programs in Canada that targets the employment needs of youth through a supported employment model.

At Prospect, as with other agencies that provide supported employment, the focus is on fast job placement. "Our goal is to assist individuals in getting into an employment setting as quickly as possible so they can gain the skills and have the experience as it relates to what they'll actually be doing," says Dueck. That could mean that Prospect staff act as job coaches and sometimes accompany clients to work.

These individualized programs also help young people prepare for job searching and interviews and provide ongoing support once they find work. They also involve teaching "softer" skills like advocating for yourself, communicating with co-workers and accepting feedback

*"Because it's been a difficult process or they've been out of work for a while, our young clients seem to have a greater appreciation and loyalty towards being in a job. It's really their goal to work and have paid employment."*

from a boss. Clients also get individualized counselling around issues like proper social etiquette and whether and how to disclose their illness to an employer.

Gastown Vocational Services, a vocational and educational service for young people aged 16 to 30 in Vancouver, British Columbia, also prepares young people for work. "We have two streams of people coming to see us. With the younger ones, it's often to get their first work experience," says Colleen McCain, an occupational therapist and team leader for the youth employment and educational program. "Because of their illness, they may have been delayed in school and haven't gotten the life experiences to know how to get a job. The other stream is more for career exploration, where we do vocational assessments and find out about clients' skills, abilities and aptitudes." Clients use the service anywhere from six months to a few years.

That flexibility in program offering is something Susan Miner knows about. Miner, the director of street outreach services for LOFT Community Services in Toronto, which works with youth under 25

involved in or at risk of being involved in prostitution, began incorporating individualized job training as part of LOFT's overall program when she noticed that clients were ill-prepared for job searching and job placement, which proved to be one of their biggest barriers to changing their lives.

"We have to be consistent and available, so young people may pop into the program on day one to see a counsellor and have an assessment, and then return for five days in a row, or we may not see them again for three months," says Miner. "There's no time limit. There isn't the expectation that you have to do this by such and such a time." While she does instill clients with high expectations to succeed, time itself isn't an issue.

Studies show that the expectation to succeed isn't an unrealistic one. A study published in a 2008 issue of the *British Journal of Psychiatry* found that in a six-month period, young people aged 15 to 24 who had experienced first-episode psychosis and who received supportive employment were able to get and keep jobs. The study also found that supported employment participants worked more hours than participants who did not receive supported employment. They also earned more income in a wider variety of positions and lowered their reliance on social assistance benefits by 25 per cent.

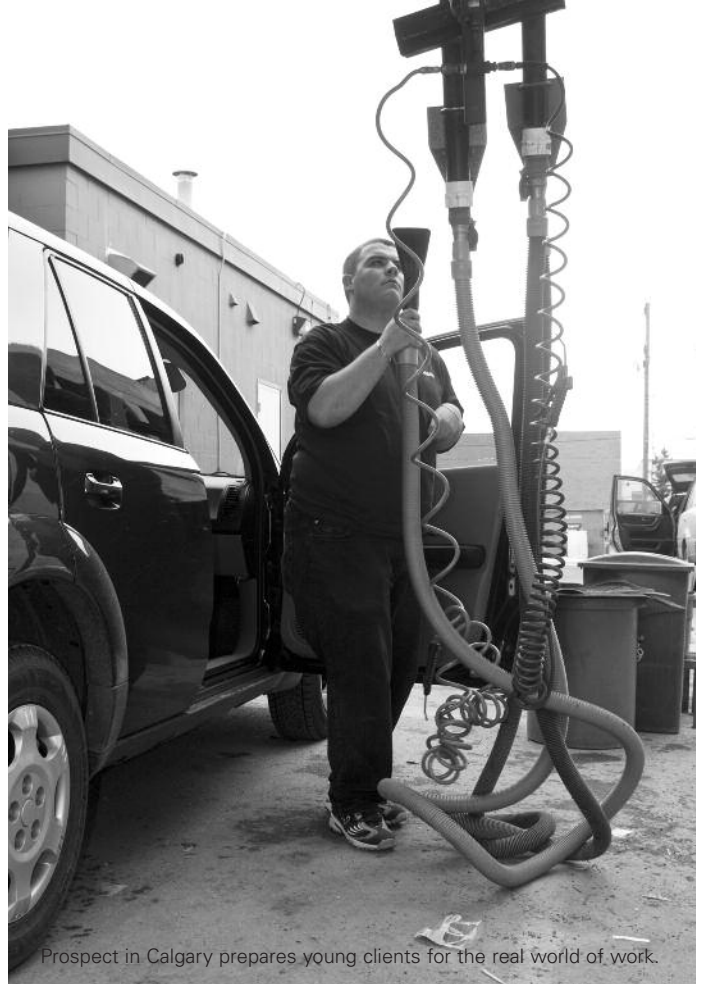
Expecting youth with mental illness to stay on the job isn't unrealistic either. "Because it's been a difficult process or they've been out of work for a while, they seem to have a greater appreciation and loyalty towards being in a job," says McCain at Gastown. "It's really their goal to work and have paid employment."

It is insights like these that set apart supportive employment initiatives from standard employment programs for youth. There is a real practical component as well to helping youth on the road to employment. "One thing that matters to most youth here is having a fairly regular schedule," says Judi Clooney, a community support staff member at Laing House in Halifax, Nova Scotia, a support centre for young adults living with mental illness. "They often don't like to work varying shift work. They'd prefer to work the same shifts each day. Because of medication and sleep schedules, they'd like to maintain a regular work schedule."

Another common concern is around disclosing mental illness to employers or potential employers. "Many of our youth will debate whether to tell their employer because they fear discrimination," says Judy Bell, Laing's director of programming.

McCain agrees: "Sometimes people get worried – what if someone finds out?" she says. The additional stress that comes with that worry can hinder clients' attempts to feel comfortable in their positions and focus on work. "For some people, we're a safety net. We can be involved in the disclosure and can help educate the employer and let them know they can come to us if they have any questions." Ultimately, the choice to disclose or not is the client's.

When it comes to the employer, some youth agencies work hands-on, front and centre with employers, while others stay more behind the scenes. Prospect has employment placement specialists in the community looking for job opportunities for its clients. They also talk to potential employers about the importance of having a diverse workforce that includes employees with mental illness. These professionals sometimes work with employers more directly on on-the-job training. "We help them figure out how to train someone who might learn differently, or structure a role so that it makes sense to someone with a different learning style," says Dueck. The specialists also help



Prospect in Calgary prepares young clients for the real world of work.

#### YOUTH EMPLOYMENT SERVICES LEADING THE WAY

Gastown Vocational Services, Vancouver, British Columbia.  
[www.gvsonline.ca](http://www.gvsonline.ca)

LOFT Community Services, Toronto, Ontario. [www.loftcs.org](http://www.loftcs.org)

Laing House, Halifax, Nova Scotia. [www.lainghouse.org](http://www.lainghouse.org)

Prospect Now, Calgary, Alberta. [www.prospectnow.ca](http://www.prospectnow.ca)

employers break down job tasks into more manageable components for employees and provide them with strategies for working more effectively with a broad range of individuals.

Just as accommodations may vary, so do client definitions of success. "We have had young people who are ecstatic to have jobs at coffee shops, which is terrific," says Miner at LOFT. "We've seen other youth go on to university, graduate and find different types of jobs. For each of them, that success is equal. Some people love to talk about one of our young people who is now a lawyer, but I love that one of my young people held a job for a year at a donut shop. I'm not sure I could have. It's very individual."

While supported employment paves a promising road to workplace success, more such programs are badly needed. "We have a wait list of six to eight months," says McCain. "We have 32 clients and my wait list is 37 people. Because we follow through that whole process to give young people the best service, there's not a high turnover. We need more resources and more people for programs like these." ■

# Giving for a living

## Peer support worker draws on a lifetime of experience

BY ELIZABETH SCOTT

**P**AULETTE WALKER KNOWS HOW HARD IT CAN BE TO BUILD A GOOD life. Her struggle with a 20-year crack-cocaine habit seemed like a hopeless one, but what she is doing with that experience has become a story of redemptive empowerment. Walker has turned her addiction and the spectre of a drug trafficking charge from bane to brawn. Today, rather than being in court as a defendant, Walker earns a living working for it: One year ago, she became the Toronto Drug Treatment Court's (DTC) first and only peer support worker.

While Walker's turnaround story is breathtaking in scope, it is the memory of her darker days that she has turned into an invaluable on-the-job asset: "The heart of the peer support worker is in lived experience," says Walker, "We speak from the 'I' perspective – this is what happened to *me*; this is how *I* responded to situations. I provide insight into the thinking of an addict. I've been through a lot in that chaotic world that I can relate to."

In turn, sharing those insights has helped to build her own self-esteem: "I wanted to speak out to try to encourage others that it is possible, but that you really have to start loving yourself and building on your self-worth. Giving back to the community really helps to build anyone's self-esteem, and as a recovering addict you always have to think about what is really good for you."

With support and time, Walker ventured onto the road to recovery, facing each day anew. Still, she didn't know when she became a participant in the DTC program while still in jail that it would lead her to where she is today: "I wasn't even thinking recovery then," she says. But in going through the motions, Walker started feeling better and hopeful. The counsellors, clinicians, judges and court clerks treated her with respect and caring, which flew in the face of what she had for a long time believed she deserved: "They made me feel so important, and with how they cared I couldn't help but start caring about myself," she says.

Feeling grateful and optimistic, Walker began to look for ways to help others: "I just felt that I had to give something back," she says, so she volunteered for five years in court to do what eventually became a paid job.

It was emotionally draining to regularly talk about her past at first, but Walker found a way to make it manageable when she realized the positive impact her sharing had on clients with whom she worked: "I came into work one day and waiting for me were messages from women calling to say 'thank you,' that what a big difference I had made for them. That lifted my spirit," says Walker.

Walker's peer support role involves various tasks, such as facilitating groups (e.g., women's art therapy, talk therapy maintenance groups), attending court to speak with new clients, helping clients connect with social services like disability support programs and getting them to appointments. Sometimes she brings in home-cooked meals to share with clients "because I know what it's like in the first couple of months of treatment. You don't have any money, you're broke." Prior to her peer support position, Walker worked full-time as a chef in one of the cafeterias at the Centre for Addiction and Mental Health where she still works part-time.



Paulette Walker is Canada's first and only drug treatment court peer support worker.

But it is the peer support position that has confirmed Walker's mission: "I have a real purpose now," she says. The role also provides a much-needed framework for her days. "People with addiction need structure in order to be healthy and productive," says Walker. "When I became a client of the DTC, I kept hearing 'You have to be here, you have to be there.' I thought, 'Fine, just tell me where I need to be' because I had lost all sense of myself and how to live a normal life. I used for 20 years, almost a lifetime. I had to be 'born again,' so to speak, in my life."

While Walker gives clients much needed support, she herself has been received wholeheartedly by DTC staff and others she works with. "My experience with them has been nothing but positive and very encouraging and empowering," says Walker. "They're happy that I'm part of the team." She hopes other mental health and addiction services will also embrace the peer support role because it benefits everyone. For Walker, it has led her to follow dreams she never thought could become reality. "This job has uplifted me and it's making me believe that I want more," she says. That may mean pursuing a career in social work or another area of social services, but at the moment Walker is dedicated to her role with the DTC. "With this job, you have to be flexible. Whatever the needs are, you just go with it," she says. "For now, it's where I want to be." ■

# What you should know about helping addiction clients return to work

BY AVRIL ROBERTS

## What are the challenges for people recovering from addiction and returning to work?

“Clients put pressure on themselves to get back to work quickly,” says Brooke Eagle, co-ordinator of Ontario Works and Adult Programs at Rideauwood Addiction and Family Services in Ottawa, Ontario. “They want to prove themselves as skilled and valuable employees, but their bodies aren’t yet working 100 per cent and their ability to remember, learn new tasks and handle stress is reduced. This can be a recipe for stress, low self-esteem and relapse.”

The workplace itself can trigger relapse. For example, alcohol consumption plays a big role in socializing in the food and beverage industry, casual construction work and corporate environments, says Eagle. Work days may have been structured around substance use. “If people were using alcohol or other drugs at lunch time or slipping out in the afternoon to use, their bodies may physically crave substances at those times.”

Workplace attitudes can also be a challenge. “If co-workers know why the employee was away, he or she upon returning to work may feel the general stigmatization of addiction,” says Alison Nielsen-Jones, substance abuse professionals (SAP) program administrator for Family Services Employee Assistance Programs in Toronto. “There may also be suspicion or lack of trust, particularly if the employee’s work performance was affected prior to addiction treatment.” Colleagues who don’t know why the person was away may resent having had to shoulder additional tasks during the absence.

Exclusion from social events like baseball games, where everyone goes out for beer afterwards, can be an unpleasant surprise. “People don’t know what to say or how to act, so they end up excluding recovering employees from the very activities that help make the workplace worthwhile, rather than engaging them and giving them opportunities to participate without jeopardizing their recovery,” notes Dr. Rick Csiernik, professor of social work at the University of Western Ontario in London.

Another issue is that aftercare follow-up and support may be inadequate, says Reza Roodi, director of recruitment at Embers Staffing Solutions, an employment agency in Vancouver, British Columbia, that helps people recovering from addiction find jobs. Employees may be unaware of supports available in the workplace or unwilling to access them because of stigma or confidentiality concerns.

People living on the margins who need long-term support may find that support is no longer available once they return to full-time employment. For example, as Eagle explains, Ontario Works funding of a participant in the Addiction Services Initiative ends once the client is no longer receiving social assistance.

## What job search issues does a person in recovery face that a person without addiction doesn’t?

Post-acute withdrawal syndrome is a major barrier for job seekers, says Liam Carey, a counsellor with Oasis Addiction Recovery Society in Toronto. Depending on the drug and the length of time using, these physical and emotional symptoms can last up to two years

and may include an inability to think clearly, memory problems, limited focus, emotional instability, overreaction or numbness, sleep disturbances, physical co-ordination problems and extra-sensitivity to stress. People may not have enough energy to do a full day’s work. “In early recovery, many people can just about handle four hours,” notes Carey.

## 10 ISSUES TO DISCUSS WITH CLIENTS RETURNING TO WORK

Our Q&A sources identified these issues that addiction clients often want to discuss in treatment.

- 1. Workplace structure and environment** and how they may have contributed to addiction. Work goals and career change.
- 2. Disclosure.** How to ask for workplace accommodation. What is appropriate to disclose to fellow workers. What wouldn’t be good to disclose.
- 3. Job performance.** The possibility of disciplinary action for non-performance, inappropriate conduct or unacceptable attendance.
- 4. Follow-up alcohol or drug testing** for employees in safety-sensitive positions, in accordance with organizational policy.
- 5. Stress management.** Links between addiction, stress and relapse. Strategies for stress reduction. Adapting to change. Healthy eating and recreation as self-care activities.
- 6. Relationships in the workplace.** Dealing with supervisors. Building friendships. The consequences of workplace romances.
- 7. Money management.** For example, setting up online saving accounts or daily withdrawal limits to prevent or limit immediate access to money at times of high risk for relapse.
- 8. Time management.** Strategies for getting to work and completing tasks on time.
- 9. Promotions and raises.** Developing scenarios for handling success and failure.
- 10. Overcoming isolation.** Learning to lead healthy lives away from work by connecting to healthy support systems.

Explaining gaps in a resume can be tricky. Eagle notes that clients who participate in Ontario's Addiction Services Initiative for people on social assistance typically have a host of issues: long-term, chronic street-level addiction, precarious housing or homelessness, generational welfare, limited education and training, criminal backgrounds, sporadic work history, multiple addictions, including sex addiction and co-occurring mental health problems. It's not easy to disclose this type of background to potential employers.

Once on the job, requesting time off during the work day can be a problem. People may need flexible scheduling to attend 12-step meetings, counselling, therapy, court diversion or other recovery activities, says Carey.

#### **How do you know when an addiction client is ready to return to work?**

For Nielsen-Jones, who conducts substance abuse assessments of employees who have tested positive for substance abuse, "The clear gauge for return to work is that the person has completed the treatment portion of their referral to addiction services and is now on to relapse prevention." However, she cautions that from a liability perspective, addiction counsellors should never state in writing that a person is ready to go back to work. "All risk management needs to remain on the shoulders of the employer," she says. She suggests that a better course of action would be to issue a letter to the client noting: "You have successfully completed such-and-such a treatment program. You are successfully complying with the relapse prevention program. At this point, there's no clinical reason that I see that you need to remain off work."

Roodi requires his job-seeking clients to be clean and sober for a minimum of three months and have some stability, for example, stable accommodation, a telephone for contact and treatment for mental health issues.

Eagle individually assesses each client, asking, Is this workplace, workload or work environment a good match for you? Is this a good time for you to be returning to work? She says the Ontario Works clients who reintegrate successfully into community and work environments typically stay in the Addiction Services Initiative program for up to three years.

Work readiness may include the kinds of pre-employment preparation available to Oasis clients: basic life skills training in areas such as task completion, problem-solving, conflict resolution, time

## **10 CHARACTERISTICS OF A HEALTHY WORKPLACE**

Sources interviewed for this Q&A provide these tips for creating healthy workplaces for people with addiction – and all employees.

1. Create a written alcohol and drug policy.
2. Provide a safe alcohol- and drug-free environment.
3. Offer alternatives to alcohol at work-related functions and meetings.
4. Become educated about addiction.
5. Recognize signs that an employee may have a problem with addiction.
6. Be proactive – encourage early intervention and treatment.
7. Make it easy for employees to access appropriate support and services.
8. Create a climate that supports addiction treatment and recovery.
9. View employees as a valuable resource.
10. Understand that employees' physical and mental health affect the bottom line.

management and interpersonal communication, personality/career assessment and computer training.

#### **Can return-to-work policies promote medication use and even create addiction?**

In qualitative research on return to work after injury, Dr. Ellen MacEachen, a scientist at the Institute for Work and Health in Toronto, has found that aggressive return-to-work policies are resulting in injured workers returning to work earlier than they should and taking increasingly higher doses of addictive pain medications, such as opioids, to keep functioning at work.

Nielsen agrees that injured workers may be pressured to return to work, but says that increasing pain medication doesn't necessarily lead to addiction. "It's not the dosage that creates an addiction. There have to be other factors contributing to the risk of having an addiction."

#### **How can clinicians help clients return to work and stay at work?**

Clinicians should develop a firm, structured relapse prevention plan detailing concrete actions clients should take and have clients sign off on it. For example: Attend AA or NA meetings three or four times a week, or attend a specific aftercare program two nights a week for 16 weeks. The plan should also include immediate steps clients can take if they think they are in danger of relapse, for example, calling a supportive friend. "The more connections they have, the quicker people go back into recovery," says Carey.

Clinicians should also prepare clients for return to work by having extensive discussions about the workplace – colleagues, friends, supervisors, social aspects, triggers for relapse, job expectations, job stressors. Role playing is a good way to develop strategies for dealing with workplace issues, such as asking for accommodation or managing conflict on the job.

Tapping into client's dreams – asking, What do you want to do? What were your dreams when you were a kid? – can boost clients' self-motivation and uncover hidden talents and potential, says Roodi, who is a firm believer in the merits of vocational training: "Not just any vocation that will keep people at a minimum wage, but vocation that will eventually turn into work where people can make a substantial living."

#### **What workplace supports exist to assist employees recovering from addiction?**

Employee Assistance Programs (EAP) can offer personal supportive counselling to employees returning to work after addiction treatment. EAP counsellors are generalists who may not have expertise in addiction, but they can address workplace and personal issues that influence recovery, monitor progress on the relapse prevention plan and help clients meet recovery goals. EAP counsellors can also provide referrals to community-based organizations and services.

Workplace accommodation, the other key form of workplace support, can offer a variety of choices to assist in the gradual reintroduction to work. Peer assistance can be another valuable support. Some large organizations, typically in the industrial and manufacturing sectors, hold self-help meetings on-site. Many professions, such as medicine, law, policing and aviation have peer recovery groups. In unionized workplaces, there may be counsellors to provide ongoing support. Temporary workers, casual and seasonal labourers may be able to find peer recovery support locally. ■

# Choice disordered: Addiction as a bookkeeping error

Gene Heyman's new book on addiction has garnered an unusual amount of media attention. Not surprising, given its provocative subtitle – “a disorder of choice.” It is fascinating to see how quickly and easily Heyman's ideas about choice were not just misunderstood, but appropriated to feed pop psychology's appetite to see addiction as more about misguided free and bad decisions than as a real mental health issue.

However, this quick resort to reductive popular notions about volition misses the unconventional argument Heyman develops. First, he does not privilege choice as a uniquely human capacity, pointing out that all mammals behave in ways that are mostly voluntary. If you can halt a behaviour by changing the factors that shape decisions, it must be voluntary. Since drug use, like most other behaviours, is governed by its consequences, it can only be a matter of choice. Heyman quickly adds that does not mean voluntary behaviour is necessarily rational, or that “someone addicted to drugs can choose to quit.”

In Heyman's model, choice depends on context. What makes addiction a disorder of choice is the way drug use draws the user into a pattern of decisions biased towards “local equilibrium” – choosing something because you will feel better now, rather than towards “global equilibrium” – choosing the better option for the long run. This undermines the “global bookkeeping” needed for

healthy, rational functioning. Substances and behaviours are addictive because they are behaviourally toxic, poisoning the field and “making everything else relatively worse.” The rewards they provide are “specious,” mixing immediate benefits with hidden, deferred costs that keep the user thinking and acting “locally” – bound by the immediate situation, trying to get high and avoid withdrawal.

But since context shapes choice, when surroundings shift, people may choose to change. You couldn't do that if what you had was a disease, argues Heyman. In fact, his choice theory leads him to ask, Why aren't there more addicts? The theory predicts there should be more, but social factors come to the rescue. Having religious convictions, being married and having conventional social values protect people. By being good bookkeepers, we see that the costs and benefits of being addicts don't add up. Addiction is thinking locally; prevention and recovery are about thinking and acting globally.

Heyman's spirit of inquiry has an honest bent, and he tries to patch some of the holes in the model, but not quite adequately. For example, he reduces treatment to pharmacotherapy, contingency-oriented strategies and “AA and its offshoots.” To miss the wider array of therapies is to hurry through terrain that deserves fuller consideration.

Where Heyman does a better job is in his critique of other approaches to addic-

tion. He shows that people who do not seek treatment differ from those who do. Those in treatment are more likely to have complex problems, causing us to lose sight of the fact that most people with addiction discontinue the behaviour by their 30s, often without formal help. He also offers narratives of people with addiction that illustrate how changing life circumstances led people to choose to stop using drugs. For Heyman, that sets addiction apart from diseases, where biological factors keep people ill in ways that volition cannot resolve.

While allowing that biology is integral to the nature of drug use, Heyman vigorously attacks the view that addiction is a chronic, relapsing brain disease. Yet even if his economics-informed psychology of choice enhances our understanding of addiction as a complex process, it too is insufficient. And if addiction is a disorder of choice, his argument leads away from failed volition and willpower and towards the ways social factors and biology shape physical space to make it easy or hard to engage in behaviours that lead into – and out of – addiction.

*Addiction: A Disorder of Choice.* Gene M. Heyman. Harvard University Press, Cambridge, 2009, 216 pp., \$26.95US.

**Wayne Skinner** is deputy clinical director of the Addictions Program at the Centre for Addiction and Mental Health in Toronto.

d o w n l o a d e d

SHEILA LACROIX

## Mental health at work

**Mental Health Works** [www.mentalhealthworks.ca](http://www.mentalhealthworks.ca)

From the Ontario Division of the Canadian Mental Health Association, this resource provides cross-linked sections for employers and employees. For example, in the *Employee* section *Talking to Co-Workers*, there is a link to the *Employer* resource *How Can I Explain the Situation to Other Employees?* There are also scenarios offering guidance on what to say or how to respond to situations and questions. Employers can purchase manuals and eLearning modules, and consulting services and workshops are offered as well.

**Guarding Minds @ Work** [www.guardingmindsatwork.ca](http://www.guardingmindsatwork.ca)

The Consortium for Organizational Mental Healthcare in British Columbia offers the online, interactive *Workplace Guide to Psychological Safety and Health* to help employers promote, measure, monitor and evaluate workplace psychological safety and health. Register for the online tools that enable your organization to manage psychological health and safety through interactive surveys and audits, which generate reports and action plans.

**Mental Health at Work** [www.cgsst.com](http://www.cgsst.com)

The Université Laval Chair in Occupational Health and Safety Management offers the *Prevention Kit for Work-Related Mental Health Problems*. Three well-designed, easy-to-read booklets are available online covering occupational stress, its sources and predisposing factors, and practical solutions, from primary to tertiary prevention.

**Working Well with a Psychiatric Disability in Work and School**

[www.bu.edu/cpr/jobschool/index.html](http://www.bu.edu/cpr/jobschool/index.html)

This resource from the Center for Psychiatric Rehabilitation at Boston University offers information and advice on topics like *Disclosing Your Disability* and *Dealing with a Difficult Boss. How Does Mental Health Affect My Work Performance?* provides strategies for dealing with issues like lack of stamina and inability to concentrate.

## Poor access to disability supports perpetuates cycle of poverty

BY RUTH-ANNE CRAIG

In the summer 2009 issue of *CrossCurrents*, Dr. Richard Warner argues that disability benefits create disincentives to employment. He makes some valid points about his study comparing disability earnings and employment income in the United States. He also makes good points about the importance of high-quality vocational rehabilitation programs for people with mental illness whose goals are employment-related. However, his argument oversimplifies the complex problems associated with mental health and employment.

While it is true that disability policy requires restructuring as a whole, the situation in Canada is extremely tenuous for people with a mental illness disability. The problem lies mainly in access to disability initiatives, which ultimately creates dependence on provincial assistance programs. Provincial welfare has commonly been referred to as the program of last resort, and was originally conceived as a temporary income replacement. Approximately 70 per cent of unemployed individuals with a psychiatric disability subsist on social assistance payments and live in poverty. According to the National Council on Welfare, in the 10 provinces, the yearly income of an individual with a disability can be as low as \$7,851. All welfare incomes in the provinces were below two-thirds of the low income cut-off line. The poverty gap for individuals with a disability was larger than the amount of income they received in each of the provinces. This cycle of poverty, combined with the overwhelming stigma attached to mental illness and lack of accommodation in the workplace, creates the biggest barriers for people with mental illness and reduces opportunities for quality employment.

Yet research indicates that most people with a psychiatric disability want to work, and since mental illness affects people from all occupations, why is it that so many highly qualified individuals never realize their former earning potential in the competitive labour market after being diagnosed with mental health problems? The answer lies in our nation's deficit approach to mental health and mental illness and our lack of a

comprehensive recovery and strengths-based mental health initiative that considers the complex and unique needs of people with mental illness. Our income support programs are not designed for this disability population.

In Canada, there are three federal income security programs connected to disability – the Canada Pension Plan Disability (CPP-D), Employment Insurance (EI) and the Disability Tax Credit (DTC). All these programs are contributory, which means that individuals who have been employed for a specific period of time have contributed or are eligible for credit when filing their income tax returns. Only those who have had steady employment are eligible for Canada Pension Plan disability benefits or Employment Insurance sickness benefits. This poses a problem for people with mental illness, who often have sporadic or cyclical patterns of employment. Mental illnesses like schizophrenia or mood disorders often arise in late adolescence or early adulthood, interrupting education, with lifelong effects on occupational success. More than 50 per cent of CPP applications are denied benefits because of insufficient earnings.

Applying for EI poses the same dilemma. There are no safeguards to help those who have entered the labour market to maintain their attachment to work when periods of unemployment occur due to problematic mental health symptoms. But initiatives could be developed to alleviate the problems with EI and EI eligibility. The duration of EI sickness benefits could be extended. The current 15 weeks do not always allow sufficient time and opportunity for rehabilitation. Like CPP-D, the qualifying period for EI eligibility needs to be modified. Returning EI to its pre-1996 status by readopting a 360-hour qualifying period for benefit eligibility will assist many people whose disabilities are cyclical in nature, as well as those for whom part-time work is the only alternative because of mental health symptoms and medication side-effects.

Accessing disability income support programs has become a major problem for people with mental illness because the eligibility criteria and definition of disability are

not framed within a recovery perspective. This means that a person must be permanently unemployable and unable to pursue any employment to qualify. But many people with mental illness have the potential to work. Because of this, medical professionals are often reluctant to fill out forms for CPP-D or the Disability Tax Credit Assessment form. Unable to access these programs, people with mental illness are forced to apply for provincial assistance programs. Once in this system, it is extremely difficult to escape the cycle of poverty and demoralization offered by this meager subsistence.

Many more people with mental illness could be employed given appropriate workplace accommodation. The federal government has acknowledged its responsibility for a national mental health strategy by creating the Mental Health Commission of Canada. This strategy should include a substantial fund to work with provinces and territories to expand supported education and training programs, supported employment programs that help people achieve success in the competitive labour market, and training and resources for employers to implement workplace accommodations. These supports would greatly enhance the opportunity for people experiencing mental illness who have steady employment, as well as those who wish to enter the labour market. Stigma associated with mental illness, one of the biggest barriers to employment, can be addressed through workplace health education regarding the extent and impact of mental illness and workplace stress.

Meaningful work is important to people with mental health issues. Being employed has implications that reach much further than economic security. Employment is a determinant of health, opening the door of recovery for many people struggling with mental illness. We must do whatever we can to keep the door unlocked, so that more people have the opportunity to pass through it.

**Ruth-Anne Craig** is executive director of the Canadian Mental Health Association, Manitoba Division.

## CANADA

### Culture and International Mental Health Conference

October 15–16, Toronto, Ontario  
 Contact: Janissa Wan, Mount Sinai Hospital, Department of Psychiatry, 600 University Ave., Toronto, ON M5G 1X5  
 tel 416 586-4800, ext. 5185  
 fax 416 586-8654  
 e-mail jwan@mtsina.on.ca

### Canadian Federation of Mental Health Nurses National Conference

October 21–23, Halifax, Nova Scotia  
 Contact: CFMHN, 1 Concorde Gate, Ste. 109, Toronto, ON M3C 3N6  
 tel 416 426-7029  
 fax 416 426-7280  
 e-mail reg.cfmhn@firststageinc.com  
 www.cfmhn.ca/conference.html

### Wounded Souls and the Vulnerable Self, Trauma and Addiction

October 27–29, Vancouver, British Columbia  
 Contact: Kirsten Marchand  
 tel 604 682-2344, ext. 62942  
 fax 604 806-8210  
 e-mail kmarchand@mail.cheos.ubc.ca  
 www.cheos.ubc.ca

### 6th National Conference on Tobacco or Health

November 1–4, Montreal, Quebec  
 Contact: Canadian Council for Tobacco Control, 192 Bank St., Ottawa, ON K2P 1W8  
 tel 613 567-3050  
 fax 613 567-2730  
 e-mail conference@cctc.ca  
 www.ncth.ca

### Making Gains Conference

November 2–4, Toronto, Ontario  
 Contact: Meeting Management Services, 4380 South Service Rd., Unit 25, Burlington, ON L7L 5Y6  
 tel 905 335-7993  
 fax 905 332-1587  
 e-mail linda@mmsonline.ca  
 www.makinggains.ca

### Annual Methadone Prescribers' Conference

November 6, Toronto, Ontario  
 Contact: Kendra Brown  
 tel 416 967-2600, ext. 307  
 fax 416 967-2605  
 e-mail kbrown@cpso.on.ca  
 www.cpso.on.ca

### Issues of Substance Conference

November 15–18, Halifax, Nova Scotia  
 Contact: Canadian Centre on Substance Abuse, 75 Albert St., Ste. 500, Ottawa, ON K1P 5E7  
 tel 613 235-4048, ext. 276  
 e-mail ios@ccsa.ca  
 www.issuesofsubstance.ca

### Addictions Treatment Design for Youth and Adults Living with Fetal Alcohol Spectrum Disorder

November 18–19, Calgary, Alberta  
 tel 403 949-3991  
 fax 403 949-4051  
 e-mail liz.lawryk@obdtriage.com  
 www.obdtriage.com

### 3rd International Chronic Disease Conference

November 23–26, Calgary, Alberta  
 Contact: EventPlan Coordination and Management  
 tel 403 247-0321  
 fax 403 266-6709  
 e-mail cdm.conference@albertahealthservices.ca  
 www.cdmcalgary.ca

### Canadian Refugee Health Conference

November 24–25, Toronto, Ontario  
 Contact: Office of Continuing Education and Professional Development, Faculty of Medicine, University of Toronto, 500 University Ave., Ste. 650, Toronto, ON M5G 1V7  
 tel 416 978-2719  
 e-mail info-int0933@cmetoronto.ca  
 www.canadianrefugeehealth.ca

### 4th National Biennial Conference on Adolescents and Adults with Fetal Alcohol Spectrum Disorder

April 14–17, 2010, Vancouver, British Columbia  
 Contact: UBC Interprofessional Continuing Education, 2194 Health Sciences Mall, Rm. 105, Vancouver, BC V6T 1Z3  
 tel 604 822-0054  
 e-mail ipconf@interchange.ubc.ca  
 www.interprofessional.ubc.ca/Adults.html

## UNITED STATES

### 61st Institute on Psychiatric Services of the American Psychiatric Association

October 8–11, New York City, New York  
 tel 703 907-7815  
 e-mail jgruber@psych.org  
 http://nycgo.com/meetingplanners/psych-IPS

### Association for Academic Psychiatry Annual Meeting

October 23–28, Seattle, Washington  
 Contact: Association for Academic Psychiatry, 1127 Gate Post Ct., Powder Springs, GA 30127  
 tel 770 222-2265  
 e-mail dlevreaupa@gmail.com

### 56th Annual Meeting of the American Academy of Child and Adolescent Psychiatry

October 27–November 1, Honolulu, Hawaii  
 Contact: AACAP, 3615 Wisconsin Ave. N.W., Washington, D.C. 20016-3007  
 tel 202 966-7300  
 fax 202 966-2891  
 e-mail meetings@aacap.org  
 www.aacap.org/cs/AnnualMeeting/2009

### The Future of Addiction Education, Practice and Research Conference

October 29–31, Jersey City, New Jersey  
 Contact: Peter Myers  
 e-mail NYProf@gmail.com  
 http://incase-edu.net/annualconference.aspx

### 40th Annual Meeting of the American Academy of Psychiatry and the Law

October 29–November 1, Baltimore, Maryland  
 Contact: AAPL, 1 Regency Dr., P.O. Box 30, Bloomfield, CT 06002  
 tel 860 242-5450  
 www.aapl.org/meetings.htm

### American Society of Clinical Psychopharmacology

October 31–November 1, New York City, New York  
 Contact: ASCP, P.O. Box 40395, Glen Oaks, NY 11004  
 tel 718 470-4007  
 fax 718 343-7739  
 www.ascpp.org

### 17th World Congress on Psychiatric Genetics

November 4–8, San Diego, California  
 Contact: NYU School of Medicine, 650 First Ave., 5th flr., rm. 543, New York, NY 10016  
 tel 212 263-3420  
 fax 212 263-3407  
 e-mail lynn.delisi@med.nyu.edu  
 http://cme.ucsd.edu/psychiatricgenetics

### American Public Health Association Annual Meeting

November 7–11, Philadelphia, Pennsylvania  
 Contact: APHA, 800 I Street, N.W., Washington, DC 20001-3710 USA  
 tel 202 777-2742  
 fax 202 777-2534  
 e-mail annualmeeting@apha.org  
 www.apha.org/meeting

### 43rd Annual Convention of the Association for Behavioral and Cognitive Therapies

November 19–22, New York City, New York  
 Contact: ABCT, 305 7th Avenue, 16th flr., New York, NY 10001  
 tel 212 647-1890  
 fax 212 647-1865  
 e-mail tchilders@abct.org  
 www.aabt.org

### 20th Annual Meeting of the American Academy of Addiction Psychiatry

December 3–6, Los Angeles, California  
 Contact: AAAP, 345 Blackstone Blvd., 1st flr. – Weld, Providence, RI 02906  
 tel 401 524-3076  
 fax 401 272-0922  
 e-mail annualmeeting@aaap.org  
 www.aaap.org/meetings/2009AM/2009info.html

### 21st Annual Conference of the Federation of Families for Children's Mental Health

December 4–6, Washington, DC  
 tel 240 403-1901  
 e-mail ffcmh@ffcmh.org  
 www.ffcmh.org

### Society for Social Work and Research 14th Annual Conference

January 14–17, 2010, San Francisco, California  
 Contact: SSWR, 11240 Waples Mill Rd., Ste. 200, Fairfax, VA 22030  
 tel 703 352-7797, ext. 213  
 fax 703 359-7562  
 e-mail lewis@sswr.org  
 www.sswr.org/conferences.php

### Foundation for Psychocultural Research Conference

January 22–24, Los Angeles, California  
 Contact: Constance Cummings, Foundation for Psychocultural Research, P.O. Box 826, Pacific Palisades, CA 90272  
 e-mail connie@thefpr.org  
 www.thefpr.org/conference2010/overview.php

## ABROAD

### 5th European Association of Addiction Therapy Conference

October 5–7, Ljubljana, Slovenia  
 Contact: EAAT, c/o Cortex Congress Ltd, Mortlake Business Centre, 20 Mortlake High Street, London, SW14 8JN United Kingdom  
 e-mail info@eaat.org  
 www.eaat.org

### International Council on Alcohol and Addictions 52nd Conference on Dependencies

October 11–16, Estoril, Portugal  
 e-mail icaa2009@icaa.ch  
 www.icaaestoril2009.com

### 6th European Congress on Violence in Clinical Psychiatry

October 21–24, Stockholm, Sweden  
 Contact: Oud Consultancy and Conference Management, Hakfort 621, 1102 LA Amsterdam, The Netherlands  
 tel 31 0 20 409 0368  
 e-mail conference.management@freeler.nl  
 www.oudconsultancy.nl/stockholm/index.html

### 25th World Congress of the International Association for Suicide Prevention

October 27–31, Montevideo, Uruguay  
 e-mail info@iasp2009.org  
 www.iasp.info

### 2nd International Conference on Psychiatric Museums and History of Psychiatry

October 29–31, Prague, Czech Republic  
 Contact: ICMHP Secretariat, Dagmar Zaludova, Psychiatric Hospital Bohnice, Ustavni 91, 181 03 Prague 8 Czech Republic  
 e-mail info@icmhp.eu  
 www.icmhp.eu

### 18th European Psychiatric Association European Congress of Psychiatry

February 27–March 2, 2010, Munich, Germany  
 Contact: EPA, 1–3, Rue de Chantepoulet, P.O. Box 1726, CH-1211 Geneva 1, Switzerland  
 tel 41 22 908 0488  
 fax 41 22 906 9140  
 e-mail epa2010@kenes.com  
 www2.kenes.com/epa/Pages/home.aspx

### Europad 2010

May 28–30, Helsinki, Finland  
 www.europad.org/europad2010.aspx

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