

crosscurrents

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The Journal of Addiction and Mental Health



ADVANCES in schizophrenia treatment and recovery

WHAT CLIENTS WANT

Quality of life tops the list

BEYOND SYMPTOMS

CBT promises to improve functioning

INTEGRATED TREATMENT

Tackling schizophrenia and substance use

POSITIVE PARTNERSHIPS

Embracing peers as service providers in recovery

Voice hearers' groups

Inspiring new ways to listen

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#4019

Tiger Lily, Ted Bock, acrylic on paper, 8" x 11"

Ted Bock is an art student at the University of Western Ontario in London. He has been painting for six years in a variety of mediums, and with a fascination in nature.





Schizophrenia affects only a small percentage of the population – about one per cent worldwide – but it can be devastating. Schizophrenia often interferes with the ability to think clearly, distinguish reality from fantasy, manage emotions, make decisions and relate to others, with obvious implications for daily living. However, although the World Health Organization has identified schizophrenia as one of the 10 most debilitating diseases, it is treatable, and the growing recovery movement attests to the fact that people with schizophrenia can lead full, meaningful lives.

The stories in this issue examine advances in psychosocial approaches to schizophrenia treatment, with a strong focus on recovery. As psychiatrists Dr. Julian Leff and Dr. Richard Warner write in their book *Social Inclusion of People with Mental Illness*, “Recovery from mental illness is about more than just getting rid of the symptoms and staying out of hospital. It is about regaining a sense of identity, belonging and meaning in life.” Chris Summerville, CEO of the Schizophrenia Society of Canada, paints a picture of hope in recovery. This is followed by an inspiring personal story of

recovery from early psychosis, which illustrates that a diagnosis of schizophrenia is not a “kiss of death,” as Summerville calls it. We also present feedback from people with schizophrenia and their families who responded to an informal *CrossCurrents* survey about what they want from treatment – and from life.

Patricia Nicholson examines two promising but little-used approaches to treatment that target cognitive issues affecting daily functioning. The goal of cognitive-behavioural therapy and cognitive remediation is to help people with schizophrenia develop the necessary skills to lead satisfying lives. Other stories examine unique issues involved in treating co-occurring schizophrenia and substance use and the valuable contribution that peers can make to recovery as formal members of treatment teams. Finally, in the Last Word column, Dr. Richard Warner challenges us to consider how our disability benefits system may discourage people with schizophrenia and other mental illness from working.

With this issue, I welcome the new *CrossCurrents* executive editor, Dr. Kwame McKenzie, whose impressive credentials are

too long to list here. Suffice it to say that his clinical expertise in schizophrenia and research focus on social equity and health will move *CrossCurrents* in exciting new directions.

Enjoy this issue. Please send us your feedback and story ideas so we can continue to provide you with stories that challenge, educate and inspire you.

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a view from CAMH

We all know the facts: Approximately 350,000 Canadians live with a diagnosis of schizophrenia. Each year there are 31,000 hospitalizations – more than 2.3 million hospital days – and direct and indirect costs over \$7 billion. But these costs do not adequately reflect the impact of the illness on individuals and their families. Recent studies have reported that people with a diagnosis of schizophrenia are more likely to develop physical illness. This results in a lifespan shortened by up to 15 per cent.

This is grim reading, but there is hope on the horizon. Medication has improved the outlook for many through symptom control. But there is now a resurgence of interest in the wider factors that can improve outcomes for people with serious mental health problems. The aim

is to move on from a target of symptoms reduction towards recovery.

This is happening at various levels. The Mental Health Commission of Canada (MHCC) has embraced recovery and family and consumer involvement as important facets of its vision of care. The MHCC has recently finished the consultation process on the goals for its national strategy and it looks very exciting.

Similarly, David Caplan, the minister of Health and Long-Term Care for Ontario, is developing a 10-year plan that will look at system redesign and access to care, as well as communities and supporting the workforce to improve outcomes for people with serious mental health issues. In line with this and like many top centres

worldwide, CAMH’s Schizophrenia Program has embraced the concept of recovery. It is actively developing a number of new initiatives that diversify the treatment available, and some, such as the new cognitive-behavioural therapy service, are already seeing clients.

I am proud, and indeed lucky, to be able to be brought into the fold at *CrossCurrents* at a time when there is so much change and renewal.

Kwame McKenzie, MD, MRCPSYCH (UK)

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Voice hearers' groups inspire new ways to listen

KIM GOGGINS

Traditionally, auditory hallucinations have been considered a symptom of schizophrenia or psychosis, with the solution being medication to get rid of the voices. But for the last 10 years, Dr. Margaret England, associate professor in the Faculty of Nursing at the University of Windsor in Ontario, has tested alternative ways of helping people understand and manage voices, which includes holding voice hearers' groups.

While it is common for nurses and other mental health professionals to avoid talking to clients about these voices, England says the opposite should happen. "Nurses were taught early on not to get into conversations with people about their voices," says England. "I found when I first started doing these groups that that was exactly what nurses needed to do but were taught not to. I began to realize that people were not getting accurate information from patients about the problem of the voices," says England, who volunteers as facilitator for two voice hearer groups, in addition to doing voice hearer research at the university.

A growing number of mental health professionals understand that medication needs to be enhanced with other kinds of treatment, such as psychosocial and cognitive interventions. Some even believe that hearing voices can occur without mental illness. Intervoice and the Hearing Voices Network are two international organizations that propose alternative ways of understanding voices.

These alternative perspectives are beginning to gain attention from the mainstream mental health system. In a March 2009 article in the *Canadian Journal of Psychiatry*, author Dr. Emmanuel Stip, a professor in the Department of Psychiatry at the University of Montreal in Quebec, notes that many people who hear voices can cope with them and even view them as a positive part of their lives: "Having attended some European meetings and symposia organized by the International Network for Training, Education and Research into Hearing Voices, I observed that this phenomenon can be considered either as a purely pathological or as a completely normal phenomenon."

Often the problem is not hearing voices, but the voice hearer's reaction. Voice hearer groups are rare in Canada, but the ones facilitated by England in Windsor and groups offered in Quebec City give voice hearers a non-judgmental place to talk about their experiences, as well as a forum where participants get valuable feedback and suggestions for how to cope.

Le Pavois in Quebec City facilitates social, professional and school integration of people with severe mental illness. In 2007, the organization created a 15-week group called "Vivre avec les voix" (Living with Voices), which was inspired by the Hearing Voices Network.

"This hearing voices group has been created to answer needs that remained unsatisfied despite all the efforts of the mental health system," explains Brigitte Soucy, one of the group's founders. "We realized that the voice hearer is left alone with his or her feelings. A lack of comprehension can lead the voice hearer to deny voices, to perceive them only as a symptom of mental illness, to feel helpless and misunderstood and to avoid social relationships."

People who attend Le Pavois' groups are able to express their feelings about what is commonly seen as a taboo topic. Sharing com-

mon experiences lifts the sense of loneliness and marginalization. Participants describe voice-neutralizing activities, customize coping strategies and choose whether to follow their voices' advice.

"We have noted that people tend to get more involved in their empowerment; they try new strategies," says Soucy. "They no longer consider their voices only as a symptom over which they have no power. For some people, distress and negative feelings lighten; voice frequency diminishes and qualitative content becomes more positive. For most, voices are no longer perceived as major obstacles to self-achievement."

Back in Windsor, for the last five years, England has facilitated a weekly self-help group for people 25 and older in the summer and fall. The 13-week course includes a weekly assessment of voice hearing experiences, information sharing, reflective thinking strategies and critical thinking. England chooses the members from an extensive list of people she has interviewed for her research and forms each group according to whether participants find the voices comforting or distressing.

"I do that because some people hear voices that are very upsetting," explains England. "If someone is hearing voices telling them to kill people or they're hearing voices of the devil, that could frighten others." England adds that once formed, the group is closed to outsiders in order to ensure privacy and secure trust.

To be eligible to participate, individuals must not have been hospitalized in the previous six months and must have had the same home address over that period; they must be able to perform basic activities of daily living; they must not have an apparent impulse to harm themselves or others; and if they take medication, they must adhere to it at least 80 per cent of the time. Participants must also be comfortable with the group sessions being audio-taped for the purpose of education and recall. These tapes are destroyed at the end of the 13-week session to ensure confidentiality.

"I've been told that some voice hearing experiences are akin to long, drawn-out rape or invisible beating," writes England in an article about structured group work with people who hear voices. "Structured group work is a nursing therapy with the potential to emancipate voice hearers from destructive and self-depreciating effects of hallucinated voices." Ultimately, the intervention strategies provide voice hearers with the relevant structure, stimulation and affirmation they say they need in order to learn how to manage thoughts and feelings associated with their voices. ■

RESOURCES TO HELP CLIENTS WHO HEAR VOICES

Hearing Voices Network. www.hearing-voices.org

Intervoice: The International Community for Hearing Voices
www.intervoiceonline.org

National Empowerment Center
www.power2u.org/articles/selfhelp/voices.html

Revisiting myths about schizophrenia with implications for treatment

In 1994, Dr. Courtenay Harding and colleagues published a paper entitled “Empirical correction of seven myths about schizophrenia with implications for treatment” in *Acta Psychiatrica Scandinavica*. It presented evidence to challenge myths about schizophrenia that persist across mental health disciplines and that stand in the way of effective treatment and recovery. Fifteen years later, *CrossCurrents* summarizes these myths so you can reflect on what has changed – and what hasn’t.

Myth: Once a schizophrenic always a schizophrenic.

Fact: This myth reflects the “clinician’s illusion,” in which clinicians may repeatedly see the few most severely ill in their caseloads as “typical,” when in fact, these individuals represent a small proportion of the actual spectrum. Recent studies have investigated the assumption of downward course and have found wide heterogeneity in the very long-term outcome. These studies have consistently found that half to two-thirds of individuals significantly improved or recovered, including some chronic cases.

Myth: A schizophrenic is a schizophrenic is a schizophrenic.

Fact: There is a lot of variation within the diagnostic category. There is a tendency in the field to lump everyone with the same diagnosis together for treatment and research. In reality, every group of individuals has substantial heterogeneity. In addition to the major impact of gender, there are considerable differences in age, developmental tasks, education levels, job histories, symptom presentation, coping skills, personal strengths and weaknesses, meaning systems, response to stress in general and to stress of particular situations. Schizophrenia is itself heterogeneous, which Swiss psychiatrist Eugene Bleuler recognized in renaming dementia praecox (meaning a premature deterioration of the brain) as “the group of schizophrenias.” This heterogeneity requires a comprehensive, biopsychosocial assessment of each client’s unique status, the place in his or her own course trajectory and ecological niche. Individual differences require individualized treatment planning, appreciation of developmental achievements and goals and recognition of the “person behind the disorder.”

Myth: Rehabilitation can be provided only after stabilization.

Fact: Rehabilitation should begin on day 1. “Real treatment” in today’s managed care climate consists of assessment, diagnosis and medication. Anything else, such as rehabilitation, often must wait until stabilization and is often considered an ancillary service. However, stabilization usually leads merely to “maintenance,” not rehabilitation. “Real treatment” has been only modestly successful in reducing symptoms, and in helping the client by increasing the levels of functioning in self-care, work, interpersonal relationships and community reintegration. The burgeoning field of psychiatric rehabilitation combines with medical treatment to significantly improve the client’s level of functioning.

Myth: Why bother with psychotherapy for schizophrenia?

Fact: Supportive psychotherapy is crucial for integrating the experience and enhancing continued adult development. Research findings about the ineffectiveness of psychotherapy in curing schizophrenia have led to widespread discouragement in this area and to a relative

lack of innovation and research. However, instead of abandoning psychotherapy altogether, the challenge is for clinicians to use psychotherapy appropriately for maximum benefit. Surveys and personal accounts of consumers have indicated that they value psychotherapy and find it beneficial. Moreover, several different types of psychosocial interventions have demonstrated a positive impact on the lives of people with schizophrenia, including family interventions, tailored group therapies and very specific, targeted cognitive remediation.

Myth: People with schizophrenia must be on medication all their lives.

Fact: Only a small percentage may need medication indefinitely. Long-term studies have shown that a surprising number of people (25%–50%) were completely off medication, experienced no further signs and symptoms of schizophrenia and were functioning well. Over time, most people with schizophrenia altered their dosages and schedules.

Myth: People with schizophrenia cannot do anything except low-level jobs.

Fact: People with schizophrenia can and do perform at every level of work. The idea that individuals with schizophrenia are unable to work or can only achieve a low level of functioning has had long-standing credence, with only 10–30 per cent of people with schizophrenia working full-time. The early vocational approach consisted primarily of sheltered workshops designed for people with developmentally disabilities, with little thought about whether these workshops were appropriate for people with serious mental illness. There has also been little appreciation of the power of stigma and the low priority for vocational rehabilitation. Studies have found that symptoms and levels of functioning, such as work, were only loosely related to one another, and that some people can work well despite ongoing and persistent positive symptoms.

Myth: Families are the cause of schizophrenia.

Fact: Families can provide critical information and provide environments to lower a relative’s vulnerability. The myth that families cause schizophrenia flourished before the most recent biological revolution in psychiatry. Proponents of this myth targeted the family’s severe dysfunctions as the cause of schizophrenia. Although many researchers have since discarded this myth, it has survived even in the current biological era. Family researchers have demonstrated that the emotional and interactional climate of families can help precipitate relapses, as well as that enhanced family communication can lower vulnerability to relapse, but they have failed to show that family factors are necessary and sufficient causes of schizophrenia. It is now recognized that schizophrenia is vulnerable to environmental stresses and triggers, but that stressors, such as family environment, are not sufficient. The optimal roles of families in treatment and the appropriate relationships between clinicians and families are now well-established, if not widely realized.

Source: Harding, C.M. & Zahniser, J.H. (1994). Empirical correction of seven myths about schizophrenia with implications for treatment. *Acta Psychiatrica Scandinavica*, 90 (suppl. 384), 140–146.

Mindfulness meditation paves the road to recovery in addiction

HELEN BUTTERY

Kerry* sits in the bathroom at a party, concentrating on her breathing. Thoughts float in and out of her head about the cocaine sitting just outside the door on the table, seemingly beckoning to her. “Breathe,” she tells herself. Focusing on her breath, she visualizes herself on a surfboard; the deep cravings are waves coming towards her, trying to knock her off her board, but she doesn’t fight the waves. Instead, she steadies herself on the surfboard and continues to breathe. In and out. In and out. Finally, she finds herself sitting calmly on the board, in clear, still water. The waves – the cravings – are gone. She opens the bathroom door and quietly leaves the party.

Kerry has just used mindfulness-based relapse prevention (MBRP), which is showing potential as an adjunct therapy for people recovering from addiction. MBRP merges mindfulness-based stress reduction (MBSR) with traditional clinical practices and is built on the concept of mindfulness credited to Jon Kabat-Zinn more than 30 years ago at the University of Massachusetts Medical

Center’s Stress Reduction Program. Since then, mindfulness practice has spread to more than 240 hospitals and treatment centres across North America and Europe. Its usefulness is also growing, and now embraces addiction.

“Mindfulness is a component of all psychotherapy and any type of self-regulation,” says Tony Toneatto, a senior scientist at the Centre for Addiction and Mental Health (CAMH) in Toronto and an associate professor in the Departments of Psychiatry and Public Health Sciences at the University of Toronto. Toneatto, who has himself practiced mindfulness meditation for the past 20 years, has been studying its potential use in treatment for gambling and addictions for almost 10 years.

First used to treat physical pain and illness, mindfulness meditation moved on to treat anxiety and depression and now has extended its reach further to help people with addiction, including smoking and gambling. Once dismissed by skeptics as a passing fad, mindfulness meditation now sits firmly atop a body of scholarly research supporting its potential as an adjunct to conventional psychological therapies.

A study published in the *American Journal of Drug and Alcohol Abuse* in March suggests that MBSR should be integrated further into treatment for substance use disorders. Another study, currently under review, supports the remedial validity of MBRP. The study is planned for publication in an upcoming issue of the journal *Substance Abuse*. In fact, the entire issue of the journal will focus on mindfulness, a cognitive state that practices being aware, non-judgmentally, in the present.

Still, mindfulness is hardly new. In fact, almost all world religions, for example, Judaism, Christianity and Hinduism, include some form of meditation or contemplation. Mindfulness meditation’s roots reach back to fifth-century B.C. in India, where Buddhism was born. Now, it is finding its way into academia. Two years ago, under the guidance of Toneatto, the University of Toronto started a minor program, and soon

will offer a major, in Buddhism, Psychology and Mental Health. The curriculum includes classes on Buddhist psychology, Buddhism and the science of mindfulness meditation and Buddhism and cognitive science. Toneatto says the program’s popularity stems from interest in understanding consciousness and behaviour outside of the dominant western discourse of reductionism that pervades psychology.

Mindfulness meditation also strays from traditional western approaches to therapy, as it breaks down the dichotomous clinician-patient divide as – more often than not – clinicians teaching mindfulness are also practicing it. Like Toneatto, that is how Kabat-Zinn got turned on to mindfulness meditation – by practicing it to cope with the stress of graduate school.

It is also how Dr. G. Alan Marlatt, a native of Vancouver, British Columbia, and now professor and director at the Addictive Behaviors Research Center at the University of Washington, discovered it. In fact, those facilitating the eight-session MBRP course under Marlatt must practice what they preach. “The facilitator is sharing in the process, and that makes a big difference,” he explains.

The popularity of mindfulness meditation may also be attributed to the fact that, despite its Buddhist roots, it has no religious affiliation. “Kabat-Zinn secularized mindfulness,” explains Lisa Vettese, a clinical psychologist in private practice in Toronto and a mindfulness researcher and educator. Vettese teaches MBSR to six groups every year. Participants’ issues range from stress to chronic pain, and in some instances, associated drug problems. Anyone can do and benefit from mindfulness meditation, whether it’s a clinician, like Vettese, who says that mindfulness has brought a sense of equanimity into her busy life, or a former cocaine user, like Kerry, who uses mindfulness meditation to deal with thoughts of recidivism.

There are several ways to “do” mindfulness meditation. The most basic involves deep, or diaphragmatic, breathing, where

RESOURCES FOR TEACHING MINDFULNESS

Buddhism, Psychology and Mental Health program, University of Toronto
www.newcollege.utoronto.ca/programs/buddhism.htm

Center for Mindfulness in Medicine, Health Care, and Society, University of Massachusetts
www.umassmed.edu/content.aspx?id=41252

Mindfulness-Based Cognitive Therapy, University of Oxford
<http://mbct.co.uk/about-mbct>

Therapist’s Guide to Evidence-Based Relapse Prevention, by Katie A Witkiewitz and G. Alan Marlatt, eds. Elsevier, 2007

Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors (2nd ed.), by G. Alan Marlatt and Dennis Michael Donovan. Guilford Press, 2005



the person focuses on breath. Another strategy used in both MBSR and MBRP is the body scan, which focuses on feeling different body sensations. “People with craving find this very helpful, as we try to teach that cravings are natural, to pay attention to feelings and sensations, to learn to accept them and they will pass,” says Marlatt. Another technique for people with impulses related to addiction is “urge surfing,” used by Kerry in the opening of this story.

The key, regardless of the motivation behind it, is that the person accepts their thoughts and feelings in a non-judgmental way. The practice is the same, but what it is being applied to is different. “You can’t get rid of these thoughts and cravings, but you can relate to them in a different way,” explains Marlatt. Allowing and accepting thoughts, such as cravings, strays from traditional cognitive-behavioural therapy (CBT), which supports learning new ways of thinking by giving up, or pushing out, these thoughts.

Mindfulness meditation and CBT may seem like strange bedfellows, but Toneatto’s study published in the January 2007 issue of the *Journal of Gambling Issues* describes the usefulness of mindfulness meditation as an intervention compatible with CBT. Toneatto points out that CBT is the most “scientifically validated psychotherapy” around, stressing that mindfulness meditation is not a stand-alone therapy; rather, it is useful as a supplementary and complementary approach to traditional therapies. Although stemming from two very different worldviews – mindfulness is rooted in Buddhist India and CBT emerged from western psychotherapy – they are quite compatible, says Toneatto.

Some, like Diane Frederick, who calls herself a “cognitive-behaviourist with heart,” attributes this compatibility to mindfulness having a “softening” effect on CBT. This allows for a more compassionate approach to treatment, says Frederick. What separates mindfulness meditation from traditional therapeutic techniques is that during intense emotional periods people don’t have to try to understand or analyze their problem. Simply put, mindfulness meditation allows

the person to recognize thoughts in a non-judgmental way, and then CBT addresses these thoughts when the person is more grounded.

Frederick runs a clinical private practice in Kitchener, Ontario, and agrees that mindfulness meditation is a useful adjunct to CBT, especially for people with addiction. “CBT is about changing the content of thoughts,” she says, but “it is beyond anyone in early addictions recovery.” This is because a client isn’t ready for CBT until he or she can accept those thoughts – that is, be mindful of them. “What mindfulness does is allow the person to develop a non-judgmental

attitude toward the thoughts and sensations that occur,” she says. This is particularly useful for people with addiction, who, Frederick says, have a critical voice and who tend to relapse around negative emotional states and interpersonal conflict. Mindfulness meditation allows the person to slow down and simply let the thoughts occur, without judgment. “Mindfulness teaches a person to be witness to themselves,” she says. Then, once a person is able to see their behaviours as addictive patterns without judgment they can start the hard work of CBT to change these patterns. ■

* Not her real name

A MINDFULNESS PRIMER

The practice of mindfulness entered the world of health and psychology more than 30 years ago. Since then, it has branched out into several overlapping and compatible incarnations. Here’s a summary of its underpinnings and clinical applications.

Mindfulness underpinnings

- Mindfulness – the core value of any of the mindfulness varieties. It is a cognitive state that emphasizes being in the present, without judgment.
- Mindfulness meditation – the first incarnation of western mindfulness, it is secular in nature but based on the traditional Indian practice of Buddhism. It combines mindfulness (a cognitive state) with discernment, and in this way lends itself well to therapeutic practices, as it ultimately allows for the transformation of thoughts. Mindfulness meditation is the foundation for therapeutic practice.

Mindfulness clinical applications

- Mindfulness-based stress reduction (MBSR) – an eight-session practice of mindfulness meditation targeting stress that has been shown to be beneficial for various conditions, including chronic pain, anxiety, depression and addiction. It combines several mindfulness meditation techniques, including body scans, sitting meditations and focused breathing.
- Mindfulness-based cognitive therapy (MBCT) – based on MBSR, Zindel Segal, Mark Williams and John Teasdale developed this approach, specifically for people with repeated episodes of depression.
- Mindfulness-based relapse prevention (MBRP) – developed by G. Allan Marlatt, MBSR targets thoughts specifically related to addictions and relapse. It too is an eight-session practice and participants must be free from substance use for 30 days before participating.
- Buddhist psychology – merges Buddhism, which, like mindfulness, focuses on the cognitive state of being present in the moment, with western psychological treatments, such those used in addiction.



Early intervention shows promise for first-episode psychosis

The development of specialized services for the treatment of first-episode psychosis (FEP) gives reason to believe that prognosis may be better than previously thought and indicates that there is a critical period early in the illness when intervention can be most effective. Now, a new multi-site Canadian study has found that people experiencing FEP can in fact achieve high rates of symptomatic remission after a year of early intervention treatment. The study followed 200 individuals over the course of one year of treatment at four specialized FEP programs in London, Hamilton, Toronto and Ottawa. The programs emphasized specialized early intervention, including pharmacological and psychosocial treatment. At the end of the year, 74 per cent of participants had achieved symptom remission, and 51 per cent had experienced functional recovery. In terms of functional outcome, 68 per cent were either working or in school, and 71 per cent reported being in a satisfactory relationship. These results show that intensive, integrated treatment may result in better outcomes than has previously been reported with standard care. The authors also note that the best predictors of outcome at 12 months were positive and negative symptoms at six months and the presence of substance use. They conclude that there is a need for aggressive treatment of symptoms early in the course of the illness and for more focus on substance use.

Acta Psychiatrica Scandinavica, February 5, 2009, doi: 10.1111/j.1600-0447.2009.01346.x. Natasja Menezes et al., Schizophrenia Program, Centre for Addiction and Mental Health, Toronto, Ontario.

Case managers struggle with client disengagement

A new study from New York University highlights the difficulty case managers often face in building hopeful relationships with their clients when faced with the reality that many of those clients leave their programs before achieving a successful outcome. Eighteen case managers were interviewed, examining their perceptions of 29 consumers who disengaged from service with four different programs that help homeless people with co-occurring disorders to gain access to housing in New York City. Consumers were followed for one year, and disengagement was deemed to have occurred when the consumer left the program during that year. More than half of the consumers who disengaged experienced homelessness after leaving the program. Case managers tended to attribute disengagement to substance relapse or to clients finding other housing. When clients disengaged, case managers usually indicated that they had anticipated that the client would leave, based on previous experience. Most managers spoke of disengagement as an inevitable part of their work. Disengagement was almost always considered a negative outcome. Case managers generally regarded disengagement as a mistake on the part of the consumer and often felt disappointed, especially where they believed the consumer showed promise of success. They rarely saw disengagement as resulting from problems with the program itself, although they did acknowledge consumer dissatisfaction. In spite of these perceptions, case managers generally managed to remain positive and support their consumers even when they anticipated disengagement. The researchers conclude that programs serving homeless consumers should consider their own role in causing disengagement and provide more flexible recovery-oriented services that would encourage consumers to remain in the programs."

Psychiatric Services, April 2009, v. 60: 459–464. Victoria Stanhope et al., Silver School of Social Work, New York University, New York, New York.

Adjustment disorders common among refugees

Research from the University of Zurich in Switzerland has found high rates of adjustment disorders (AD) among refugees from countries that have experienced recent conflict. Using data from a previous epidemiological survey, researchers looked at life events and AD diagnoses among 3,048 refugees in Algeria, Ethiopia, Gaza and Cambodia. They focused on life events that were not directly life-threatening and that are known to be related to AD, defined as maladaptive responses to psychosocial stressors such as divorce, unemployment or migration, as opposed to life-threatening events related to post-traumatic stress disorder (PTSD). The prevalence of AD among the study population ranged from six per cent in Ethiopia and 16 per cent in Gaza up to 31 per cent in Cambodia and 40 per cent in Algeria. Most refugees had experienced at least one life event related to AD, ranging from a low of 54 per cent in Gaza to a high of 100 per cent in Ethiopia. Among Ethiopian refugees, the most commonly reported AD-related life events were bad shelter conditions (100%) and lack of food (69%). Algerians were most likely to report forced social isolation (61%) and illness of a family member (51%). Gazans were more likely to report bad shelter conditions (32%). Cambodians were primarily concerned with lack of food (41%). Intrusions, failure to adapt and avoidance were the most commonly reported AD symptoms. Rates of PTSD were higher than for AD: 53 per cent in Ethiopia, 66 per cent in Cambodia, 67 per cent in Gaza and 70 per cent in Algeria. The highest rate of comorbidity was between AD and PTSD, followed by AD and anxiety disorders and AD and mood disorders. The high rates of comorbidity between AD and PTSD led the authors to conclude that the two disorders are part of a "stress response spectrum."

Social Psychiatry and Psychiatric Epidemiology, March 31, 2009, doi: 10.1007/s00127-009-0039-z. Martin Dobricki et al., Department of Psychopathology and Clinical Intervention, University of Zurich, Zurich, Switzerland.



Methadone use increase babies' risk of withdrawal

A new study from Princess Royal Maternity in Glasgow, Scotland, highlights the risk of withdrawal in babies born to women prescribed substitute methadone during pregnancy. The study looked at 450 infants born to drug-dependent women prescribed substitute methadone. Forty-six per cent of these infants developed the withdrawal symptoms characteristic of neonatal abstinence syndrome (NAS), requiring pharmacological treatment. Forty-eight per cent of the infants were admitted to the neonatal unit with an average hospital stay of 10 days. Although infants born to drug-misusing mothers represented almost three per cent of hospital births, they occupied 18 per cent of total cot days in the neonatal unit during the period of the study. An infant's risk of developing NAS turned out to be primarily related to the methadone dose given to their mothers. However, infants who were breastfed for 72 hours or more during the study were significantly less likely to require treatment for NAS. The authors explain that the beneficial effects of breastfeeding are due to its soothing effect on infants and the fact that small amounts of the drugs taken by the mother are excreted in their breast milk, thus reducing withdrawal symptoms in the baby. Based on their findings, the researchers recommend that mothers who use drugs be encouraged to breast-feed their babies. They also recommend a prolonged neonatal stay to watch for signs of NAS, to support breastfeeding and to provide parenting support to mothers.

BJOG, April 2009, v. 116: 665-671. C. Dryden et al., Neonatal Unit, Princess Royal Maternity, Glasgow, United Kingdom.

"Wet" housing reduces health costs for people with alcohol problems

Programs that provide housing for homeless people with severe alcohol problems without requiring them to become abstinent can significantly reduce health care costs, according to new research from the University of Washington in Seattle. Researchers followed 95 individuals housed in a Housing First program in Seattle, which provides housing to homeless people with severe alcohol problems without requiring abstinence or participation in an alcohol treatment program. A comparison group consisted of 39 individuals on a waiting list for housing. The researchers found that the average monthly cost of services for Housing First participants declined from \$4,066 in the year preceding the study to \$1,492 after six months in housing and \$958 after 12 months. Total costs for those in the housed group declined from \$8.2 million in the year before the study to \$4.1 million in the year after enrolment in the study, for a reduction in total costs of \$4.1 million. After six months, total costs were 53 per cent less for those given housing compared with those on the waiting list. In addition, the average daily number of drinks consumed among participants in the housing program dropped from 16 per day prior to housing to 11 per day by the end of the study, even though participants were not required to abstain from drinking or to enter treatment. The researchers conclude that permanent housing would achieve the best cost savings because the savings in this study increased the longer participants were housed.

Journal of the American Medical Association, April 1, 2009, v. 301: 1349-1357. Mary E. Larimer et al., Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle, Washington.



Drugs often involved in sexual assault

Drugs are used to facilitate a significant number of sexual assaults, according to new research from Women's College Hospital in Toronto. Researchers screened 882 sexual assault victims at seven hospital-based sexual assault treatment centres in Ontario, looking for evidence that the victims had been drugged. Most victims were screened within 24 hours of the assault. Twenty-one per cent met criteria for suspected drug-facilitated sexual assault. Reasons for suspecting that they had been surreptitiously drugged included the presence of total or partial amnesia, loss of consciousness, drowsiness, confusion, dizziness or light-headedness, nausea or vomiting and a hangover or symptoms inconsistent with the amount of alcohol or drugs the participant recalled consuming. Based on self-report, 12 per cent of study participants reported consuming over-the-counter medications in the three days before being examined, while 33 per cent had consumed prescription medications and 21 per cent had used street drugs. Sixty-five per cent had consumed alcohol immediately before the assault. Those who suspected they had been drugged were more than two times as likely as other sexual assault victims to have been seen in a large urban centre. Given that drug-facilitated sexual assault is often associated with the victims' own voluntary substance use, the authors of this study emphasize the importance of public awareness campaigns to increase awareness of the effects of alcohol, especially in combination with street drugs and prescription or over-the-counter medications.

Canadian Medical Association Journal, March 3, 2009, v. 180: 513-519. Janice Du Mont et al., Women's College Research Institute, Women's College Hospital, Toronto, Ontario.

Integrated treatment for substance use and depression effective

Integrated psychological treatment shows promise for people with co-occurring substance use disorders and depression, but not for those with substance use disorders combined with anxiety, according to research from the University of Aarhus in Denmark. Using a comprehensive search of the Medline and PsycINFO databases, the author found nine trials that compared integrated treatment for substance use disorders and either depression or anxiety with programs that treated substance use disorders alone. Meta-analyses showed that integrated treatment for substance abuse and depression resulted in more days abstinent from substance use and lower levels of depressive symptoms and also led to longer treatment program retention. However, only days abstinent proved to be statistically significant. The author therefore concludes that, while integrated treatment for depression and substance abuse appears promising, further study is needed to replicate these findings. No meta-analysis could be carried out for studies of integrated treatment for substance abuse and anxiety disorders. However, the review conducted in this study found little evidence that integrated treatment would benefit individuals with a combination of substance use disorders and anxiety. On the contrary, several of the studies found that integrated treatment resulted in worse outcomes than treatment focusing on substance use alone. The author sees a need to develop new forms of treatment for people with comorbid substance use disorders and anxiety.

BMC Psychiatry, February 20, 2009, v. 9(6), doi: 10.1186/1471-244X-9-6. Morton Hesse, Centre for Alcohol and Drug Research, University of Aarhus, Copenhagen, Denmark.

Hope in recovery

There *is* life after a diagnosis of mental illness

BY CHRIS SUMMERVILLE

FOR MANY, LEARNING THAT ONE HAS SCHIZOPHRENIA IS LIKE receiving a “kiss of death” diagnosis. The history of our understanding – or lack of understanding – about severe mental illnesses like schizophrenia is, for the most part, encapsulated in this grim sentence handed down by psychiatrists and others – “poor prognosis with progressively downhill course.” The *DSM-IV*, the standard tool for diagnosing schizophrenia and other mental illnesses in North America, describes the illness with such dark, devastating language that it is easy to think that any sense of hope is a delusion.

But for most people, schizophrenia does not seem to be an illness of slow, progressive deterioration. Researchers have found that even in the third decade of illness, the potential for full or partial recovery remains. For the past 25 years, people with mental illness have been sharing their stories of their struggle through and recovery from or in mental illness. As one woman with schizophrenia recently told me about her recovery progress, “It’s like a resurrection!”

These words capture the essence and hope of the recovery model. This model is being embraced at the national level, where the Mental Health Commission of Canada (MHCC) recently completed its first round of consultations for a mental health strategy, proposing that the first guiding value or principle be “The hope of recovery is available to all.” Canadians are finally discussing the concept, which has been realized in the recovery-oriented mental health strategies of countries like New Zealand, Australia, Scotland, England and the United States.

At the heart of the recovery movement lies an emphasis on the individual’s potential growth, a shift from the pathological focus of the prevailing medical model. That potential is developed by integrating medical, psychological and psychosocial interventions in the context of family and community support. Functional outcome, not merely symptom relief, must be the clinical focus in schizophrenia treatment.

According to William A. Anthony, a guru of the recovery movement and executive director of Boston University’s Center for Psychiatric Rehabilitation, “Recovery is a way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness.”

Although many people do not like the word “recovery” because it implies a cure, it is used in the literature and by people with mental illness. Some people don’t use the word because their health care providers don’t use it or don’t talk about the possibility of recovery.

But recovery is real. It includes personal, social and illness-related dimensions. Personal recovery is about acceptance and regaining purpose and meaning in life as one comes to terms with mental illness. Social recovery involves social inclusion – living a safe, full, dignified life in the community with appropriate supports and services. Illness recovery means illness management using your own “personal medicine,” for example, stress management techniques, support groups, meditation or yoga and medication. Fundamentally, recovery is about recovering a quality of life.

As the sibling of a brother with schizophrenia and another with bipolar disorder, as the son of a father who died by suicide, and as someone who has worked for 15 years with people affected by schizophrenia and psychosis, I argue that recovery should be the expectation, not the exception, in mental health care. Services must be oriented to the single most important goal of the people it serves – the hope of recovery. Our recent quality of life survey (see p. 10) emphasizes this goal.

What then is the role of service providers and family members? We don’t do the recovery work; that is the individual’s responsibility. Recovery is not another program or intervention that we “do” to clients. Rather, our role is to create environments in which recovery can take place. *Supporting* recovery is what the system and community do. This requires changing the health care paradigm – imparting a message of hope and belief that recovery is possible, redesigning services to support recovery, shifting from a focus on symptom reduction to supporting meaningful engagement and roles, building collaborative partnerships, and establishing different measures of success that include enhanced quality of life.

Ultimately, to understand the recovery model, we need to understand what it is that people with mental illness are recovering from: the illness; medication side-effects; non-recovery oriented mental health systems; trauma; stigma and discrimination; learned hopelessness and helplessness; co-occurring disorders; and lack of access to comprehensive, co-ordinated, continuous treatment options; as well as the loss of self, goals, social relationships, friends and family, income and housing and adequate community supports and services.

If we are serious about the vision of recovery, then the mental health system, which has been characterized by low expectations, control and no consumer-based vision, must change. Service providers must not focus their hopes on a “pill”; rather, they must listen to their clients. It is they who will tell us what helps and what hinders their recovery. ■

Chris Summerville is CEO of the Schizophrenia Society of Canada, executive director of the Manitoba Schizophrenia Society and a board member of the Mental Health Commission of Canada.



Recovery is not another program or intervention that we “do” to clients. Our role is to create environments in which recovery can take place.

First steps through psychosis

A journey through early intervention to lasting recovery

BY ELIZABETH SCOTT

AT AGE 17, ROB NEVILLE APPEARED TO BE LIVING A REGULAR teenage life. He had always been somewhat of a loner, so no one took much notice when he started to talk less, and then grew silent altogether. What others couldn't see, however, were the disturbing voices running through his head and his overwhelming anxiety and panic.

"My heart was racing, I was gasping for breath, I couldn't sit still, I started seeing things," he says. "Strange and severe headaches, paranoia and delusions occurred," he continues, reading from a story he has written about the experience. "To avoid the painful voices, I would wear music headphones to drown them out. I was crying out for help and pushing people away at the same time." Rob tried to deal with the chaos on his own, turning to alcohol and other drugs.

Eventually, however, his world came crashing in. A few false starts later, Rob became a participant in the Early Psychosis Prevention and Intervention Service (EPPIS), a program of the Manitoba Adolescent Treatment Centre in Winnipeg. Today, six years later, Rob credits the program for his recovery, one that has banished his debilitating symptoms and has restored a relatively calm mind and a meaningful life.

That renewed sense of meaning motivated Rob to give back to his community and society in general. He has become a public speaker about mental illness and shares his story with schools, police, family support groups and at mental health events. When one clinician noted Rob's talent for articulating his experience, the team encouraged him to become involved in educating people about schizophrenia – the challenges, issues, hopes and barriers he and others face. Rob hopes to help others understand what psychosis is and why it can be hard to treat – but that recovery is possible. "There are a lot of misperceptions out there," he tells me quietly over the phone.

Rob found valuable support through the early intervention program: "I believe my success is a result of the knowledge and education that was poured into me," says Rob, who is now 25. "The dedication of a few people who refused to give up on me played a large part."

At EPPIS, a psychiatrist and mental health clinician work with clients to evaluate their situation and develop an action plan that includes establishing goals and strategies to pave the road to recovery. Over two years, clients learn about their illness and develop skills to take care of themselves. In addition to learning skills of daily living, they participate in recreational days and social events, such as going to a baseball game or to the gym, which provide an opportunity to apply the strategies they have learned to deal with stress. For Rob, each small step brought him closer to his goals – long-term stabilization, independence and a sense of positive self-worth.

Rob's mother, who recently passed away, also played a vital role in his early recovery. During the six months he was in hospital, she drove from one end of Winnipeg to the other to visit him: "She would actually come to see me every other day," says Rob with a note of pride. In the six years since Rob finished the program, supports there continue to play a role in his life: "I've had many more obstacles in my way and my worker has supported me through them all," says Rob.



Rob vividly captures the chaos of psychosis.

Strong supports have not only helped Rob in his recovery and encouraged his participation as a speaker and educator; they have also helped him realize his artistic talent. He joined Artbeat Studio in Winnipeg, which accommodates artists with mental health issues, and got funding for art supplies from the First Episode Family Support Group, part of EPPIS. "Creating art has always been very big in my recovery, mostly because it has always been one of the ways I could express myself," says Rob.

Creativity also played a role in the relapse prevention plan that Rob developed with EPPIS. "I still had symptoms, such as hallucinations, anxiety and panic, so we created a plan that would consider those factors – symptom triggers, daily triggers and stressors and stable medications." After finding the right medication – Rob suffered an acute dystonic reaction early on from the wrong one – Rob has remained committed to taking his medication and has never had a relapse.

Another key to relapse prevention and recovery – appropriate housing – often remains elusive to people in recovery. Rob's mother helped him find housing. He has been living on his own in an apartment since he finished the EPPIS program, and although he has moved several times since his initial discharge, he has always found a place to live within the same block. "I have a good landlord," he says, knowing that this is often not the case for people with mental illness.

Considering the challenges strewn along the recovery path, Rob's story attests to the importance of patience, consistent support, knowledge sharing and comprehensive treatment. When I ask Rob whether early intervention made a difference to his recovery experience, his answer is simple but resounding, "Oh yeah. Definitely, yeah." ■

What clients want from treatment

Quality of life issues top list of desired outcomes

BY HEMA ZBOGAR

THE SCHIZOPHRENIA SOCIETY OF CANADA HAS RECENTLY RELEASED the results of North America's largest-ever poll of people living with schizophrenia. The Quality of Life Survey asked 1,086 mental health consumers and family members what quality of life means to them and what they perceive as barriers to its attainment. The survey found that people with schizophrenia have similar hopes and frustrations as the general population.

The survey findings challenge other quality of life research on people with mental illness that has focused heavily on clinical issues and managing negative life events rather than on the concept of recovery. The respondents' views indicate that service providers, policy planners and funders need to move beyond a narrow focus on treating symptoms of mental illness to also supporting clients' hopes and goals in the areas of employment, housing, economic security and freedom from discrimination and violence. Respondents also wanted more community-based services, family education and social and recreational opportunities.

CrossCurrents conducted its own informal survey of people with schizophrenia and their families to find out what they want from treatment and treatment providers, and what they want from life. We posed three questions:

1. Is there an aspect of your life related to having schizophrenia that treatment doesn't address but that you wish it would?
2. What does a good outcome for schizophrenia treatment look like to you? In other words, what is the most important outcome for you?
3. Do you feel that the mental health professionals you have dealt with have different expectations and goals than you?

This is what some of our respondents, from across North America, had to say.

Byron, Toronto, Ontario

For me a good outcome means a return to relationships. The symptoms of schizophrenia often make it difficult or impossible to main-

tain and enjoy these necessary relationships. We, like everyone else, need the laughter, sharing, trust, companionship, and the perspective and objectivity that come from friendships and family. Sometimes as a sufferer of this disease it can be difficult to assess the veracity of our own perspective, to figure out whether or not what we feel and perceive is grounded in reality or is in part or wholly changed, shifted, modified by our disease. Surrounding ourselves with positive people gives us a sounding board. Without them it can be incredibly lonely. Thirty years ago it might have made sense to have lower expectations of people with schizophrenia because medication had such strong side-effects and many people were left undiagnosed and untreated. I've had several doctors who had clearly given up on me achieving the things I am now doing. One of them actually told my mother that she should "lower her expectations" of me. This was early in my recovery. If my mother or I had listened to the doctor I may not have believed in myself enough to make the efforts I have.

Mental health practitioners also need to realize that these outcomes occur in their own time and that progress may be slow and difficult to perceive, but that it is nevertheless happening. I've recently finished a redirection through education program with straight A's. I socialize on a regular basis and organize social events; I'm learning how to live on my own; I have a girlfriend; I have creative and career ambitions; I make and keep all of my appointments. I'm getting closer to full recovery.

We shouldn't be punished by unnecessarily low expectations because of assumptions that are based on old truths and old knowledge. Realistically and practically, hope for your patients to reach the stars, because they may need your belief and conviction to get there.

Tamara, Winnipeg, Manitoba

I am 26 years old and have been living with schizo-affective disorder for 11 years. The ideal outcome for treatment allows for good quality of life and achievement of goals and dreams. Being diagnosed with schizophrenia doesn't mean we can't achieve our goals and dreams. It just means that they require necessary adaptations and available opportunities.

Often people living with schizophrenia receive treatment in just one area of their lives and not others. The ideal treatment for schizophrenia includes necessary outlets such as having a psychiatrist for discussing medications and a counsellor to address issues inside and outside the realm of mental illness because mental illness affects all areas of life.

There should be more opportunities for obtaining education and career goals through adaptations and mentoring. I am a university student and have endured many obstacles over the past five years, but my family and workers believe in me and encourage me to pursue my goals, so that I may one day achieve my goal of becoming an occupational or recreational therapist.

Angela, Orlando, Florida

I was diagnosed with schizophrenia about four years ago when I was 25. A good treatment outcome is to be motivated to pursue life to the best of your ability. I wish more treatment would address how to cope with the real world. More education about the illness is helpful. We need awareness and ways to cope and challenge ourselves while living with this illness. Without constant motivation and sometimes even guidance there is little to look forward to. My advice to clinicians: Never expect too little or too much from your clients.

Natasha, Belleville, New York

I've had paranoid schizophrenia since 1991. A good outcome involves reduced hallucinations, delusions and paranoia to the point where we can function on the job or at home on a day-to-day basis. My ideal treatment for schizophrenia is a psychiatrist who will listen to us, educate us and our families and recommend supports and community resources. It is important that psychiatrists remind us that we can lead a happy, productive life. There is always hope of recovery, even if our symptoms don't go away.

Jake, Boston, Massachusetts

No hallucinations and the ability to function without having paranoid thoughts is the ideal outcome. I would like better medication that can treat anxiety along with psychotic symptoms. I want fewer side-effects, especially weight gain and muscle stiffness. I'd also like to see more non-drug related treatments.

Anna, Seattle, Washington

I wish that more doctors would *listen* to the "patient" rather than *telling* them.

Raymond, Toronto, Ontario

Most psychiatrists focus on symptom reduction, without an image of wellness to drive a recovery-based model of care.

George, Annapolis, Maryland

Most of us with mental illness wish for a better life than just collecting disability. I want to work for a living and not be a disability recipient, even though I could live on the payments I get. Some of us gave up

on work because of drug side-effects. I want more from life. I want more power. I want the power to be alive!

John, Regina, Saskatchewan

We need more coaching towards developing coping skills for school and work. On several occasions I attempted returning to school, only to drop out after I became depressed. I did try evening courses and when taking only one subject I often earned an A. Most of my learning since the psychiatrist advised that I should have "no more school" has involved self-teaching. Now, with supports in my life, I am successfully self-employed.

David, Winnipeg, Manitoba

I am 33 years old and have had schizophrenia for nine years. The best outcome is full participation in society, whatever the role. My goal was to find employment with an income that reflected my academic credentials and skills. I underwent psychological-social rehabilitation and now have a high-income job that matches my education and skills. My counsellor had the same view of empowering me to learn life skills (independent living, leisure, etc.) and to obtain and keep a job.

Dan, Midland, Ontario

One ideal treatment that doesn't exist is medication that controls negative symptoms. I've had paranoid schizophrenia for 22 years (I'm 38), and my positive symptoms are under control with medication, but I've yet to find a drug that treats negative symptoms like blunted affect. I still struggle in my relationships and often would rather spend time alone. I also can't concentrate the way I used to and was unable to progress in my education as well as I might have hoped. Negative symptoms should be as much of a priority as the positive ones.

Maureen, Toronto, Ontario

This morning I worked on an extensive survey for family members of residents of the supported home where my daughter, who has schizophrenia, lives. This itself speaks volumes. Staff welcome me and communicate with me about my daughter and the goals of the house for her. On the other side of the street, figuratively and literally, where my daughter receives treatment, I know nothing about her treatment and goals. I have never spoken with her doctor, though I have asked time and again, but I finally gave up.

Mike, White Rock, British Columbia

My daughter is 22 and has had schizophrenia for six years. The ideal treatment would provide constant support to both the person with the illness and the people who support them. Currently, support is sporadic at best for both. This illness is devastating, and without good support and education a successful outcome is difficult.

To download the Schizophrenia Society of Canada report, "Quality of Life: As Defined by People Living with Schizophrenia and Their Families," visit www.schizophrenia.ca/QualityLife.htm ■

It's about more than symptoms

Cognitive-behavioural therapy promises to improve functioning

BY PATRICIA NICHOLSON

TRADITIONAL SCHIZOPHRENIA TREATMENT FOCUSES HEAVILY on medication to treat psychosis. But new approaches that incorporate cognitive-behavioural therapy (CBT) suggest that neurobiology may not be destiny when it comes to schizophrenia, and quality of life issues suggest there is more to treat than paranoia and voices.

“There are also negative symptoms that patients struggle with,” says Dr. Gail Myhr, director of the CBT Unit at the McGill University Health Centre in Montreal, Quebec. “Difficulty doing things, getting out and resuming their lives after a psychotic break; maybe they’ll go home and live with their parents and stay in the basement.”

These are often people whose positive symptoms are under control, but whose functioning remains low. “They’re not actually hallucinating or frightened or anxious or depressed, but they’re not doing a lot,” says Myhr. “This is an aspect of schizophrenia which is troubling, particularly for families. With CBT, we can focus on that [functioning] and gradually get people in a stepwise fashion to resume a life which is satisfactory to them.”

Traditional therapy does not address cognitive deficits, but CBT – which has enough evidence behind it to make it a mandated treatment in the United Kingdom – is growing in popularity in North America as an adjunct treatment.

Widely used in the treatment of anxiety and depression, CBT addresses distorted thoughts and dysfunctional behaviours. It is a client-focused intervention that encourages clients to set and pursue their own goals. “It takes a bit of courage because it’s a very different paradigm than what we’re used to,” says Myhr. “We’re used to dealing with psychosis as a strictly biological difficulty.”

This new paradigm can focus on issues such as employment or personal goals, but Myhr says her overall goal is to reduce suffering and help clients feel better. “There’s the concept of recovery, where people can work towards the most satisfactory, rewarding life that they can have within the limitations of whatever they’re dealing with – just like anyone else,” she says.

Negative symptoms such as apathy, social withdrawal and lack of ambition have often been viewed as outcomes of neurobiological or structural brain abnormalities, says Dr. Neil Rector, director of research in the Psychiatry Department of Sunnybrook Health Sciences Centre in Toronto.

“It may be that there are certain neurocognitive components,” Rector says, “but from a cognitive perspective, we have noted that people with many negative symptoms have a lot of negative expectancies: they don’t expect to do well at the things they try, they expect to fail, they expect to derive very little pleasure. These are the types of appraisals that really get in the way of thinking that making an effort is worthwhile.”

CBT can help address those negative expectancies and the underlying dysfunctional beliefs. “As we were targeting those types of appraisals we found that patients became more engaged,” Rector says.

CBT isn’t entirely new to schizophrenia treatment. Social worker Virginia Lafond of the Schizophrenia Program at the Royal Ottawa

Mental Health Centre in Ottawa, Ontario, uses CBT to help clients manage positive symptoms like paranoia and voices.

She begins by helping clients understand that the voices are a symptom of the illness. A careful assessment of the voices, including their nature and the client’s beliefs about them, is followed by an exploration of what types of activities, events or other factors affect the voices. “The goal is for the person, not the voices, to be in charge,” says Lafond.

Paranoid thoughts are an example of distorted thinking that CBT can address. “A common expression of paranoia is that the person will think that if they are in public people are looking at and talking about them, laughing about them,” Lafond says. “In a worst-case scenario, the behaviour is that the person stays home and is not able to attend to their basic needs.”

Using CBT and a tool called meta-thinking (thinking about thoughts), clients learn to assess situations more objectively. “The person can learn to look at that thought and appreciate that that is a narrow, negative take, possibly paranoid,” Lafond says.

Back in Montreal, Myhr uses CBT to treat both positive and negative symptoms, as well as mood shifts, self-esteem and behavioural issues like avoiding social situations. “We find that these tend to improve,” she says. She adds that clients with schizophrenia often have depression. “CBT can help, and there’s some evidence that it may reduce suicidal thoughts in this population,” she says.

While Myhr stresses that medication remains a mainstay of treatment, she also describes CBT as “one of the most hopeful areas of development in the treatment of schizophrenia.” She gives the example of a woman in her 50s who was referred for treatment because the voices she had been hearing for 30 years had become louder and more distressing. The situation forced the woman to abandon her regular activities, and medication was not helping. “She ended up in the emergency department,” Myhr says. “She hadn’t slept for a long time and the voices were insulting and instructing her to do unwise things.”

CBT enabled the woman to trace the escalation to a stressful event in a relationship. Exploring the influence of elements such as sleep and lifestyle factors on the voices helped yield potential ways to control the volume of the voices – playing music, relaxing and distracting herself helped to quiet the voices. By examining the distressing nature of the voices, which were insulting her, the woman was able to understand that what the voices were saying was incorrect.

This process of reflection successfully lowered the disturbance caused by the the voices and pushed them into the background so the woman could resume regular activities. “That’s a small example,” says Myhr. “But in the old days, when you saw someone with a 30-year history of voices, you would significantly increase the medication, but the voices would persist, and the person would still be upset. Cognitive therapy gave this woman another important tool to deal with her voices.”

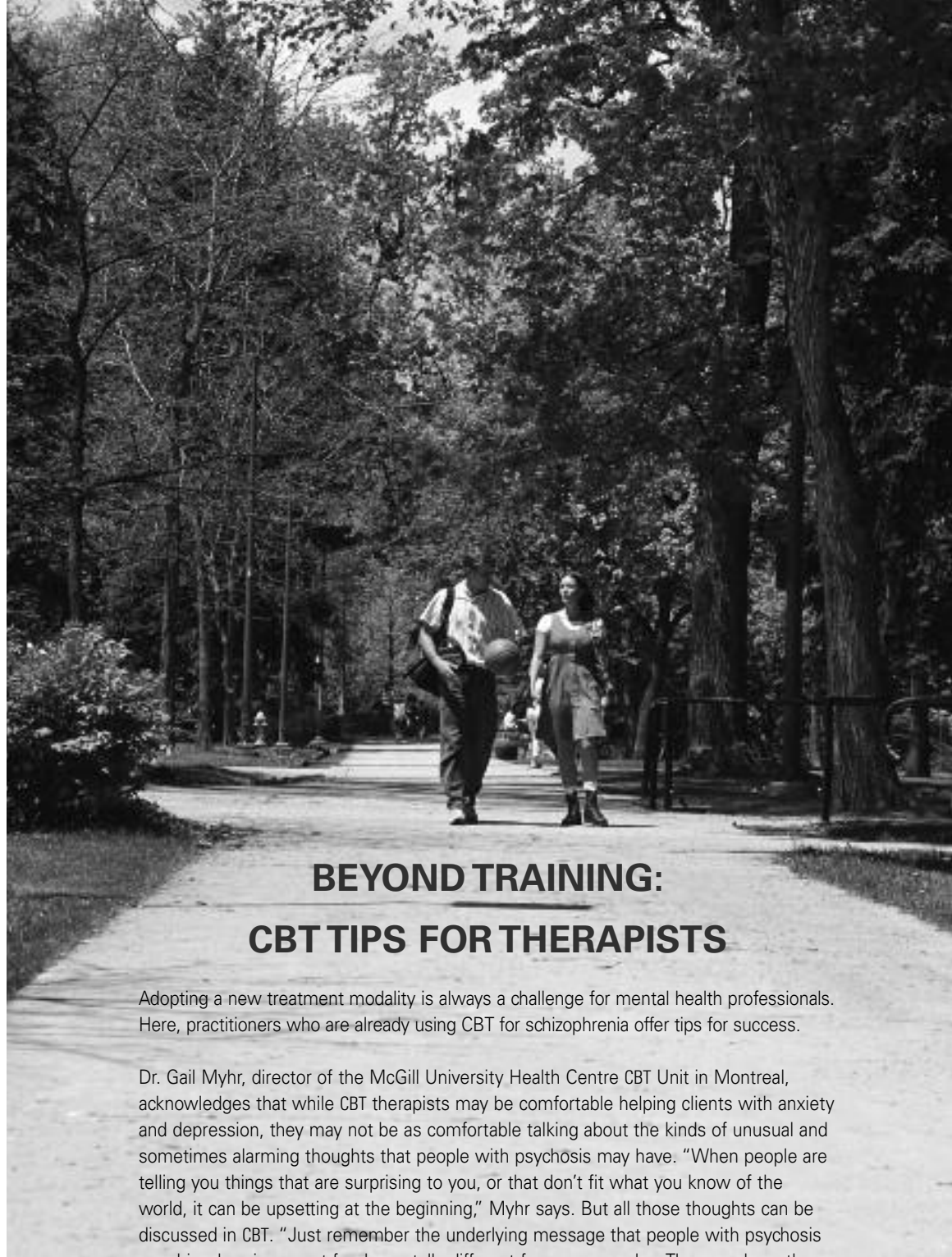
CBT is beginning to be offered in schizophrenia programs across the country, including the Centre for Addiction and Mental Health in Toronto, but it has yet to be widely adopted in North America.

Part of this lag relates to lack of training and resources. But it may also be related to lingering doubts about the usefulness of CBT. “There’s a bit of skepticism, even though we have studies to prove it, and meta-analyses have shown the power of this intervention,” says Helene Racine, director of nursing and director of quality at the Douglas Mental Health University Institute in Montreal.

Racine is training front-line workers such as nurses, social workers and occupational therapists to deliver CBT to clients with schizophrenia. Currently, the intervention is not widely available in Quebec outside of major urban centres; but Racine’s program, which works with the McGill University Health Centre CBT Unit, is trying to broaden accessibility by training throughout the province using teleconferencing. “We’re organizing so eventually each region can have a supervisor for CBT for psychosis, and people will learn the theoretical part through teleconferencing with us,” she says. “Staff will have a supervisor on site helping them with the practical part.”

As trainees begin to treat clients using CBT, the on-site supervisor can provide guidance. “I think we’re able to do things we would not have been able to do in terms of training even a couple of years ago,” Racine says. “Hopefully we can enlarge this model throughout Quebec.”

Racine acknowledges the challenges of changing long-standing treatment approaches and overcoming lingering skepticism. “Wanting to change a practice with people who have been practicing in a certain way for a long time, people have to really want change; we have to put the energy into making changes in practice,” she says. “It takes a lot of energy to do that.” ■



BEYOND TRAINING: CBT TIPS FOR THERAPISTS

Adopting a new treatment modality is always a challenge for mental health professionals. Here, practitioners who are already using CBT for schizophrenia offer tips for success.

Dr. Gail Myhr, director of the McGill University Health Centre CBT Unit in Montreal, acknowledges that while CBT therapists may be comfortable helping clients with anxiety and depression, they may not be as comfortable talking about the kinds of unusual and sometimes alarming thoughts that people with psychosis may have. “When people are telling you things that are surprising to you, or that don’t fit what you know of the world, it can be upsetting at the beginning,” Myhr says. But all those thoughts can be discussed in CBT. “Just remember the underlying message that people with psychosis or schizophrenia are not fundamentally different from anyone else. Then you have the confidence to move ahead and try new forms of treatment.”

For Virginia Lafond of the Royal Ottawa Hospital’s schizophrenia program, acknowledging the grieving of mental illness in CBT work is key. “The person is often restive, discontent, rarely happy with him- or herself,” she says. “Conscious, constructive use of the grieving process can help bring resolution of the practical problems.” Lafond encourages clients to use two key coping questions: How can I help myself cope with a specific problem? Can I put the feeling of anger or fear or sadness etc. to constructive use?

Helene Racine, director of nursing and director of quality at the Douglas University Mental Health Institute in Montreal, says it is important to be confident that clients can learn these skills. “Stay open-minded,” she says. “If you are open-minded that they can achieve things on their own, then they can be successful at achieving what they want and they can learn about their own thought processes.”

Meeting the challenge

Integrated treatment tackles co-occurring schizophrenia and substance use

BY ANNE PTASZNIK

SUBSTANCE USE ISSUES AMONG PEOPLE WITH SCHIZOPHRENIA ARE more common than most people realize, with significant implications for symptoms and treatment. According to the Schizophrenia Society of Canada, 40 to 60 per cent of individuals with severe mental illness will develop a substance use disorder in their lifetime, and about 50 per cent currently meet criteria for substance abuse or dependence. The most common substances, other than tobacco, are alcohol, cannabis, opiates and cocaine, according to the Epidemiological Catchment Area study, cited in a 2003 issue of the *Canadian Journal of Psychiatry*.

Traditionally, people with concurrent disorders receive separate treatment for mental health and substance use issues, often resulting in ineffective care. Growing understanding of the complex interaction between mental health and substance use issues has prompted a move towards evidence-based integrated treatment.

Various hypotheses address the link between substance use and schizophrenia, as outlined in a March 2007 study in the *American Journal of Psychiatry*. According to one hypothesis, a neurobiological vulnerability interacts with environmental stressors, including substance abuse, to precipitate the onset of schizophrenia or psychotic relapse. Support for this hypothesis comes from recent findings that vulnerable adolescents who use cannabis may be at greater risk for psychosis.

The second hypothesis asserts that people with schizophrenia are more likely to develop substance abuse problems due to the cumulative risk effects of poor cognitive, social, educational and vocational functioning, as well as poverty, victimization and familial and social factors. According to the third hypothesis, people with schizophrenia use substances to self-medicate, in order to reduce symptoms of the disorder or to ease medication side-effects.

As these latter two hypotheses have not been substantiated with research, the study authors propose a fourth hypothesis, relating increased risk to an attempt to correct the dysfunction that occurs with the neurotransmitter dopamine, which studies have shown to be associated with schizophrenia.

Whatever the relationship, one thing is certain – co-occurring substance use and schizophrenia has a particularly deleterious impact. According to *Concurrent Disorders: A Resource for Families*, published by the Centre for Addiction and Mental Health (CAMH) in Toronto, people with concurrent disorders are more likely to end up in jail, have increased relapses and poorer treatment adherence, and have more problems with general health, finances, housing and personal relationships. They also have increased thoughts of suicide and are more likely to act out.

Given these serious potential consequences, effective treatment is crucial, but accurate diagnosis is a challenge. Alison Gilbert, a registered nurse at the Foothills Medical Centre's Addiction Centre in Calgary, Alberta, says that among people with chronic schizophrenia, it can be difficult to determine whether they are experiencing

psychotic breakthrough symptoms or the effects of substance use.

The Centre offers an “open group,” which operates on a harm reduction drop-in model. Clients are always welcome and are not ejected from the program for non-attendance or using substances. “There is a lot of acceptance of where clients are in their journey,” says Gilbert. The goal is to work towards abstinence, with support from the Centre's other programs once clients are more stable. Gilbert stresses the importance of forming organizational partnerships, especially in locations with limited resources.

However, simply engaging people in treatment can be a challenge. Mike Pett, an advanced practice clinician with SPICeD, CAMH's new Schizophrenia Program Initiative in Concurrent Disorders, found in his previous position in CAMH's Concurrent Disorders Service that there is a subgroup of people with co-occurring schizophrenia and substance use problems who have difficulty even showing up. “These tend to be those with chronic schizophrenia who may not respond well to medication, are uninterested in or ambivalent about taking medication or take it irregularly, all of which can be influenced by problematic substance use,” says Pett. This subpopulation is also characterized by histories of trauma, homelessness, multiple hospitalizations and incarcerations and chaotic, unstable housing. They often have co-morbid diagnoses such as anti-social personality disorder and are at higher risk of acting out against themselves and others.

Pett realized that in order to engage this population, he had to meet them where they were, and liaise with assertive community treatment (ACT) teams, shelters and community health facilities. He also had to learn about supportive housing, street outreach engagement strategies, the law and crisis intervention, and had to be ready to give mental status examinations, even in a coffee shop. This type of assertive outreach and case management will be an important part of integrated treatment through SPICeD.

SPICeD will also offer an “engagement group” in the form of a drop-in breakfast club with guest speakers about concurrent disorders and field trips for people who have not made a decision to reduce use; a persuasion group, where harm reduction strategies and motivational interviewing will be used to help clients “get off the fence” and set goals; and action groups, where clients will develop plans to cut back or become abstinent and practice relapse prevention strategies. The SPICeD team will also provide consultation and training to inpatient and outpatient programs in CAMH's Schizophrenia Program, with future plans to extend consultation and education to community and external agencies.

The overall goal of SPICeD, according to Dr. Tony George, clinical director of CAMH's Schizophrenia Program and Chair in Addiction Psychiatry at the University of Toronto, will be for all clinicians in the Schizophrenia Program to develop basic skills to initially assess and initiate treatment of co-morbid addictions. Ultimately, the program hopes to develop specialized services, such as medical withdrawal management tailored to people with co-morbid addictions

SCHIZOPHRENIA AND SUBSTANCE USE RESOURCES

Best Practices: Concurrent Mental Health and Substance Use Disorders. Health Canada. Search www.hc-sc.gc.ca

The **Co-Occurring Disorders: Integrated Dual Disorders Treatment Toolkit.** Substance Abuse and Mental Health Services Administration. Search www.samhsa.gov

Family Guide to Concurrent Disorders. Centre for Addiction and Mental Health. Visit www.camh.net, and under Publications search by title.

The **Foothills Medical Centre Addiction Centre** in Calgary, Alberta, provides on-line educational tools, including podcasts about concurrent disorders, for professionals. Visit www.addictioncentre.ca and search the Education section.

Report on Concurrent Disorders. Canadian Centre on Substance Abuse. This soon-to-be-released report contains a chapter on psychosis and substance use disorders. Visit www.ccsa.ca

The **Schizophrenia Society of Canada** has a web site devoted to co-occurring schizophrenia and substance use, with resources for clients, families and professionals. www.substance-use.schizophrenia.ca



and psychosis and “dual recovery therapies,” which integrate long-term treatment of co-morbid addictions and schizophrenia.

Much of the knowledge about the components of effective treatment for this population comes from the work of Dr. Kim Mueser, a leading expert in concurrent disorders at Dartmouth Medical School in New Hampshire. Mueser says that integrated treatment begins with collaborative teams that understand how mental health and substance use issues interact. For example, if a person with schizophrenia is using substances to overcome social limitations, helping them develop stronger interpersonal skills may affect both issues.

Mueser says that the other essential components include the capacity to do assertive outreach to engage people who might not otherwise be reached; motivational-based or stage-wise interventions, which recognize the importance of the different stages of readiness; comprehensive treatment, which includes addressing social, housing, medical and family needs; and taking a long-term perspective rather than placing artificial time limits on how long it takes to recover. Social support from self-help groups, particularly Dual Recovery Anonymous or Double Trouble, as well as friends and families, is another critical component of integrated treatment. Mueser has found that clients with family support tend to have a better and quicker course of recovery from substance use.

Evidence-based treatment will get a boost through the latest recommendations from the Schizophrenia Patient Outcomes Research Team (PORT), funded by the Agency for Health Care Policy and Research and the National Institute of Mental Health in the United States. The recommendations will be published by the end of the year in *Schizophrenia Bulletin*. Dr. Lisa Dixon, professor of psychiatry at the University of Maryland School of Medicine, who led the literature review for PORT, says there was sufficient evidence to recommend that people with schizophrenia and co-morbid substance use should be offered substance use treatment, including motivational enhancement and behavioural strategies that focus on engagement and treat-

ment, coping skills training and relapse prevention training integrated with mental health care.

Improvements in functioning, however, cannot always be attributed to integrated treatment. A study of 10-year outcomes for people with schizophrenia who received integrated treatment was reported in *Schizophrenia Bulletin* in 2006. Despite severe and prolonged disabilities, many of them were able to control their schizophrenia symptoms, reduce episodes of hospitalization and homelessness, obtain employment, achieve success in community functioning and attain a better quality of life. The authors concluded, however, that the improvements could be attributed to other factors beyond integrated treatment, such as an increased emphasis on employment and self-help in that area at that time, or the natural course of improvement that occurs with age.

Researchers have also been examining new pharmacological interventions. Naltrexone and acamprosate, which have been proved effective for alcohol dependence, are now being studied for their use with people who have severe mental illness. Atypical antipsychotic medications like clozapine may reduce the desire for substances by ameliorating the dopamine dysfunction related to schizophrenia, according to a 2008 article in the *Journal of Substance Abuse Treatment*.

Ultimately, Mueser stresses that most important in working with this population is helping clients identify an achievable goal, whether it be related to school, work or relationships, so that they have a sense of purpose. He recently met a consumer at a mental health conference who had experienced schizophrenia and substance use issues and had spent significant periods of time homeless, but who was now abstinent for two years and worked part-time. The consumer talked about his experience as a recipient of ACT team services and made it very clear that he needed to acquire housing before he could get sober and allow people to help him work on his substance use issues. “It’s always reasonable to be hopeful about the ability of people to recover,” says Mueser. ■

Positive partnerships

Embracing peers as service providers to enhance recovery

BY LESLEY YOUNG



WHEN CERTIFIED PEER SPECIALIST ROY MUISE MEETS WITH A new client, one of the first questions he asks is, “What do you want me to help you with?” “The reaction is always the same,” says Muise. “The person says, ‘I’ve never been asked that before.’” This anecdote is a perfect example of the unique role that peer specialists can play in helping clients with schizophrenia along the road to recovery.

“I look at treatment from a recovery perspective as opposed to a medical perspective,” says Muise. “Treatment is very much about getting symptoms under control, often through medication and talk therapy, but there’s more to it. Peer specialists take the time to explore avenues that mental health professionals, because of the number of people they see, may not be able to do. And, of course, peers bring the perspective of someone who has been there.”

Muise has indeed “been there.” He has lived with severe depression for 25 years, but it didn’t stop him from becoming the first certified peer specialist in Canada. He works at a community-based program called the Consumer Initiative Centre in Dartmouth, Nova Scotia, where he helps people with mental illness pursue career and lifestyle goals and work on coping skills.

But Muise’s ambitions extend beyond this role. His goal is to become an integrated member of a mental health treatment team, a position for which he is advocating across hospitals in the province. “My dream is for every psychiatric unit in Nova Scotia hospitals to have one peer specialist,” he says. He may get his wish sooner than he thinks.

That is because peer support plays a clear role in the growing recovery movement, with acknowledgement at the national level through the Mental Health Commission of Canada and provincially, through the Psychiatric Patient Office in Ontario. Both have made formal recommendations to include peers in mental health treatment.

In the United States, more than 10 states have adopted the Georgia State peer support certification model, pioneered by the Division of Mental Health, Developmental Disabilities and Addictive Diseases in Atlanta. Since the first class in 2001, the GA Certified Peer Specialist Project has graduated 497 peers, eight of whom are Canadian (including Muise), according to Bob Patterson, the project’s director.

In Canada, Ontario and Quebec lead the way in creating a made-in-Canada approach to peer support. For example, the Ontario Peer Development Initiative is assessing the viability of a peer support certification program. But with the advancement of peer roles come

hard questions, including whether there are valid reasons to be reluctant to include peer specialists in a formal treatment program, and more unsettling for some, whether formalizing the peer specialist role may dilute the peer’s original goal — to be a distinct, experienced pillar of support among a sea of well-intended, well-trained “experts” who have never been tormented by voices in their head or unable to get out of bed for days on end.

An article about peer support in the July 2006 issue of *Schizophrenia Bulletin* provides optimism but encourages realistic attitudes. “The unique ways in which persons with histories of mental illness and recovery can be useful in facilitating the engagement and recovery of others are just beginning to be explored and developed,” conclude the authors of the article. They insist that this is not a reason to be discouraged, but “a cautionary note about making claims that go beyond existing data.”

In practical terms, peer support specialists on formal teams participate in treatment team meetings, facilitate peer support group meetings, help with discharge transitions and provide individual support by helping clients articulate recovery goals, assisting with treatment (e.g., ensuring that clients take their medication), modeling coping techniques and self-help strategies based on their own recovery experience and enabling clients to advocate for themselves in obtaining effective services. Underscoring these activities is the core value of peer specialists — the intrinsic (harder to quantify) benefits of having had a personal history of mental illness.

According to Muise, a shared mental health experience opens the door to a unique relationship. “What I have found is that people tend to be a lot more open, more willing to talk,” he says. “You can see this light go on when they find out you’re a survivor too.”

Patrick Veysey is a formal peer specialist with the Nipissing Assertive Community Treatment Team (NACTT) at North Bay General Hospital in North Bay, Ontario. He has lived with paranoid schizophrenia for more than 10 years. “I know what it feels like to suffer from mental illness for a long time,” he says. “I can empathize with the client about the challenges and decisions they have to make regarding meds, with what they have to do to recover. What I bring to the team is demonstrated recovery.”

As a formal treatment team member, Veysey is able to draw on his experiences to offer a different perspective from that provided by clinicians. The team takes advantage of his experience by checking in

with him first if they aren't sure how to approach a client or whether a treatment is right for them. "If it doesn't make sense to me, it's not going to make sense to the client," he says. The connection Veysey makes with clients also allows him to help build a good rapport among clients and the entire treatment team.

While peer support specialists are not matched based on diagnosis ("We don't see the illness, we see the person," as Patterson puts it), Veysey explains just how helpful peers can be for clients with severe mental illness. "I've experienced psychosis. I can really identify with what's going on in that client's mind." Veysey is able to verbalize what a client is going through to team members when they struggle to do so.

Veysey says he has been treated as a respected, valued member of NACTT. However, the fact that there is a long-standing reluctance among mental health professionals to formally integrate peer support is not news to him. He learned at a recent ACT conference that one-quarter to one-third of all ACT teams in Ontario "don't have a peer specialist because they don't believe in them."

Some peer specialists are hoping that certification will serve not only to train specialists in a standardized manner, but also to add credibility to integrated peer support services. Patterson contends that certification can eliminate clinicians' concerns, such as those involving confidentiality, for example, by asking members to agree to a code of ethics (as does the GA certification). With standardized training, peer specialists are properly educated in establishing professional boundaries, ensuring that the peer relationship does not evolve

into friendship and that the peer specialist does not compromise personal mental health, both valid concerns.

But the most pressing challenge facing the future of integrated peer support is ensuring there is a distinction between what separates the clinical experts from the consumer experts in a medical model. Fiona Wilson, a co-ordinator of Peer Support Services at the Mental Health Addictions Program at St. Joseph's Healthcare Hamilton in Hamilton, Ontario, explains: "The concern when you embed a peer provider on a team is that the purity of the peer role can be diluted. There could be situations where a peer provider is delivering medication to people or negotiating compliance. That's not the pure peer role, when they are not using their lived experience in a productive or therapeutic way." Ultimately, upon "professionalizing" the role, peer specialists will need to take care to protect their goals, which should be 100 per cent people-driven, from becoming treatment-driven, adds Wilson. "Recovery is about individual needs. It doesn't replace treatment goals and outcomes, but rather complements them."

Any future Canadian certification program will need to take this into account, a reason why it is important to the Ontario peer support community to maintain control over its development, explains Wilson. A program will also need to be flexible and accessible in order to prevent certification from being a monetary or educational barrier to potential peer specialists who don't have certain qualifications. Because at the end of the day, as Veysey puts it, "peer specialists are really people who have a degree in lived experience." ■

TIPS FOR INVOLVING PEERS ON TREATMENT TEAMS

In 2008, Vermont Psychiatric Survivors and the Vermont Council of Developmental and Mental Health Services held a forum on the integration of peer services into the community mental health system, which culminated in the development of a report called *Integrating Peer Services in Community and Inpatient Settings in Vermont's Mental Health System of Care*. For the full, free report, which included tips for hiring and working with peer support workers, visit www.healthvermont.gov/mh/documents/forumreportfinal.pdf

Here are some recommendations from the report:

- Prepare clinical staff. This involves many layers of training on a variety of subjects to prepare staff for working with peer support workers on formal treatment teams.
- Good job descriptions should be developed prior to hiring, and allowances should be made for flexibility and revision of responsibilities after peers are hired.
- Positions should be placed at appropriate levels of supervision. Make sure supervisors are strong supporters of the peer role.
- There is a need for advisory and support groups for peers in these positions, both within and outside hospitals.
- More than one peer specialist should be hired for any given setting, particularly if they are hired in an entry-level position.
- Ensure a good interview process throughout the hiring process and include task-oriented questions (e.g., What would they do in a given situation?)

HELPFUL TRAINING LINKS

B.C. Ministry of Health Services Peer Support Resource Manual. Visit www.health.gov.bc.ca/library/publications and search alphabetically by title.

Georgia Certified Peer Specialist Project
www.gacps.org/home.html

The National Association of State Mental Health Program Directors has published a peer training manual called **Paving New Ground – Peers Working in In-Patient Settings**. Visit www.nasmhpd.org. Under Publications, select "Office of Technical Assistance (OTA) Publications and Reports" and scroll down to "Technical Reports."

National Association of Peer Specialists
www.naops.org

Peer Specialist Alliance of America
www.peerspecialistallianceofamerica.org

University of Pennsylvania Collaborative on Community Integration
www.upennrrtc.org



Peer specialist Patrick Veysey brings demonstrated recovery to his ACT team in North Bay, Ontario.

Can cognitive remediation benefit clients with schizophrenia?

BY PATRICIA NICHOLSON

Evidence is growing that cognitive remediation – often used to help people with traumatic brain injuries restore function and compensate for cognitive impairments – may help people with schizophrenia improve cognitive skills necessary for good functioning in life. *CrossCurrents* interviewed Dr. Susan McGurk, an associate professor at the Psychiatric Research Center at Dartmouth Medical School in New Hampshire, about how cognitive remediation is being used in the Dartmouth Supported Employment Program.

What is cognitive remediation?

There is very good evidence that cognition is related to the ability to live independently, and many people with severe mental illness have a recovery goal related to community-based activities. Cognitive remediation is a set of strategies designed to help people practice thinking skills such as attention, memory, problem-solving – skills that are commonly used in everyday activities, but that are often impaired in people with severe mental illness, particularly schizophrenia. The techniques are designed to isolate and force practice of these cognitive skills with the goal of improving them.

What is the difference between cognitive remediation and cognitive-behavioural therapy?

Cognitive behavioural therapy (CBT) addresses the person's thinking styles and belief systems about the world, and how the belief system may cause distress. It involves helping the person examine and change automatic ways of thinking that may cause distress and that may be inaccurate. Cognitive remediation does not focus on thought content; rather, it involves practicing specific cognitive skills.

How is cognitive remediation used with people with schizophrenia?

It varies. Many programs provide broad-based practice of cognitive skills, including practical skills such as paying attention and concentrating, learning and remembering information, planning ahead, problem-solving and responding to environmental demands in a reasonable amount of time. The software typically provides practice of cognitive skills that are important for functioning in the community, and that tend to be impaired in severe mental illness.

For software, we use Cogpack, which was developed for people with severe mental illness. There are different exercises, some of which are very contextualized. For example, there are exercises that use what looks like a street map, and the goal is to connect different locations in the shortest distance possible. Some clients in our New York City work studies are employed as couriers, which is a common entry-level job. In the map exercise, we suggest "You're planning your delivery route; try to do it in the most efficient way possible." These exercises provide a platform to both practice a cognitive skill and link it with a community-based activity.

What results are achieved in terms of cognition and functioning?

The meta-analysis we published in 2007, where we looked at 26 randomized controlled trials, indicated a modest but significant

improvement in cognitive skills. The rationale for using cognitive remediation lies in the relationship between cognition and everyday functioning. Cognitive remediation is expected to improve cognition, but the broader goal for many programs is that people apply these improved skills to achieve what they want in the community.

Some argue that it is not reasonable to expect studies of cognitive remediation to demonstrate significant improvements in functional outcomes in addition to cognitive improvements. Many other factors can influence functioning, such as psychotic symptoms; therefore, many research studies may not have sufficient statistical power to detect beneficial effects on functioning. It is interesting that the expectation for antipsychotic medications is that they improve psychosis, not functioning, even though psychotic symptoms are related to psychosocial functioning, whereas cognitive remediation may be being held to a higher standard with expectations that it improve both cognition and community functioning.

How is cognitive remediation best implemented?

An intriguing result from the meta-analysis is that in studies in which people received cognitive remediation alone, and in which some aspect of community functioning was assessed, there was gain in cognition, but not in community functioning. But in studies in which cognitive remediation was combined with psychiatric rehabilitation geared toward a specific functional goal, functioning was improved in the combined group but not in the group that received psychiatric rehabilitation alone.

We work with people with severe mental illness who have work as a goal and who are enrolled in supported employment. We strive to integrate our restorative cognitive work with strategy coaching. We bring the employment specialist to the table and put together a picture of the person's cognitive difficulties and how they may have contributed to past work problems, and we suggest compensatory strategies. Even though cognition may be improving in laboratory practice, we don't expect that to be all that is necessary to improve work outcomes. Therefore, we also suggest compensatory strategies to the client and the employment specialist that they may apply on the job.

What advice would you give to front-line professionals interested in using cognitive remediation?

We encourage new programs or agencies interested in starting a program to really consider cognitive remediation in service of the person's stated community goal or other goals, and to work with clients on doing exercises that practice the particular cognitive skills needed to achieve their goal. It makes the training more relevant, more face valid and more interesting for the client, and we think it helps improve motivation. Choose a standardized program with published, replicated evidence of efficacy in improving cognition. ■

Readers may contact Dr. McGurk at Susan.R.McGurk@Dartmouth.edu

Voluntary madness: A questionable commitment to fighting stigma

For Norah Vincent, who lived as a man for her book *Self-Made Man*, her latest foray into immersion journalism takes her into three mental health and addiction facilities posing as a client. Unfortunately, she called her book *Voluntary Madness: My Year Lost and Found in the Loony Bin*. One would hope that after Vincent's experiences, her language would change. Not so. She uses stigmatizing terms like "the bin," "zombie parlor," "insanitarium" and "asylum." Clients are "mad," "insane," "psychotics" and "society's rejects," never just people.

Immersion journalism allows the public a glimpse into the private domain through lived experience. Although the writer/observer also becomes subject, yielding a certain amount of subjectivity, this is still meant to be journalism. But Vincent offers a story without investigation, sorely lacking in objectivity. She describes her desire to "inform" and "entertain," but what she exposes are her own biases, stereotypes and grudges.

Anyone who has worked in or sought help through the mental health system knows it has problems. Seeing the system through the lens of a client can offer a fresh perspective and a critical analysis that professionals cannot provide. However, Vincent's criticisms seem more like the ravings of a

petulant child than the insights of someone interested in reform.

Vincent admits herself to a large public hospital with an acute population; a small, private hospital in a rural setting with a less acute population; and a private alternative treatment facility. From the outset, she states her goal to expose and ridicule the system. She is predisposed to not like staff, calling them "lazy mindless bureaucrats" and "paper pilers." She resents the nurses who follow orders and enforce rules, but saves most of her vitriol for psychiatrists, who are arrogant and entitled – "a prick on a power trip," a "pug jailer with an advanced degree." So she is surprised when one doctor agrees with her decision to not use medication and grants her request for community passes. Vincent is able to recognize that not everyone in the system is the enemy, but only those who meet her needs.

It is noteworthy that Vincent herself has a diagnosis and during one of her admissions had gone off meds and became depressed. But she does not identify with her fellow patients, seeing herself on a different plane of existence. Her intention to promote social justice and defend her co-patients turns to "visceral disgust and hatred," particularly for those who are psychotic. Although she hates that medication is used liberally,

she believes clients are "mildly more acceptable when tranquilized or debilitated."

Vincent struggles with her diagnosis and whether her depression is biological, or whether medication has produced a chemical imbalance. She questions the role of "the will" in depression and whether depression is just a "bratty rebellion" in the face of adversity. She describes herself and her fellow patients as consuming their depression, "rolled in it like pigs" and "reclining in the arms of a disease." It is unfortunate that her own internalized stigma and denial lays blame on her fellow patients. She judges them, most of whom she sees as unwilling to change, even when given compassion, understanding and freedom.

Aside from the obvious – that offering respect, programming and outpatient resources improve chances of recovery – *Voluntary Madness* fails to offer insights into how to improve the system or better respond to client needs. It reads more like a self-indulgent blog that contributes to, rather than challenges, stereotypes and prejudice.

Voluntary Madness: My Year Lost and Found in the Loony Bin. Norah Vincent. Viking Adult, New York, 2008, 304 pp., \$25.95US.

Cheryl Peever is manager of the Women's Program at the Centre for Addiction and Mental Health in Toronto.

downloaded

SHEILA LACROIX

First-episode psychosis

Canadian Mental Health Association www.camh.ca

Download *A Guide to Canadian Early Psychosis Initiatives* and other resources from the ongoing Early Psychosis Intervention project at CMHA's web site under About CMHA, National Projects.

Centre for Addiction and Mental Health www.camh.ca

A helpful resource that clinicians may want to recommend to family members is the newly released CAMH guide for families, *Promoting Recovery from First-Episode Psychosis*. Although it was created for CAMH clients and families, it may be adapted for other environments.

Psychosis Sucks www.psychosissucks.ca/epi

This web site from British Columbia that targets youth features personal stories and resources about substance use and psychosis, harm reduction strategies and popular drugs like crystal meth, as well as recovery information with practical tips, for example, about returning to school or work.

e-earlypsychosis.ca <http://earlypsychosis.medicine.dal.ca>

The Nova Scotia Early Psychosis Program of Dalhousie University offers an educational resource called *The Sooner the Better: Get Help for Early Psychosis*, which includes an information guide, a video that can be viewed on-line and a poster. Multimedia education modules are being developed.

Early Psychosis: A Care Guide www.gov.bc.ca/mcf

This guide, developed at the University of British Columbia, is available on the BC Ministry of Children and Family Development web site. It provides researched practices with input from experts in treating and assessing early psychosis with the goal of standardizing practice and improving service delivery.

Why work? Disincentives to employment in the benefits system

BY DR. RICHARD WARNER

At least half of people with schizophrenia or a similar mental illness are capable of competitive work. This may seem improbable to many mental health professionals, few of whose patients may be working, but the evidence exists.

In studies of patients with schizophrenia in routine care in northern Italy, at least half work – a quarter full-time. In the developing world, people with serious mental illness are very likely to be employed. Two-thirds of individuals with chronic schizophrenia in a recent study in Chennai, India, were working, mostly in mainstream jobs; three-quarters in Madras were employed; and more than half of those in a study in urban Chandigarh, India, had held full-time paid employment for the past two years. In nearly all controlled studies of the modern vocational approach called supported employment, more than half of those with serious mental illness achieved competitive employment, whether the study was conducted in the United States, Canada, Australia or Europe. This was two to six times the proportion in the control groups.

Employment rates for people with schizophrenia in routine treatment vary. A recent EQOLISE (www.eqolise.sgul.ac.uk) study of supported employment in six European cities found that in Heilbronn, Germany, 60 per cent of participants with schizophrenia were working, whereas 10 per cent or less were employed in Lyon and Lille in France, or in London, England. In most studies, only 15 to 20 per cent of people with psychotic illness in developed countries were working.

Why the big differences? The answer appears to lie in disincentives to employment in the disability pension system. A few years ago, psychiatrist and economic development expert Dr. Paul Polak and I gathered information on income and expenses from people with long-term mental illness in Boulder, Colorado. We discovered that the income difference between being employed and unemployed offered little economic incentive to work. The total income of peo-

ple who worked part-time was only slightly more than that of those who were unemployed, largely because when people started to work, many lost part of the disability pension (usually 50 cents on the dollar) and part of their rent subsidy (25 cents on the dollar). For the average part-time worker, the loss amounted to what economists term an “implicit tax” of 64 per cent on earned income. The situation was better for full-time workers, who met an implicit tax of only 23 per cent on their earnings, but because of the economic obstacles to part-time work, few people in our study achieved full-time employment.

The EQOLISE study demonstrated that in Britain and the Netherlands, where disincentives to employment in the disability pension system are high, the impact of the vocational intervention was significantly less than in Italy and Bulgaria, where disincentives were negligible. Other surveys have shown that in Germany and Italy, where disincentives in the national disability pension schemes are less severe and where vocational services tend to be well developed, employment rates for people with mental illness are better. Similarly, researchers in India attribute the high rate of employment among mentally ill people to the lack of disability support. Whereas more than half of people with schizophrenia in U.S. and British cities receive disability benefits, the equivalent proportion in cities in India or Colombia is zero to four per cent. Clearly, it is not psychosis *per se* that imposes high rates of idleness; it is the economic system.

Disability pension systems can be redesigned to minimize disincentives. The United States has two major disability support programs – Supplemental Security Income (SSI) and Social Security Disability Income (SSDI). Under both programs, support payments decline when people accept employment. SSI recipients lose 50 cents on the dollar when earnings exceed a small amount. SSDI recipients lose nothing until they earn a much greater amount, but then lose it all. In practice, SSDI creates fewer dis-

incentives to work, as recipients continue to collect full benefits as long as they don't earn too much. Disincentives are more severe in Britain, as disabled people run the risk of losing all their benefits if they earn more than a small weekly amount, and this “earnings disregard” is permitted for only a few months. Since a full benefits package is worth more than a full-time minimum-wage job, there is little incentive to work. Consequently, less than five per cent of those receiving benefits for two years return to work. Ontario's benefits system is similar to Britain's.

Italy has less severe work disincentives than the United States or Britain because fewer people qualify for benefits – the person must be “80 per cent disabled.” This system is possible because 80 to 90 per cent of Italians with psychosis live with and are supported by their families. The scarcity of governmental income support increases the incentive to use vocational services, which are often quite comprehensive. Beyond these formal system features, moreover, many Italians who receive disability benefits continue to work in the “black market” labour force – along the beaches in summer and on family farms.

At the policy level, econometric labour-supply models can inform legislators what the effects of benefits policy reforms will be. At the clinical level, a valuable approach is to advise clients about the remedies that are already in place to ease disincentives. A British study reported success with advisors who gave clients information about return-to-work benefits. A U.S. study demonstrated that people receiving benefits counselling improved their income by \$1,250 per year more than those who didn't get counselling. Where benefits counsellors are not available, case managers can assist clients by learning enough about benefits regulations to help them make good decisions about work and income.

Dr. Richard Warner is the director of Colorado Recovery in Boulder, Colorado.

CANADA

50th Annual Institute on Addiction Studies

July 12–16, Barrie, Ontario
 Contact: Addiction Studies Forum, Box 322,
 Virgil, ON LOS 1T0
 toll-free tel 1 866 278-3568
 toll-free fax 1 888 898-8033
 e-mail info@addictionstudies.ca
 www.addictionstudies.ca

5th Critical Multicultural and Diversity Conference: "Integrating Traditional Healing Practices into Counselling Psychology and Psychotherapy"

August 4–5, Toronto, Ontario
 Contact: Ontario Institute for Studies in
 Education, Centre for Diversity in Counselling
 and Psychotherapy, 252 Bloor St. W., 7th flr.,
 Toronto, ON M5S 1V6
 tel 416 978-0683
 e-mail cdcp@oise.utoronto.ca
 http://cdcp.oise.utoronto.ca/conference2009.htm

117th Annual Convention of the American Psychological Association

August 6–9, Toronto, Ontario
 Contact: APA, 750 First Street, N.E.,
 Washington, DC 20002-4242 USA
 tel 202-336-5500
 e-mail convention@apa.org

59th Annual Conference of the Canadian Psychiatric Association

August 27–30, St. John's, Newfoundland
 Contact: CPA, 141 Laurier Ave. W., Ste. 701,
 Ottawa, ON K1P 5J3
 tel 613 234-2815
 fax 613 234-9857
 e-mail conference@cpa-apc.org
 www.cpa-apc.org

14th International Congress of the International Psychogeriatric Association

September 1–5, Montreal, Quebec
 Contact: IPA Secretariat, 550 Frontage Rd.,
 Ste. 3759, Northfield, IL 60093
 tel 847 501-3310
 fax 847 501-3317
 e-mail IPACongress@ipa-online.org
 www.ipa2009montreal.com

International Symposium on Gambling and Addictions

September 3–4, Montreal, Quebec
 Contact: Symposium Secretariat, c/o Opus 3
 Inc., 417, rue Saint-Pierre, bureau 203,
 Montreal QC H2Y 2M4
 tel 514 395-1808
 e-mail jeux-gambling2009@opus3.com
 www.jeux-gambling2009.org

Annual Meeting of the International Society of Addiction Medicine

September 23–27, Calgary, Alberta
 e-mail office@isamweb.com
 www.isamweb.org

5th International Multidisciplinary Academic Conference on Spirituality and Health

September 24–26, Calgary, Alberta
 Contact: Conference Co-ordinator, Continuing
 Medical Education and Professional
 Development, University of Calgary,

3330 Hospital Dr., N.W., Calgary, AB T2N 4N1
 tel 403 220-4251
 e-mail jlanger@ucalgary.ca or spirit@ucalgary.ca
 wcm2.ucalgary.ca/files/Spirituality_Call.pdf

Native Mental Health Association of Canada Annual Conference

September 24–27, London, Ontario
 Contact: NMHA, 852 Wellington Ave., Skwah
 First Nation (IR#4), Chilliwack, BC V2P 6H7
 tel 604 793-1983
 e-mail nmha@telus.net
 www.nmhac.ca

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@mtsinai.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

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
 e-mail ios@ccsa.ca
 www.issuesofsubstance.ca

UNITED STATES

International Nurses Society on Addictions Annual Educational Conference

September 30–October 3, Albuquerque,
 New Mexico
 Contact: INSA, P.O. Box 10752,

Raleigh, NC 27605
 tel 919 821-1292
 fax 919 833-5743
 e-mail intnsa@intnsa.org
 www.intnsa.org/events.php

28th Annual Research and Treatment Conference of the Association for the Treatment of Sexual Abusers

September 30–October 3, Dallas, Texas
 Contact: ATSA, 4900 S.W. Griffith Dr.,
 Ste. 274, Beaverton, OR 97005
 tel 503 643-1023
 fax 503 643-5084
 e-mail atsa@atsa.com
 www.atsa.com/conf.html

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 dlevreauaap@gmail.com
 www.netforumondemand.com/eWeb/StartPa
 ge.aspx?Site=AAP&WebCode=HomePage

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

October 27–November 1, Honolulu, Hawaii
 Contact: AACAP, 3615 Wisconsin Avenue
 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

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

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/meetings

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 tchillers@abct.org
 www.aabt.org/dMembers/?m=mMembers&f
 a=Convention

Research Society on Alcoholism Annual Scientific Meeting

June 20–24, San Diego, California
 Contact: RSOA, 7801 North Lamar Blvd.,
 Ste. D-89, Austin, TX 78752-1038
 tel 512 454-0022
 fax 512 454-0812
 e-mail debbyrsa@sbcglobal.net
 www.rsoa.org/2009meet-indexAbs.htm

College on Problems of Drug Dependence 71st Annual Meeting

June 20–25, Reno, Nevada
 e-mail ebgseller@temple.edu
 www.cpdd.vcu.edu

ABROAD

World Mental Health Congress of the World Federation for Mental Health

September 2–6, Athens, Greece
 Contact: ERA Ltd, 17 Asklepiou Str., 106 80
 Athens, Greece
 tel 30 210 3634 944
 fax 30 210 3631690
 e-mail info@era.gr
 www.wmhc2009.com

1st International Hearing Voices Congress

September 17–18, Maastricht, The Netherlands
 e-mail hearingvoicesmaastricht2009@gmail.com
 www.intervoiceonline.org

2nd European Conference on Schizophrenia Research

September 21–23, Berlin, Germany
 e-mail: schizophrenia@cpo-hanser.de
 www.schizophrenianet.eu

7th World Congress of Depressive Disorders and International Symposium on Posttraumatic Stress Disorder

September 24–26, Mendoza, Argentina
 Contact: Jorge Nazar, Rivadavia 122, Piso 1,
 Dpto 25 (5500), Mendoza, Argentina
 e-mail Jorge_Nazar@hotmail.com

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

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- Diagnosis and Treatment
- Stigma/Discrimination
- Workplace Mental Health and Addiction Policies

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Early Bird Registration Deadline

July 3, 2009

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Congress Website

www.wwrepcamh.org

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