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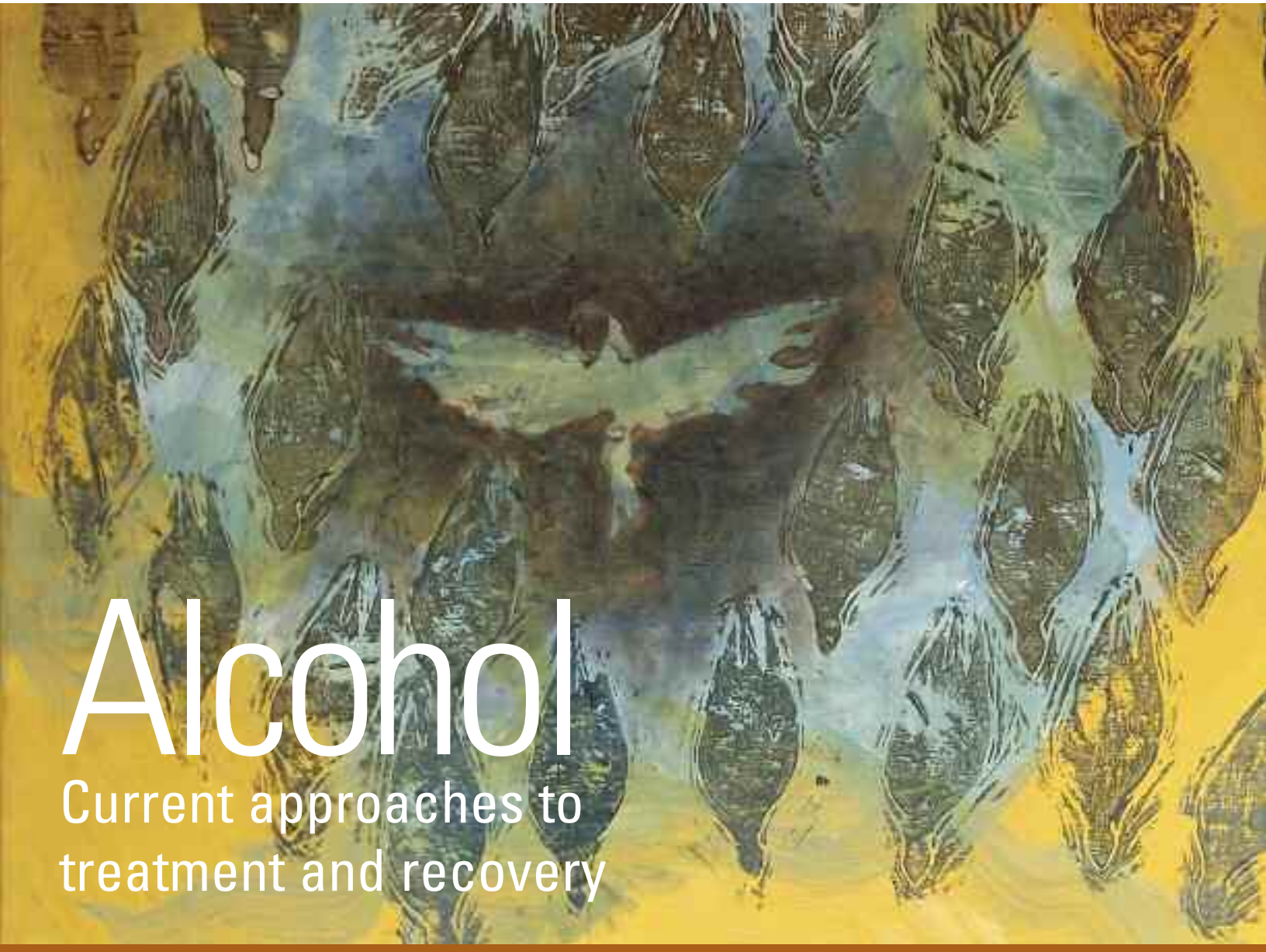

Alcohol

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

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Scarboro Sky, Patti Lennox, acrylic and linoprint, 18" x 20"

Patti is a Toronto-based artist whose inspiration is nature and the urban landscape as they meet, reflecting the possibilities of the soul. Her art is displayed through the Creative Works Studio in Toronto (www.creativeworks-studio.ca).

camh
Centre for Addiction and Mental Health
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note from the editor

Canadians love to drink. In fact, alcohol is the psychoactive substance of choice for nearly 80 per cent of Canadians over age 15, according to the Canadian Centre on Substance Abuse (CCSA). But while most people tend to drink moderately, consuming on average one or two drinks a day, about 7 per cent, or 2.3 million people, engage in problem drinking. It's a problem that costs jobs, relationships and health. The CCSA estimates that the economic cost of problems associated with alcohol use in 2002 was $14.6-billion. A 2008 study by the Centre for Addiction and Mental Health reported that alcohol problems cost each Canadian $463 per year, and that the direct health care costs associated with alcohol use problems exceed those of cancer.

This issue of *CrossCurrents* explores alcohol treatment and recovery. Treatment and recovery support options seem to be growing, as reflected in the emergence of evidence-based treatments that include brief interventions and new pharmacotherapies and the proliferation of addiction recovery mutual aid groups well beyond Alcoholics Anonymous. The stories in this issue cover some of these innovations.

We begin the issue with an overview of pharmacologic and psychosocial treatments and discuss the implications of newly emerging pharmacotherapies for non-prescribing treatment providers. Next, Helen Buttery's story challenges mutual aid organizations and treatment providers to work more closely together. Patricia Nicholson discusses unique issues in diagnosis and treatment among people with co-occurring fetal alcohol spectrum disorder and mental health or substance use issues. These are followed by two remarkable personal stories of hope, inspiration and success. Anne Ptasznik then delves into the heated debate about harm reduction around alcohol with Aboriginal populations. Dr. Tomislav Svoboda finishes this issue with another controversial topic – wet shelters for men who are homeless.

In this issue of *CrossCurrents* you will also find a new feature: Myth Busters will be a regular column that distills the facts from the fiction related to that issue's focus topic. It is a column that aims to contribute to the stigma-fighting efforts of the Mental Health Commission of Canada. Reflecting this issue's theme, the inaugural column focuses on myths around alcohol.

Enjoy this stimulating issue of *CrossCurrents.* Send us your comments and ideas so that we can continue to cover the issues you want to know about.

Hema Zbogar
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a view from CAMH

With this issue's focus on alcohol following the autumn 2008 issue's scrutiny of tobacco, we continue to examine aspects of the other great legal addiction in Canada – one that, like cigarettes, causes inordinate morbidity and mortality. But, unlike the diminishing number of Canadians who smoke, the number of us who drink in moderation represents a sizeable majority of the adult population. And among adolescents, binge drinking remains a significant problem. Alcohol also likely represents our longest continuing substance of addiction in Western culture.

The history of our relationship to alcohol at societal, cultural, legislative, economic and religious levels is a fascinating story. At CAMH, we are fortunate to have among our research scientists the historian Jessica Warner, whose books on this subject should be of interest to anyone curious about this complex historical relationship. Her first book, *Craze: Gin and Debauchery in an Age of Reason* (2002), looks at the impact of gin on British society in the early 18th century and how society responded. Her new book, *The Day George Bush Stopped Drinking: Why Abstinence Matters to the Religious Right*, shifts the focus to the United States and the changing political and religious context of the abstinence movement. Both books take us out of the immediacy of our clinical encounters with people who have alcohol-related problems into a larger view of our world across time.

This issue of *CrossCurrents* addresses a number of timely and provocative issues related to alcohol in the Canadian context in the 21st century. It reminds us of the enormous challenges that remain, the debates that persist and the new approaches that help. It inspires us to advance understanding and treatment. And it stirs us with a profoundly human story of recovery and hope.

David S. Goldbloom, MD, FRCPC
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Remedial program puts drivers back on track

JACLYN GREENBERG

As a facilitator of Back on Track (BOT), a remedial measures program for impaired driving offenders, Michele Cloutier asks people why they got behind the wheel. "I didn't think I was that drunk" is a popular answer. As is "I wasn't that far from home and I was the least intoxicated."

That judgment call is what Cloutier works to change. "The goal of the program is to separate drinking from driving," says the addictions counsellor from Oshawa's Pinewood Centre, one of the program's 28 sites. "The two should never mix."

Preventing people from re-offending is integral to shrinking the number of impaired driving charges laid each year. As part of a multi-pronged strategy that includes public education and enforcement, reducing recidivism may have helped to create a decline in charges from a high of 162,048 in 1981 to a low of 69,192 in 2000, according to a 2007 BOT evaluation report.

Despite legislation and programming, the reality remains sobering: MADD Canada estimates that in 2005, impaired driving in Canada, including impairment by drugs other than alcohol, resulted in 1,210 fatalities and 71,413 injuries. These numbers are not extreme – in an average year, it is estimated that impaired driving kills 1,203 people and injures 70,973 more. The cost of damages is estimated to be in the billions.

In an effort to ensure a continuing decline, in 1998 the Ontario government mandated completion of a remedial program for convicted impaired drivers, and for good reason: North American research suggests that remedial programs can reduce recidivism by 20 per cent or more.

Ontario's BOT program, developed and managed by the Centre for Addiction and Mental Health (CAMH) in Toronto and supervised by the Ministry of Transportation, consists of four core components: an assessment to identify those at high risk of re-offending, an education program, a treatment program for those more likely to re-offend and a follow-up interview.

Stakeholders applaud this comprehensive approach. "The beauty of Back on Track is that it identifies the track the person needs to be in and provides the appropriate help," says Andy Murie, CEO of MADD Canada.

Providing the appropriate help starts with the key goal of reducing heavy drinking and heavy drinking occasions, says Robert Mann, a senior scientist at CAMH involved in evaluating BOT. These risk behaviours are targeted partly in the treatment program, where facilitators address motivational factors that can trigger or influence alcohol consumption, and partly through the education component, which all participants complete. Participants learn about safe drinking and the health consequences associated with heavy alcohol use. They also learn about the financial, legal, criminal and social implications of re-offending.

"The program appeals to how you think about drinking and driving," says James, who completed Back on Track in 2000. "Whether you think it is unethical to drink and drive, or that it is too expensive or that is a concern for your health – one way or another, the program gets everyone to think about not mixing the two again." The hefty price tag – $578 plus GST that participants must pay themselves – is itself an incentive to change attitudes towards drinking and driving.

Program facilitators help participants establish drinking-related goals to maintain post-program and provides strategies to avoid recidivism. But engaging people can be a challenge, Cloutier admits, especially male participants in the treatment program. Despite difficultly gauging the program's influence in the moment, follow-up interviews months later consistently prove the program's lasting impact. "Former participants say 'I wasn't happy being in the program, but I really did learn a lot,'" says Cloutier.

Anecdotal information aside, BOT is the most evaluated program of its kind in Canada. According to Mann, between assessment and follow-up, participants reported a 26 per cent reduction in the number of days of alcohol use, and a 21 per cent reduction in the number of drinks per drinking occasion.

Another promising, if unanticipated outcome was the reduction in use of substances other than alcohol, says Mann. Cannabis and cocaine showed the most significant reductions, at 71 per cent and 80 per cent, respectively. "Considering last summer's new legislation giving police the tools to determine a driver's sobriety with substances other than alcohol, these results are as timely as they are significant," says Mann. "The data suggest that we're seeing some real fundamental change for a lot of these participants and how they're approaching the world."

CAMH plans to collect recidivism and collision data to measure BOT's impact. In the meantime, program organizers are assessing the opportunity to tailor the program further, given two promising evaluation outcomes: The latest data shed light on the extent to which motivational factors such as negative affect or self-esteem affect a participant's likelihood of success. This relationship, in addition to the confirmation that people with more severe problems benefit from more intense interventions, could lead to an even more targeted approach than the current two-stream system.

Murie considers BOT a pillar to permanently eradicating drunk driving in Ontario. Given the program's unparalleled completion rate of 97 per cent and the positive result of participating, Murie hopes to see the province boost the participation rate, which is about 60 per cent of eligible convicted drinking drivers.

James hopes the need for such programs will eventually disappear. He sees increased awareness about the dangers of drinking and driving among his friends' younger siblings. In the meantime, he encourages the work of programs like Back on Track: "From the spirit of the program, if it's successful it won't exist forever." ■

REMEDIAL PROGRAMS ACROSS THE COUNTRY

See Health Canada's web site at www.hc-sc.gc.ca. Under "Healthy Living," choose "Alcohol"; then under "Resources," choose "Reports on Driving While Impaired." The 2004 report, *Best Practices: Treatment and Rehabilitation for Driving While Impaired Offenders,* lists remedial programs across Canada.

How a second chance led to the founding of Second Cup.

Frank O'Dea was once that young homeless guy begging for spare change on Jarvis Street in a filthy T-shirt. Alcohol and abuse had led him there. Courage to change and a woman who simply said, "You're home" helped him come back. Ten years later he co-founded Second Cup and he was awarded the Order of Canada in 2005. O'Dea strongly believes in CAMH's amazing work in addictions care and research. And in the power of a second chance.

To hear Frank's full story, and others like it, please visit

TransformingLives.ca

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Maximizing client involvement in clinical research

AVRIL ROBERTS

Getting people with mental illness to participate in research can be difficult, but the results of a recent German study, published in the *International Journal of Psychiatry in Clinical Practice*, suggest that does not have to be the case.

Of the 83 people with schizophrenia who responded to a self-report questionnaire, an overwhelming 97 per cent approved at least "a little" of psychiatric research. The top three reasons they selected for participating in research were to help other people, to help the medical profession and to improve their own chances of recovery. The potential for access to better treatment was another reason.

Participants preferred research focusing on psychosocial treatments over research on medication or other biological treatments. They said they would rather do interviews or complete questionnaires than submit to medical procedures such as blood samples, investigational drugs, brain imaging or lumbar puncture. Almost all participants wanted details before participating in a study and wanted to be informed of the results.

Mental health consumer activists in Canada argue that these findings highlight the need for more consumer involvement and empowerment in mental health research. "Consumers are the true experts," says Dave Gallson, national program director of the National Network for Mental Health in St. Catharines, Ontario. "They know a lot about mental health issues but have historically not been provided with a podium from which they can speak from experience." Gallson says stigma from the medical community towards people with mental illness and "feelings of mistrust from being treated as a subject, not as an equal" have contributed to consumers' reluctance to participate in research.

Another reason for this reluctance is the longstanding divide between researchers focused on a medical model of clinical research and consumers who often favour more recovery-based approaches. "It was thought that consumers could not recover from mental illness to regain meaningful lives," says Chris Summerville, interim chief executive officer of the Schizophrenia Society of Canada in Winnipeg, Manitoba. "We now know that such recovery is possible. Consequently, over the past 20 years, the mantra of the consumer movement in North America has become 'Nothing about us without us.'"

Recovering consumers argue that researchers should not push forward an agenda when consumers haven't been consulted about what helps them get better, stay well longer and have less relapse and less hospitalization. Summerville says the only way to get that information is through surveys or forums with consumers in order to help researchers devise more relevant research questions and by including consumers on research planning committees.

This growing awareness of consumers' needs and priorities is having an impact on clinical research, says Dr. Gary Remington, director of the Medication Assessment Clinic in the Schizophrenia Program at the Centre for Addiction and Mental Health in Toronto. "In the field of psychopharmacology, for example, we are now looking at outcome measures that don't just rank whether or not symptoms such as delusions or hallucinations have improved with treatment," he says. "We're also interested in whether the medication impairs a person's functioning and whether it improves other domains, such as quality of life. Ten or 15 years ago, we wouldn't have asked that."

Gallson is encouraged by signs of improved co-operation between mental health researchers and consumers and looks forward to greater consumer involvement in participatory action research, where consumers are not just participants, but are actually involved in defining and carrying out the research. "If we don't get involved in all aspects of the research process, then we can't ensure the research will be of value to the consumer community," says Gallson. ■

TIPS FOR MAXIMIZING CLIENT INVOLVEMENT IN RESEARCH

Summerville, Remington and Gallson offer these suggestions:

Partner with national mental health consumer organizations. Contact them for input on research design, implementation and evaluation, and for help disseminating study results.

Invite peer support specialists to join advisory committees. They can provide input on consumer values, empowerment, meaningful engagement and appropriate language. They can also connect researchers with consumers.

Broaden the research topics. Address the questions that people with lived experience want to ask and want answered.

Request more funding for psychosocial research. "Consumers want quality of life, so let's do research in the area of what helps and what hinders people in their recovery process," says Summerville.

Build trust. Provide clear information about the research – who is funding it, what they are funded to do, ethical guidelines and the side-effects of medications.

Engage consumers more meaningfully. Have them devise questions, lead focus groups and collect information in accordance with their skills and abilities.

Offer an honorarium in appreciation of consumers' participation.

Share study results with participants in appropriate language and formats. "Doing that is treating participants with a sense of equality," says Summerville.

Offer study participants the benefits of treatment. "Wherever possible, ensure that people engaged in clinical trials have the opportunity to access treatment if they were in the group that received placebo," says Remington.

Translate knowledge into policy and practice. "Then you can say this policy not only reflects good science, but it also reflects lived experience and participants' contribution to the research," says Summerville.

Distilling fact from fiction: The truth about alcohol

Dr. Peter Selby, clinical director of Addiction Programs at the Centre for Addiction and Mental Health in Toronto, and Wayne Skinner, deputy clinical director of the program, challenge common myths about alcohol treatment and recovery.

MYTH: Alcohol has the same chemical and physiological effect on everyone.

FACT: Alcohol, like any drug, affects different people in different ways. Many factors affect a person's reaction to alcohol, including body weight, metabolism, sex and body chemistry. Even the social setting, a person's mood or whether one is tired or hungry have an effect.

MYTH: Drinking reveals a person's true personality.

FACT: Heavy drinking, either binge or chronic, can have significant effects on behaviour, perception and personality. Intoxication or withdrawing from alcohol may also exaggerate emotions, such as anger, fear and sadness.

MYTH: Anyone who drinks long and hard enough will become alcohol dependent.

FACT: Alcohol abuse and alcohol dependence are two different points on the continuum. In many individuals, dependence is preceded by abuse, but some develop dependence without progressing through drug use and abuse to dependence. In addition, many people abuse alcohol for many years without developing dependence. A complex of factors, including genetics and childhood development, shape the risk of developing alcohol dependence.

Unlike alcohol abuse, alcohol dependence is measured by tolerance and withdrawal, as well as other factors. For both conditions, the negative consequences of excessive drinking can occur on the biological level (from hangover to liver disease to cancer), the psychological level (from depression to cognitive impairment to sleep disturbance) and the social level (from relationship problems to work problems to legal involvement).

MYTH: A person who can abstain from alcohol for weeks or months or who only drinks on weekends does not have a drinking problem.

FACT: A person does not have to drink every day or every week to have a problem with alcohol. And not all people who drink daily are alcohol dependent. Alcohol dependence is not characterized solely by how often a person drinks. It is important to consider whether alcohol use affects the person's functioning in areas such as work, relationships and school, and whether the alcohol use has medical, legal and financial consequences.

Even people who drink infrequently but who binge when they do (five drinks for men, per occasion, four for women) are at risk for health problems and other consequences from drinking.

MYTH: Drinking is higher among Aboriginal people than in the general population.

FACT: Research indicates that the prevalence of drinking among Aboriginal people is approximately the same as in the general population. However, it is drinking patterns that are different. Among those Aboriginal people who drink, more engage in binge drinking than social drinking.

MYTH: People who are alcohol dependent have no will power. If they were stronger they could just stop drinking.

FACT: Alcohol dependence affects brain chemistry, which makes the person feel compelled to drink alcohol. Addressing the problem usually requires treatment and ongoing support to minimize relapse risk.

MYTH: All someone has to do to overcome alcohol dependence is go to Alcoholics Anonymous.

FACT: AA doesn't work for everyone. When it does work, people use AA to stay abstinent, reorganize their lives, draw on peer support and find deeper meaning.

MYTH: Tranquilizers and sedatives are useful in treating alcohol dependence.

FACT: Tranquilizers and sedatives can be useful during the acute withdrawal period. After that, these drugs are risky and can become a source of abuse and dependence.

MYTH: Alcohol detox is the same thing as treatment for alcohol dependence.

FACT: Alcohol detoxification, or withdrawal management, addresses the physical component of addiction by giving the body time to readjust to the lack of alcohol in the body. It does not in itself constitute treatment, but it may be the first step in the process of change, which includes the psychological and social components of alcohol dependence.

MYTH: Residential alcohol treatment is more effective than outpatient treatment.

FACT: While there are advantages to residential care, including round-the-clock attention and having a safe place to focus on recovery, the actual programs in residential and day treatment services are similar and outcomes are comparable. What is important is for treatment plans to be personalized for each situation and person.

MYTH: Relapse is an inevitable part of recovery from alcohol dependence.

FACT: Alcohol relapse is not inevitable, but it is common among individuals in recovery. Many people who try to stop using alcohol on their first attempt do not succeed. However, this does not mean that they will never succeed.

It is also not true that high relapse rates mean that treatment does not work. Although relapse is often a part of the recovery process, it is treatable. And even if a person does not achieve abstinence, treatment can reduce the number and duration of relapses, lower the incidence of related problems such as crime and poor overall health and improve the individual's overall functioning and ability to cope better with the next temptation or craving.

MYTH: If people with alcohol dependence eat three balanced meals a day, their nutritional problems will disappear.

FACT: Alcohol depletes the body of important vitamins and minerals and affects major body organs like the liver. During and after treatment, vitamin and mineral supplements help to correct deficiencies and maintain nutritional balance.

MARK DE LA HEY

CBT effective in treating traumatized youth

There is strong evidence that individual and group cognitive-behavioural therapy (CBT) can decrease psychological harm among children and adolescents exposed to traumatic events, according to a study from the Centers for Disease Control and Prevention in Atlanta, Georgia. Researchers reviewed published studies that evaluated various treatments for children and adolescents exposed to trauma, including individual CBT, group CBT, play therapy, art therapy, psychodynamic therapy, pharmacologic therapy and psychological debriefing. Treatment with individual CBT proved effective in reducing psychological harm, leading to decreases in anxiety, post-traumatic stress disorder (PTSD), depression and externalizing and internalizing symptoms. Group CBT resulted in reductions in anxiety, depression and PTSD. However, the authors found insufficient evidence to determine the effectiveness of the other therapies, often due to the limited number of studies available. They recommend that health care providers treating children exposed to traumatic events should use treatments with proven effectiveness, such as individual and group CBT. The authors note that unfortunately, according to a recent U.S. study, only 23 per cent of clinicians preferred CBT to treat traumatized children and adolescents. The authors call for future research to determine the effectiveness of those treatments for which there is currently insufficient evidence.

American Journal of Preventive Medicine, September 2008, v. 35: 287–313. Holly R. Wethington et al., National Center for Health Marketing, Centers for Disease Control and Prevention, Atlanta, Georgia.

Substance use negatively affects low-income caregivers and their children

Low-income caregivers of children fare poorly on measures of well-being and work when they have high levels of substance use, according to research from Harvard Medical School in Boston. The study involved interviews with 1,623 female caregivers of children aged 0–4 or 10–14 living in low- to moderate-income areas of Boston, Chicago and San Antonio, Texas. Participants were interviewed at baseline and at a follow-up interview administered 11–26 months later. By the end of the study, caregivers with moderate or heavy substance use were significantly less likely to be working or receiving income assistance than those with light or no substance use. They were also less likely to report improvements in mental health symptoms or their children's behavioural problems. Caregivers who reduced their substance use over the course of the study were able to achieve results for themselves and their children that compared favourably with those for caregivers with light or no substance use regarding work status, income assistance, mental health symptoms and behaviour problems in their children. However, participants who reduced their substance use were more likely than those with light or no substance use to lose their health insurance, which could make it difficult to access treatment services they needed to consolidate their gains. The authors conclude that "policies that promote, rather than impede, reduction in substance use are more likely to promote self-sufficiency and well-being."

Psychiatric Services, September 2008, v. 59: 974–981. Ellen Meara and Shelley Greenfield, Department of Health Care Policy, Harvard Medical School, Boston, Massachusetts.

Children of older fathers at increased risk of bipolar disorder

Children born to older fathers are more likely to develop bipolar disorder, say Swedish researchers. A study from the Karolinska Institute in Stockholm used data from Sweden's national health registers to identify 13,428 individuals with bipolar disorder. Each individual was then matched with five randomly selected healthy controls of the same sex and age. The results showed that the risk of developing bipolar disorder increased with paternal age. The risk peaked among the children of fathers aged 55 and older, who were 37 per cent more likely to have the disorder compared with the children of fathers aged 20–24. Maternal age had little effect. The relationship with the father's age was even more pronounced among children whose bipolar disorder had an early onset: these were 163 per cent more likely to develop the disorder. These results are consistent with the hypothesis that the increased risk in the children of older fathers results from de novo mutations in genes that are associated with neurodevelopmental disorders. DNA copy errors increase with age in men because spermatogonial cells go through large numbers of replications over the course of a man's lifetime. On the other hand, a woman's eggs go through fewer 23 replications, a process which is completed by the time she is born. Therefore, a woman's age does not increase the number of DNA copy errors.

Archives of General Psychiatry, September 2008, v. 65: 1034–1040. Emma M. Frans et al., Department of Medical Epidemiology and Biostatistics, Karolinska Institutet, Stockholm, Sweden.

Cannabis use may be linked to early-onset psychosis

Cannabis use may be associated with the early onset of psychosis, according to researchers at Santiago Apóstol Hospital in Vitoria, Spain. Researchers looked at 131 individuals who required inpatient treatment for a first episode of psychosis over a two-year period. They found that the more dependent an individual was on cannabis, the younger that person typically was at the first episode of psychosis. Compared with non-users, age at the time of first psychosis decreased by seven years for cannabis users, 8.5 years for cannabis abusers and 12 years for those who were dependent on cannabis. The effect of cannabis on age at onset could not be explained by gender or the use of other drugs. The results were similar for the youngest individuals (under age 30), indicating that the relationship between cannabis use and age at onset was not due to chance. One possible explanation for the relationship between cannabis use and age at onset is that cannabis may precipitate the psychosis. Conversely, it is also possible that early onset of psychosis increases the risk of cannabis use. The authors note that cannabis use is believed to account for approximately 10 per cent of all cases of psychosis. They conclude that their results show cannabis to be "a dangerous drug in young people at risk of developing psychosis."

Journal of Clinical Psychiatry, August 2008, v. 69: 1210–1216, Ana González-Pinto et al., Department of Psychiatry, Santiago Apóstol Hospital, CIBERSAM, Vitoria, Spain.

Students respond to risk of prescription drug use

The average first year university student believes that non-medical use of prescription stimulants and painkillers is safer than cocaine use but more dangerous than smoking marijuana or binge drinking, according to research from the University of Maryland. The study was based on personal interviews with 1,253 first-year students over one year. Approximately one quarter believed that occasional non-medical use of stimulants or painkillers entailed great risk of harm. Conversely, one quarter believed the risk was low and were about 10 times more likely to engage in non-medical use of prescription medication than those who saw the risk as high. By comparison, 72 per cent of participants saw cocaine use as very risky, whereas only 7 per cent believed that marijuana use was very risky. Seventeen per cent believed there was great risk in binge drinking (having five or more drinks once or twice every weekend). Most participants limited substance use when they perceived the risk as high, but this did not always hold true for participants who were classified as sensation-seekers. The authors conclude that for the average student, education about the risks of non-medical use of prescription medication could be a promising strategy for reducing abuse. However, since sensation-seekers may show less of a benefit from such a strategy, alternative prevention strategies may be needed for these students.

Prevention Science, September 2008, v. 9: 191–201. Amelia M. Arria et al., Center for Substance Abuse Research (CESAR), University of Maryland, College Park, Maryland.

Continuing care benefits individuals with substance use and psychiatric disorders

Continuing care for a substance use disorder after inpatient psychiatric treatment reduces the risk of early rehospitalization among individuals who have both psychiatric and substance use disorders, according to research from the Department of Veterans Affairs in Ann Arbor, Michigan. Researchers examined the treatment records of 26, 826 individuals with co-occurring psychiatric and substance use disorders who were discharged from inpatient psychiatric treatment. The records were examined in order to determine rates of rehospitalization after 90 days and 12 months. Twenty-three per cent of individuals were readmitted to hospital within 90 days of initial discharge. Only 31 per cent received continuing care for a substance use disorder during the first month following discharge from inpatient treatment. Those who did receive continuing care were 16 per cent less likely to be rehospitalized. There was no comparable benefit from continuing care for psychiatric disorders alone. Over the 12 months following initial discharge, continuing care for substance use disorders resulted in an eight per cent reduction in the rate of rehospitalization. Rehospitalization rates were higher among individuals who were younger; unmarried; or who had been diagnosed with schizophrenia, schizoaffective disorder or bipolar disorder, suggesting that those with fewer personal resources and those with a psychotic disorder are at greater risk of readmission. The authors recommend that, where integrated treatment services are not available, health care providers should consider referring patients with co-occurring psychiatric and substance use disorders to stand-alone substance use disorder programs after discharge from inpatient treatment.

Psychiatric Services, September 2008, v. 59: 982–988. Mark A. Ilgen et al., Health Services Research and Development, Department of Veterans Affairs, Ann Arbor, Michigan.

Adults abused as children prefer trauma-based therapy

Adults who were abused as children show a marked preference for trauma-based approaches to therapy, according to new research from the University of Windsor in Windsor, Ontario. Trauma-based treatment approaches the client as someone who has been harmed by someone or something, not as a person with an illness. This model "expects individuals to learn about the nature of their injuries and to take responsibility in their own recovery." For this study, researchers interviewed 30 adults with histories of child abuse who had completed a six-week inpatient treatment program using a trauma-based approach. Participants were interviewed five times in the six months after discharge and were asked what they considered to be helpful during treatment and since discharge. Participants most appreciated trauma-based therapy's shift in emphasis from what society regards as their "illness" to the harm that was done to them. They also responded favourably to therapists who recognized their right to share in the control and direction of their own therapy. Participants had the greatest difficulty dealing with the intense emotions and memories brought up in therapy and also found it difficult when therapists appeared to regard them as mentally ill. Some were reluctant to share their thoughts and feelings because they feared they might be seen as needing rehospitalization. The authors conclude that their research "points to the need for accessible, affordable, community-based services that use a trauma-based approach." However, many communities lack the resources to provide such treatment, in which case therapists need to either acquire the necessary knowledge and skills or contact trauma specialists.

Journal of Mental Health, August 2008, v. 17: 361–374. Kim Harper et al., School of Social Work, University of Windsor, Ontario.

Bridging the great divide

The challenge to integrate drug therapy with psychosocial treatment

BY KIM GOGGINS

THROUGHOUT HIGH SCHOOL, JOHN* DRANK HEAVILY. IN COLLEGE, he discovered that he could avoid his "morning-after" hangover by continuing to drink. Soon he was drinking every day, all day. "I drank a big bottle daily," he says. "I kept it in my car so I could drink at whatever job I had." John tried to quit drinking without help many times, but when he did, he experienced hallucinations and had been hospitalized for severe withdrawal symptoms. John is now getting treatment – a regimen of cognitive-behavioural therapy, boosted by a medication that keeps his cravings at bay.

He isn't alone. According to the 2004 Canadian Addiction Survey by the Canadian Centre on Substance Abuse, nearly 80 per cent of Canadians aged 15 and older drink alcohol. Although most do so moderately, 17 per cent are considered to be high-risk drinkers, according to the World Health Organization. A 2008 study by the Centre for Addiction and Mental Health (CAMH) in Toronto revealed that alcohol dependence costs each Canadian $463 per year and that the direct health care costs exceed those of cancer.

Recognized as a chronic brain disease, alcohol dependence is characterized by long-term, often permanent changes in the neurochemical properties of the brain. New knowledge from neuroscience research is helping develop pharmacologic treatments that act on brain mechanisms involved in alcohol dependence. These medications target immediate concerns like cravings and withdrawal, and can keep these in check in the long term, which is important for a disorder characterized by high rates of relapse.

In the meantime, psychosocial treatments and recovery supports like cognitive-behavioural therapy (CBT) and Alcoholics Anonymous (AA) have long been the mainstay for dealing with alcohol dependence. In fact, there has traditionally been a divide between pharmacologic and psychosocial approaches to treatment and recovery, a divide that is being challenged by studies and clinical experience that suggest that combined treatment is the most effective approach.

In Canada, three drugs have been approved for treating alcohol dependence. The recently approved drug acamprosate (Campral) blocks the rewards of alcohol and relieves withdrawal symptoms such as tremors, insomnia and anxiety. It joins naltrexone (ReVia), which reduces the rewarding effects of alcohol, thus reducing cravings. Disulfiram (Antabuse) is a deterrent that has been available for decades, but its availability is now limited due to the severe and sometimes dangerous reaction that occurs when alcohol is ingested.

Although these medications can help to promote abstinence or reduce drinking, some clinicians lament that they are not prescribed enough. "It's dismal; medications are under prescribed," says Dr. Peter Selby, clinical director of Addiction Programs at CAMH. He cites societal attitudes towards alcohol dependence and a lack of physicians trained in addiction as reasons.

Misconceptions about pharmacotherapy by non-prescribing clinicians and clients are also to blame, says Selby: "Some clinicians and clients think that medication and counselling can't go together or that it will somehow not make the recovery real," he says. "This means that many people continue to suffer longer and harder than they have to, not because of lack of science, but because of a lack of knowledge translation of that science into practice and policies."

What that science says is that combining psychosocial and pharmacologic treatments and support optimizes recovery. Dr. Juan Negrete, an addiction psychiatrist and professor of psychiatry at McGill University in Montreal, believes that nonpharmacologic interventions, such as motivation enhancement therapy, CBT and AA, should also be used to treat alcohol dependence and provide support (see sidebar). "Medication can be taken without psychosocial therapy, but that isn't advisable," he says. "Individuals who have stopped drinking need to reshape their living style and gain understanding and control of their behaviour, define their goals and deal in a different way with psychological and emotional issues. For that you need therapy."

PSYCHOSOCIAL APPROACHES TO TREATMENT AND RECOVERY

Numerous treatment approaches for alcohol dependence are well established, widely available and effective. Here is a sample:

Withdrawal Management, also known as alcohol detoxification, is the process of ridding the body of alcohol while safely controlling and managing withdrawal symptoms. This is done under medical supervision, often in a residential setting, and may be the first step in treatment.

Cognitive-Behavioural Therapy (CBT) takes a structured, problem-solving approach based on the cognitive model of emotional response. Focusing on the present, therapists help clients think differently about their current situation and as a result, to feel and react differently.

Motivation Enhancement Therapy (MET) uses motivational strategies to activate the client's own change resources. Therapists provide feedback on the risks or damage associated with the alcohol use, while emphasizing the client's personal responsibility for change. The client is advised how to make healthy changes and is given alternative change options.

Alcoholics Anonymous (AA) is a mutual support program that is based on 12 steps required for recovery and sobriety (see pp. 10–11). AA is considered to be a support rather than treatment; as such, clinicians recommend that AA works best when combined with drug or psychosocial therapy.

Adapted from www.alcohol-treatment-info.com/About_Us.html

Results from the U.S. Combining Medications and Behavioral Interventions for Alcoholism (COMBINE) study, which were released in 2006, show that individuals who received naltrexone and specialized alcohol counselling, along with medical management by a health care professional, had the best drinking outcomes after 16 weeks of outpatient treatment. Although counselling alone was effective, of the 1,383 people with alcohol dependence who participated in the study, those who received medication, counselling and medical management did much better than those who received placebo and counselling.

Pharmacotherapy of a sort is not new to the psychosocial approach, says David North, executive director of TriCounty Addiction Services in Smiths Falls, Ontario. He points out that many clients already use caffeine and nicotine to self-medicate; counsellors recommend over-the-counter herbal remedies or dietary supplements to help curb withdrawal symptoms; and historically, Antabuse and methadone have been accepted aids to addiction treatment. "The metaphor prescription is already common in the business," says North. "It's the nature of the drugs that changes, but it's the psychiatrists and doctors who prescribe, whereas the rest of us can't."

It's here that challenges emerge, as front-line addiction professionals must make referrals to prescribing physicians who usually do not have the same level of addictions training or the time to provide ongoing care to clients.

"Because you now have power and control over a particular treatment methodology, access involves a variety of rituals – referral, assessment, consultation – and some of them don't involve the client, per se," says North. "From a psychosocial perspective, we try to empower and enhance self-direction on the part of the client. Any time you introduce a new power struggle in which the client may not be involved, you restrict access to clients getting to learn about that kind of empowerment."

Even if prescribing and non-prescribing clinicians worked more closely together – a concept that North supports – it's unlikely that provincial governments will increase funding to cover the cost of medications or enable addiction treatment centres to hire physicians for their programs. In fact, the vast majority of community-based treatment centres in Canada and the U.S. do not have a prescribing physician or psychiatrist on staff.

Lack of training in pharmacotherapy among addiction counsellors and a philosophy that can conflict with complete abstinence can also be barriers, points out Christopher Shea, clinical director at Father Martin's Ashley, a residential and addiction treatment centre in Havre de Grace, Maryland. "Most physicians aren't educated in chemical dependency and addiction," he says. "Two professionals are trying to collaborate, but in most cases, neither has a good idea what the other does. If the counsellor can understand why the medication is being prescribed, then the physician can explain to the patient, 'This is the reason we are prescribing this medication and these are the side-effects.' The non-prescribing clinician can then follow up with the patient by talking about how the medication will curb cravings. That approach will enhance treatment and recovery."

Communication is another key factor, says Catherine Hardman, executive director of Choices for Change Alcohol, Drug and Gambling Counselling Centre in Stratford, Ontario. "Each professional needs to respect the other's expertise and see that person as a partner in working with the client to ensure good treatment," she says. "In the future I hope to see a closer relationship between the systems, with respect for each discipline. Both [prescribing and non-prescribing clinicians] have a lot to offer, and if we are serious about good client care, this needs to happen in all aspects of the health care system – more integration and understanding of what we do and can offer each other and our clients." ■

*not his real name

THE MILLION-DOLLAR QUESTION

"When was the last time you had more than five drinks (if male, four if female) in one day?" That's the single question that studies have found to be an effective screening tool that opens the door for clinicians to discuss a client's problematic drinking.

Brief Interventions

Brief but effective screening tools are crucial to detecting and treating alcohol problems, given that only one in three people with alcohol problems seek treatment, according to a 2003 study by the Centre for Addiction and Mental Health (CAMH) in Toronto. More than 34 randomized controlled trials in the United States have found that alcohol screening and brief interventions are effective in decreasing consumption in people with problematic drinking. These brief interventions usually involve counselling in five or fewer standard office visits. The meetings involve providing straightforward information about the negative costs of alcohol use and practical advice on how to reduce or stop drinking.

Front-line professionals, particularly those working in primary care, such as a family doctor or nurse, are well-positioned to detect problems because they are often the first point of contact and may have an established relationship with patients. Primary care providers are also important on the continuum of care because once treatment is finished with another provider, they play a key role in recovery and relapse prevention.

It may not be realistic to expect a busy physician to take more than 10 minutes with a patient, but even acknowledging the problem with the patient is beneficial, and nursing staff can follow up, notes Montreal addiction psychiatrist Dr. Juan Negrete. "What happens with many alcoholics is that the first professional contact they have is with a general physician," says Negrete. "The short intervention could be for that doctor to notice the problem, to identify it and to simply tell the patient, 'You cannot carry on. You must do something about this.' Even if the doctor doesn't do anything else, in many cases, that itself has a positive effect."

Family health teams have a promising role to play in screening, treatment and referral, but so far, most have difficulty providing this sort of service, according to Dr. Peter Selby, clinical director of Addiction Programs at CAMH. He says that inadequate training and the lack of appropriate remuneration and practice standards within these emerging models of care must be addressed: "We have to educate teams about how effective they can be using brief interventions and medications to treat alcohol dependence," he says. He adds that we need to leverage the skills of all members of the interprofessional team and apply incentive models to facilitate these changes, much like has been done to promote the management of diseases like diabetes.

It's mutual

Clinicians and support groups take steps together to enhance recovery

BY HELEN BUTTERY

KEITH HUMPHREYS, PROFESSOR OF PSYCHIATRY AND BEHAVIORAL sciences at Stanford University in California, won't win any popularity contests among colleagues for saying, "As educated professionals, we tend to look down on everybody." Yet it was one of the reasons why he found the results of his recent study so gratifying.

The two-year study, published in *Alcoholism: Clinical and Experimental Research* in 2007, found that individuals being treated for alcohol use issues had higher rates of abstinence when they received both clinical treatment and mutual aid support than cognitive-behavioural therapy alone. The study is challenging academic and clinical naysayers of mutual aid to rethink how they can help clients with alcohol problems, instead of dismissing mutual aid as separate from treatment or as having no scientific backing, as has often been the case.

Wayne Skinner, deputy clinical director of Addictions Programs at the Centre for Addiction and Mental Health in Toronto, says it's about time the value of mutual aid be acknowledged. "It's long overdue, but the whole area of mutual aid is being rediscovered by clinicians and it is being given a growing respect," he says. But why has it taken so long to get to this point?

For one, until relatively recently, there was no proof that mutual aid was effective, no benchmark study to validate the work being done by mutual aid groups. In the alcohol recovery world, Alcoholics Anonymous (AA) is the best known example. In an increasingly medicalized profession, 12-step programs and other forms of mutual aid are often dismissed by clinicians, who insist that providing effective treatment requires special training, says Humphreys. Mutual aid groups like AA, however, don't claim to provide treatment; rather, they offer support that can prevent relapse once treatment is over.

Treatment goals, from abstinence to harm reduction, can be seen as existing on a continuum, which opens the door to co-operation among services that have traditionally been seen as working at odds with one another.

The value of being able to personally relate to each other's experiences, as having "been there," is often an essential part of the healing process for people with addictions, says Humphreys. "You don't need an advanced degree to work with 'I feel lonely,' 'I need some encouragement,' 'I need a hug.' Often mutual aid groups can meet those needs."

Humphreys is not alone in his thinking. "Doctors need an acute dose of humility," says Dr. Graeme Cunningham, director of the Addictions Division at Homewood Health Centre in Guelph, Ontario. He points to two reasons for clinical resistance to working with mutual aid groups – ignorance and arrogance.

However, professional snobbery is not exclusively to blame. The disconnect also has roots in a divergence between the philosophies traditionally espoused by clinicians, who may take a harm reduction approach, and mutual aid, which tends to advocate abstinence. Traditional 12-step programs have been criticized for adhering to the rigid belief that alcoholism is a disease over which its victims are powerless. Critics say this undermines the influence of psychological factors, such as anxiety, and social factors, such as poverty, and disempowers people with alcohol use problems and other addictions. Others criticize 12-step programs, chiefly AA, for being white, religious, male-dominated and cultish.

However, many argue, this is an outdated view of AA. Translated into 28 different languages, AA is found in Tehran, Dehli and San Paolo. Advocates argue that AA is simply a reflection of the people who attend the meetings. For those who still are not satisfied, alternatives to AA have emerged (see "21st Century" sidebar).

Where 12-step programs, particularly AA, have been accused of being too rigid, with no room for personal choice, clinicians have been criticized for being too soft. An abstinence goal is not necessarily a condition of treatment, and harm reduction strategies, aimed at increasing safety while the person continues to drink or drinking in moderation, are options. But experts say that despite these seemingly irreconcilable differences, treatment goals, from abstinence to harm reduction, can be seen as existing on a continuum, which opens the door to co-operation among services that have traditionally been seen as working at odds with one another.

"Increasingly, what has emerged is a more pluralistic perspective, which acknowledges that we need all of these things, and clients need to be offered treatments based on severity and motivation," says Skinner. In the United States, studies have found that half of those treated for alcohol and other substance use problems will be readmitted to treatment within two to five years. Skinner sees mutual aid as a crucial component of the continuum of care for people who complete formal alcohol treatment. "Treatment has a finite span to it," he says. "The real challenge for people is living in the real world, and that's where mutual aid support may become essential." Mutual aid can be an invaluable support in preventing the relapse so common with alcohol dependence.

Some may consider clinical treatment to be a softer approach, but it often gets people with alcohol problems started on the road towards recovery. "We meet people where they're at," explains Cunningham. In recovery himself for more than 20 years, Cunningham knows firsthand how important it is to have services available that are nonjudgmental and accessible. "I'd be dead now if people closed the door," he says.

More and more, addictions treatment is client-driven, with approaches to care existing on a continuum, or as Cunningham envisions it, an arc. Where people fall on the arc and what services are suitable is determined by many factors. For instance, a person who started drinking after the death of a loved one may require grief counselling. Or a person with both mental illness, such as bipolar disorder, and alcohol dependence may require concurrent treatment, which also includes attending a mutual aid group for people with bipolar disorder.

Where a person falls on the arc can also change over time. A person may not be ready to abstain from alcohol, but may decide later that sobriety is their goal. It also comes down to personality. Some people simply don't like groups. And there are cases where mutual aid may be detrimental. "We don't want mutual aid to be a deal breaker to treatment," says Skinner. He says that it's better that clients receive some professional treatment than no help. Skinner also says it is important that when treatment providers suggest mutual aid to clients, they must do so in a way that the client feels respected and not confronted.

But is suggestion enough? When clients are merely given information about mutual aid groups, which is the general practice among clinicians, clients don't seem to follow through. However, a 1981 study in the *American Journal of Drug and Alcohol Abuse* showed that when clinicians systematically encouraged clients to attend – by phoning the local AA, introducing the client to an AA member, having that AA member offer to meet the client before a meeting and giving a client a reminder the day of the meeting – 100 per cent of clients attended and continued to attend.

But now, more than 25 years after that study, clinicians still are "not doing enough to encourage clients to attend mutual aid programs," says Humphreys. He says that it's not rocket science, but simply a matter of dealing with practical matters – Do they have a car to get to the meeting? – and other basic concerns clients might have – At the group, do they have to stand up and talk about their experience?

Humphreys puts himself in his clients' shoes and tries to address the types of questions or anxieties he himself might have if he were attending a meeting for the first time. "I try to answer all the questions I would have if I were going to an experience that was new and anxiety-provoking," he says. And if clinicians are not confident in their understanding of mutual aid groups, neither will their clients be. ■

MUTUAL AID IN THE 21ST CENTURY

If Alcoholics Anonymous is not a good fit for a client, here are some alternatives.

Secular Organizations for Sobriety
www.secularsobriety.org
Departing from traditional 12-step models, this program advocates sobriety, autonomy and free-thinking.

Women for Sobriety
www.womenforsobriety.org
Recognizing that women with alcohol problems require a different kind of program than men, WFS created a 13-statement program of positivity that encourages emotional and spiritual growth.

Rational Recovery
www.rational.org
This alternative to the disease model associated with AA believes alcohol use to be a voluntary behaviour. RR is a for-profit organization whose approach is based on self-recovery (there are no groups) and a cognitive-behavioural model.

Moderation Management
www.moderation.org
Rather than focusing on an abstinence goal, MM promotes moderate alcohol consumption and the prevention of potentially detrimental outcomes.

MUTUAL AID TIPS FOR CLINICIANS

Educate yourself so you can educate clients.
- Attend open meetings, read the literature provided and talk to members.
- Provide clients with introductory pamphlets from groups.

Find a good fit.
- Groups vary and are geared towards different populations. A woman may be uncomfortable in a male-dominated group and a blue-collar worker may not be able to relate to a group that's predominantly lawyers. You need to know what options are available so you can present clients with different choices.

Break the ice.
- If a client agrees, invite a mutual aid representative into your treatment centre to chat informally and answer questions about the group.
- Find appropriate mentors from groups that would be willing to create an informal sponsorship-type relationship with clients.

Help with logistics.
- Support clients in getting to and from meetings. Provide bus routes or find out if the group can supply transportation.

Provide space.
- Give free space at your workplace for open meetings.

Keep a list.
- Have an up-to-date list of meetings and schedules at your fingertips so you can make a quick reference to clients.

Follow up.
- Once clients are attending meetings ask how they are doing and if they have any questions or concerns.

Stay open.
- Challenge preconceived ideas and prejudices about mutual aid groups and remain open-minded.

Beyond bad, mad behaviour

Targeting the needs of people with FASD and mental health issues

BY PATRICIA NICHOLSON

Errin Weigel thought her 7-year-old daughter Kalen's behaviour seemed extreme, even in the context of attention-deficit/hyperactivity disorder (ADHD). As for her son, Dusty, he was often anxious, and was hospitalized for severe depression just before his 10th birthday. When Weigel read a newspaper article about fetal alcohol spectrum disorder (FASD), she felt a jolt of recognition.

Weigel suspected that her adopted children, who share the same birth mother, might have been affected by prenatal alcohol exposure, even though they did not have the physical characteristics of fetal alcohol syndrome (FAS). Through the online support group FASlink, she found a doctor who specialized in fetal alcohol exposure.

"That's when the kids were finally diagnosed under the FASD spectrum," says Weigel, who lives in Quill Lake, Saskatchewan. "Now we had some answers to why Kalen's behaviour was off the charts for a diagnosis of ADHD and why Dusty at such a young age suffered from such severe anxiety and depression."

Weigel's story reflects the reality that people with FASD are at increased risk for co-occurring mental health or substance use problems that can complicate diagnosis and treatment.

FASD encompasses the full range of disabilities caused by prenatal exposure to alcohol, including neurological, physical, behavioural, mental and cognitive effects (see sidebar). These effects vary widely, depending on when during pregnancy exposure occurred and the amount of alcohol involved. Health Canada estimates that nine out of every 1,000 Canadians have some form of FASD.

Most people with FASD have no obvious physical characteristics, but may have any combination of other symptoms. They usually have impaired executive functioning and memory, despite having normal IQs. Learning disabilities and behavioural problems such as impulsivity and volatility are common.

Dr. Ann Streissguth's groundbreaking 1996 study of secondary disabilities associated with FASD found that 94 per cent of people with FASD experienced mental health problems. Depression and personality disorders were common among adults, while 60 per cent of children with FASD also had ADHD. The study also showed that failure in school, trouble with the law, inappropriate sexual behaviour, alcohol and other drug addiction and employment and independent living were common secondary effects of FASD. Many of the individuals in the study had been in jail. These secondary effects are often the most damaging aspect of FASD.

But there is hope. The most important protective factor the research identified in decreasing risk for these secondary effects is early diagnosis of FASD and early intervention.

Breaking the Cycle, an early intervention program for high-risk mothers in Toronto, provides comprehensive services to women who have substance use problems and who are pregnant or parenting a child up to age six. The program not only addresses addiction issues, but also provides assessment and support with an emphasis on building strong mother-child relationships.

Dr. Mary Motz, a clinical psychologist with the program, says children in the program tend to follow a more normal developmental trajectory than would be expected, given their prenatal substance exposure and post-natal environments. Her research suggests that the quality of the mother-child relationship is the key to success, and is more predictive of outcomes than either prenatal or post-natal risk factors. "That seems to be the mitigating factor, with respect to both mental health and neurodevelopmental domains," says Motz.

She adds that building a strong maternal relationship may help prevent early attachment disorders, which may be precursors to some of the secondary disorders that can have such a severe impact in adults with FASD. Early intervention also provides opportunities to address specific difficulties before they can result in frustration and school problems, and create problems later in life.

Unfortunately, children with FASD may reach adulthood without being diagnosed. FASD in adulthood is underdiagnosed, in part because the syndrome was only defined relatively recently, and also because the disability is so often invisible. Of the 450 clients assessed each year at the FASD Clinic at St. Michael's Hospital in Toronto, about one-quarter are adults. Advanced practice nurse Dr. Brenda Stade, the program's team lead, stresses the importance of diagnosis, regardless of the client's age. "It's hugely important because the person gets an understanding of themselves and why life has been so difficult," she says. "Ninety per cent of the adults we see have either past or current problems with addiction and the law."

Bonnie Buxton knows the scenario well. Her adopted daughter, Collette, was almost 18 when she was diagnosed with FASD. With a string of mental health diagnoses behind her, including learning disabilities, oppositional defiant disorder and conduct disorder, Collette had dropped out of school and was living on the street.

"Having the diagnosis changed our lives," says Buxton, whose book *Damaged Angels* chronicles Collette's story. "Since the diagnosis, at least we've all been on the same side. We know what we're dealing with."

Diagnosing FASD and assessing a client's specific disabilities is crucial to accessing services such as disability support and appropriate treatment plans for mental health and addiction problems. But even with proper diagnosis, mainstream mental health and addiction services may not fit the needs of people with FASD.

Susan Opie, a therapist in private practice in Winnipeg, Manitoba, says clients with FASD require individualized treatment. "A lot of people with FASD have severe memory impairment and difficulties with executive functioning, following goals and following up on plans," she says. "All those things have huge implications if you're providing mental health services."

Behavioural problems may exclude individuals with FASD from residential or inpatient programs, while learning and cognitive disabilities make it difficult for them to succeed in mental health and addiction programs designed for people without such disabilities,

Opie says. Many clients struggle to use mainstream mental health services because many areas of Canada have few services for adults with co-occurring FASD and mental health or substance use problems.

Gaps in mental health services can be exacerbated by gaps in supported living. Adults with FASD usually require supported housing, but are excluded from many programs intended for people with developmental disabilities, whose criteria they may not meet. Although most adults with FASD have normal IQs, their other impairments make it difficult for them to live independently. "If they also have significant mental health needs that require additional treatment and follow-up with medication or self-care, it's very difficult," says Opie.

Judy Pakozdy, a founding member of the FAS Society of Yukon who now lives in Welland, Ontario, has experienced just that type of difficulty with her 28-year-old son Matthew, who was diagnosed with FASD at birth. Matthew has not been diagnosed with depression, despite feelings of anxiety and suicidal intentions that have brought him to the emergency room. "I don't really care what the diagnosis is as long as they find him something that works," Pakozdy says, noting that Matthew's FASD symptoms of impulsiveness and volatility put him at higher risk for suicide.

Matthew teaches dance classes three times a week and works as a mentor at FASD workshops, but requires a full-time caregiver. However, he only qualifies for 19 hours of support per week. "People want to believe that because he can teach dance classes he's OK," Pakozdy says. "People don't believe FASD is as debilitating as it is."

Organizations such as the National Organization on Fetal Alcohol Syndrome in the United States are lobbying to have FASD included in the *Diagnostic and Statistical Manual of Mental Disorders*. "FASD isn't really recognized as a psychiatric disability," says Buxton, who also co-founded FASworld Canada, part of an international collaboration to raise awareness of the effects of alcohol use during pregnancy. Buxton adds that Canada has no national FASD organization to work on behalf of clients and their families. "It's something that's very badly needed," she says.

For clinicians, it's important to know that even with late diagnosis, intervention helps. "You can't change the years before," Stade says of clients who have experienced years of hardship related to undiagnosed FASD. "But we are positive that no matter what, you can still improve quality of life. It makes a difference." ■

TIPS FOR CLINICIANS

Individuals with FASD and mental health and substance use problems face challenges that may require treatment accommodations. Winnipeg therapist Susan Opie offers these suggestions:

- Treatment must address neurodevelopmental challenges, such as memory and language impairments. Identify and use the client's strengths or interests, such as music or art.
- Memory or executive function problems may make it difficult for clients to attend appointments, so it can be helpful to schedule them at the same time on the same day. Clients with FASD may require a support person to help them get to appointments.
- Clients with FASD may need longer-term supports to avoid reverting to previous behaviours.
- With children or youth, or with adults who have significant supports, it can be beneficial to set up services to include the caregiver/parent/support person, rather than treating the client in isolation. Processes should involve connecting with the parent or caregiver. In the case of adults, three-way consent can help engage the support person.
- Sensory integration issues are common but often overlooked, says Liz Lawryk, founder of the Organic Brain Injuries Triage Institute in Bragg Creek, Alberta. Extreme sensitivity to light, noise or touch can have a profound influence on addiction and treatment because sensory and physical effects can combine to make individuals with FASD constantly uncomfortable. Cognitive effects have them struggling to fit in with their peers and to get by academically. These factors combine to make people with FASD particularly vulnerable to the physical and mental relaxing effects of alcohol and other drugs.
- Occupational therapy can help clients find healthy ways to relax. Treatment can include traditional rehabilitation techniques, but can also range from weight training to therapeutic massage to using dimmer switches in order to create a more soothing environment.

SIGNS AND SYMPTOMS OF FASD

Physical
- FAS facial features, including thin upper lip and smooth philtrum (ridge between nose and lips)
- high raised palate causing speech and eating problems
- history of accidents or injuries that may stem from impulsivity
- muscle hypo- or hypertonicity

Neurological and cognitive
- poor impulse control
- sensory integration problems
- executive functioning problems
- memory problems
- learning deficits
- very high or low pain tolerance
- lack of fear response
- trouble understanding cause and effect or consequences

Psychiatric
- mood and anxiety disorders
- ADHD
- borderline personality disorder
- conduct disorder
- oppositional defiant disorder
- post-traumatic stress disorder
- attachment disorders
- addiction
- suicidality

Social and behavioural
- failure in school
- problems with the law
- inability to maintain employment
- poor relationship skills
- inappropriate sexual behaviour
- impulsive behaviour
- alcohol and other drug problems
- inability to manage affairs of daily living, including finances
- inability to live independently

Adapted from Fetal Alcohol Syndrome/Fetal Alcohol Effects Outreach Project (FASEout 2006)

From second chance to Second Cup

An extraordinary story of sobriety and success

BY ELIZABETH SCOTT

In the 1970s Frank O'Dea called the dirty downtown streets of Toronto home. That's where alcohol and abuse had led him. No one then could have imagined that this desperate man would one day co-found a multi-million dollar coffee enterprise called the Second Cup. Or that he would be awarded the Order of Canada.

O'Dea is indeed no ordinary "Joe." His story is both incredulous and inspiring, one he relates in painstaking detail in his book *When All You Have Is Hope.* He has received honorary degrees and other accolades for his international philanthropic work and is part of the Transforming Lives stigma-busting campaign led by the Centre for Addiction and Mental Health in Toronto (see p. 2 ad). After 37 years without a drink, 10 of which were spent in intensive therapy, O'Dea is a man who truly understands himself and his life: where he was, how he got there and how his choices affected his life journey.

Indeed, O'Dea is so honest in his book and in person about what society often dubs as shameful that his dramatic story and insights are at times breathtaking. That's certainly how I experienced it when we met in his office with a bird's eye view of northern Toronto. His recovery reminds even the most cynical and tired among us that the most seemingly desperate situation can be overcome.

It's been several years since O'Dea sold his interests in the Second Cup, which opened its first shop in 1975, but he now heads a green building solutions corporation with offices worldwide. His private plane is parked at a nearby airport ("I'm involved in lots of things," he says). Simple but impressive trappings of success decorate his office: A replica six-foot blue marlin (which he caught on a deep-water expedition, then released) swims high up across the wall behind his desk.

But recovery isn't easy, says O'Dea. "Lives can be turned around, but to change you must first recognize that there's value in changing, that you can be something other than an alcoholic," he says. O'Dea's turning point came in 1971, two days before Christmas on a freezing Toronto street corner. Alone in the cold, he said to himself out loud: "If I don't change I am going to die." He couldn't rationalize that life on the street, panhandling and sleeping in shelters or on park benches was working anymore: "I couldn't trade off my soul any longer," says O'Dea. "That's what I seemed to be doing." Since that moment of truth, no alcohol has crossed his lips.

O'Dea began drinking at 13 as refuge from the pain of loneliness and the trauma of sexual abuse. In the spring that same year, a woman three times his age who worked on a political campaign with his father attacked O'Dea after a party. Three other men also took advantage of Frank in the ensuing years: "At times I felt as though I were wearing an invitation on my forehead, a sign visible to sexual predators that said 'Attack me!'," writes O'Dea in his book.

The sexual abuse and subsequent abandonment by his father – when O'Dea tried to tell him what had happened with one of the men, someone his father knew – added to his heart-wrenching emotional pain, which alcohol soothed. But the desire for alcohol spiraled out of control: "If you're an alcoholic, once you start, you can't stop," says O'Dea. "Until you either pass out or run out of money or run out of resources. It just becomes an obsession to drink more and more and more. "It's what I need now. It's my way, nobody else's."

In his recovery today, O'Dea owns complete responsibility for his addiction and for where alcohol led him: to about 17 accidents involving drinking under the influence – some of which were very serious – and, ultimately, to his father's request that O'Dea leave home "for the good of the family." Yet there isn't a hint of blame in O'Dea's demeanour, only gratitude for the help he got that cold December day when he turned his back to the street and made a phone call: "Very early on, the self-help group showed me by the example of others that I could be sober and happy," recalls O'Dea. "I developed a vision of myself as someone happy. And vision is everything."

> *"Lives can be turned around, but to change you must first recognize that there's value in changing, that you can be something other than an alcoholic."*

So how can health care providers help those struggling with alcohol problems to find a new vision of themselves? They can stay focused on supporting the person and they need the patience of Job, says Frank. "Some will get it. Some won't. Most won't. Don't worry. That isn't your job. You cannot live for somebody else."

As for Frank, he stays focused on delivering a message of hope, having now accepted the reality of his past: "I would never have been able to talk about my story if I hadn't spent so much time in therapy," he says. "I still bear the effects of sexual abuse and always will, and there's nothing that will stop that. That's OK. That's life. Do I cope well with it? I guess I do. My life is OK, but you're never free of it."

To counter those effects, Frank contributes to a variety of causes: "The beauty of philanthropy is, when I sit in my chair at home late at night, before I go to bed, sometimes I wonder about my life and I think I made a difference." Now that's a life worth hearing about over a second cup. ■

Working while recovering

When the personal becomes professional

BY MICHAEL DEAN

As an addiction professional, early in my career, I'd regularly meet clients in my office. But the meetings didn't stop there. I'd also meet those clients at AA. You see, that's where I went to support my own recovery.

I refer to the pinnacle moment on January 15, 1982, when my recovery from alcoholism began, as having "my faced caressed by the hand of God." That's how I described it to my care providers in the withdrawal management facility the morning after it occurred. Nine days later, I told the director of the facility, "I know what I want to do with the rest of my life – I want to do your work." If I could help others have an experience similar to mine, all the wreckage of my past would somehow be less awful, less harmful, perhaps even forgiven. My journey to becoming a "professional" in the field of addictions began at that moment.

I had several mentors who were wiser than me in the ways of the world of recovery and professional work. They were unanimous on one point: My reasons for wanting to do the work would need to be more than my personal experience, because my experience would limit what I had to offer. As profound as the experience was, it was only one person's experience, and the world of recovery is larger than that.

In order to learn I had to separate my personal experience from the actual work. My experience could only be a foundation for the work; it could not be the entire structure. So I expanded my perspective by getting as much information and training as I could. I also listened to those working in the field but not in their own recovery. Their perspectives and the other teachings I was absorbing contributed to what I call my eclectic philosophy of wellness: It doesn't really matter how someone starts a journey of wellness that may lead to recovery – what is most important is to support them in their efforts.

I have now worked in the substance abuse field for more than 25 years. I believe I have helped many individuals start the first steps in their journey to wellness. I have also been fortunate to mentor other professionals in this work. This role has challenged me to reflect on my own experience and grow from it so I can help others avoid pitfalls. Over the years, I have developed some guiding principles for new professionals – whether in their own recovery or not.

1. If you are engaged in your own recovery process and work with clients who are also in recovery, find a way to practice your recovery outside the workplace. Going to work to apply your own learning about yourself can lead to disaster. Remember, you are learning these insights for your own recovery, not that of others. Your clients will learn their own insights with your guidance, not your experience. Not everyone will have their "face caressed by the hand of God." Your values are your values; you cannot force your clients to adopt them. You can lead by example and support clients in their decisions. A therapeutic alliance between the care provider and the client is best founded on clinical skills and client motivation, not on personal attributes.

2. If you attend 12-step meetings, find meetings that your early recovery clients do not attend. This can be a challenge, but it is doable. Clients in early recovery have good intentions of respecting anonymity, but it is difficult to practice in all our affairs when new to recovery. Also, freedom of therapeutic expression is limited when the client feels what he or she is saying may not be entirely confidential. In our work, we must adhere to ethical and professional boundaries that foster a healthy opportunity for role modelling, but that prevent the entanglement of personal time and client recovery. Be a support to recovery, not a part of it.

3. If you are neither in recovery yourself, nor trained in substance abuse issues, but work intermittently with clients with such issues, obtain a broad understanding of "where the client is at." Listening with an empathetic ear can be the catalyst for positive change. Develop this understanding by attending open 12-step meetings, which welcome anyone, or attend Al-Anon, a 12-step program for people living with alcoholics. "Addictions 101" courses can also enhance your knowledge and skills.

4. Everyone who works with substance abuse clients needs clinical supervision. This is crucial to understanding vicarious trauma and counter transference and is an opportunity to learn about your own process and gain new skills. An effective clinical supervisor is not a "12-step sponsor"; it is someone who knows your work and the accountability framework within which you work, and who has the skills to listen, reflect and direct you to new ways of thinking and working.

5. Be careful about disclosing your own recovery. Many new addiction professionals ask: "What do I say if a client asks whether I'm in recovery?" I learned early on that disclosing your own recovery is rarely helpful. It can be divisive and can limit the support clients get. As a result of my disclosure, some clients wanted to work only with me, not other team members, because I understood "where they were coming from." My answer now is: "Whether or not I'm in recovery won't affect the quality of care you receive, but it could affect our working alliance, so let's just assume I know what I need to know to help you and let's start to work." ■

Michael Dean is manager of Addiction Services at St. Joseph's Health Centre in Toronto.

Confronting the negative spirit

Does harm reduction have a place in Aboriginal communities?

BY ANNE PTASZNIK

"A SPIRITUAL AWAKENING IS WHEN YOU START SEEING THE good in yourself without any mood- or mind-altering chemicals," says Joyce Paul, an elder and executive director of the Rising Sun Rehabilitation Centre, a treatment centre serving First Nations people in Eel Ground, New Brunswick. "It's a gift to be alive. It doesn't enhance your life, your ability to be a better parent, son or daughter by being on anything."

Paul, who has herself been sober for 25 years, believes that abstinence is the only option. She sees no room for harm reduction with alcohol, given the Medicine Wheel teachings that focus on physical, emotional and spiritual well-being, and that see alcohol as a negative spirit that disrupts the body's natural balance.

The debate around harm reduction, a concept started in Western society, has a long history, but nowhere perhaps is it more heated than among Canada's Aboriginal communities, particularly when it comes to alcohol, which has a unique role in Aboriginal history.

Alcohol was introduced to Aboriginal communities at the same time that colonization was eroding their traditional way of life. "People have been robbed of their culture, their values, traditions, language, parenting, that sense of belonging, and don't know who they are," says Paul. "When they pick up that first drink, it becomes a key."

Like Paul, many Aboriginal treatment programs and communities today adopt models of abstinence and prohibition for clear reasons: the destructive impact of the introduction of alcohol on the lives of Aboriginal peoples and the devastating level of alcohol and other drug abuse in some communities, says Colleen Anne Dell, Research Chair in Substance Abuse at the University of Saskatchewan. Most treatment centres established in the 1970s by Canada's National Native Alcohol and Drug Abuse Program adopted an abstinence-based medical model because that was the norm.

But abstinence and harm reduction are not the black-and-white issue some make it out to be. To begin, there is much divergence of experience among Aboriginal communities in Canada – the First Nations, Inuit, the Aboriginal people of Arctic Canada, the Métis, people of mixed First Nations and European ancestry. Susan Manitowabi, a professor at the School of Native Human Services at Laurentian University in Sudbury, Ontario, says that people's perspectives on alcohol vary, depending on their degree of assimilation and how affected they were by colonization.

Dell agrees, adding that not all harm reduction measures apply to all Aboriginal peoples and communities. Some argue that alcohol and other drugs are incompatible with their values and traditions, whereas others view it as "making sure that people live with the least harm in their life." Some Aboriginal treatment centres provide harm reduction programs, such as needle exchanges, but take an abstinence approach when it comes to alcohol. Ultimately, says Dell, developing effective policies and programs must be directed by communities themselves.

A big step forward is the work of the National Native Addictions Partnership Foundation in Muskoday, Saskatchewan, which is currently developing a harm reduction position paper. Sharon Clarke, executive director of the organization, which represents Aboriginal addiction treatment services across Canada, sees harm reduction and abstinence as complementary rather than opposing philosophies and hopes the document will reconcile them with Aboriginal worldviews. While their ultimate goal remains abstinence, Clarke sees harm reduction as part of a continuum of care from prevention to awareness to abstinence, based on the principles and values of "strong families, interconnectedness among ourselves, compassion and respect, trust and honesty."

Manitowabi supports this approach. She says that sometimes people are excluded from cultural events like pow-wows if they use alcohol because it is considered a negative spirit. She advocates a gentler approach, allowing people into events but asking them to leave the substances behind. "Sometimes people are looking for an answer, a way to heal themselves," she says. "If you close the door on them you never have that opportunity."

In the 1990s, Manitowabi helped to develop an alcohol management policy on the Wikwemikong Unceded Indian Reserve in northern Ontario. The policy outlined where and when alcohol could be served, among other requirements, such as prohibiting last call at events. Evaluations found that community attitudes towards the policy became increasingly positive over time and that violence, vandalism and drinking in public areas decreased. "When you promote abstinence the problems go underground," says Manitowabi. "If you have good controls in place, people don't go underground; they are still enjoying alcohol, but in a controlled manner."

Dell stresses the need for responses to be community driven and culturally appropriate. She cites the Mamisarvik Healing Centre, an Inuit-specific residential substance abuse program in Ottawa, which offers clients the choice of stopping or reducing their substance use. The Alkali Lake reserve in British Columbia has taken a harm reduction approach to its ban on alcohol. Heavy drinkers received food vouchers instead of social assistance funds and users were rarely exiled. The Western Aboriginal Harm Reduction Society in Vancouver runs an alcohol maintenance program where homeless people with mental health issues receive small amounts of alcohol to divert them from more harmful substances. Dell says that in Aboriginal communities, where the individual and community are integrally tied, harm reduction is not just about the individual's choice; it is linked to the broader community.

Ultimately, Dell says that reducing harm requires dealing "with the underlying factors that lead to problematic alcohol use by improving social, health, political, and economic well-being and poverty." Only then will that cherished balance truly be restored. ■

For more information: *Harm Reduction Policies and Programs for Persons of Aboriginal Descent*. Visit the Canadian Centre for Substance Abuse web site at www.ccsa.ca and do a keyword search.

Common questions about alcohol and mental health problems

BY AVRIL ROBERTS

This Q&A draws on published research and interviews with clinicians to examine challenges for diagnosis, treatment and recovery related to co-occurring alcohol use and mental health problems.

What is the prevalence of co-occurring alcohol dependence and mental health disorders?

Research suggests that the prevalence of alcohol use problems among people with mental health problems is about twice that of people with no mental health problems. Of those with mental health problems, men are more than twice as likely as women to report alcohol use problems. The most common mental health problems to co-occur with alcohol use problems are anxiety disorders, particularly generalized anxiety disorder and post-traumatic stress disorder; mood disorders, particularly major depression and bipolar disorder; schizophrenia; and personality disorders. Alcohol use and mental illness each increase suicide risk, but together, they increase the risk substantially, particularly for people with major depression.

Is there a causal link between mental health problems and alcohol use problems?

The relationship between alcohol use problems and mental health problems is complex. Many scenarios are possible: First, the psychiatric disorder may result in an alcohol problem; for example, a person with depression may self-medicate with alcohol. Second, the psychiatric disorder (or its symptoms) may occur as a consequence of alcohol use; for example, a person may experience alcohol-induced hallucinations that persist after abstinence. Third, the alcohol use problems and mental health problems may develop simultaneously and follow a similar course; for example, hallucinations associated with schizophrenia may increase with alcohol use but may disappear or lessen with abstinence. It is also possible that neither disorder causes the other, but that the two have become linked over time, such that they become an integrated system and each alters the trajectory of the other. Finally, the problems may simply co-occur and co-exist with no interrelationship; for example, a person with depression and alcohol dependence may experience no relief of depression symptoms during prolonged abstinence. Whatever the nature of the relationship, alcohol use may exacerbate some mental health conditions, for example, bipolar disorder, and may make them more difficult to treat.

How difficult is it to diagnose co-occurring mental health and alcohol use problems?

Proper screening is key, says Carol Edwards, an advanced practice nurse in the Addictions Program at the Centre for Addiction and Mental Health (CAMH) in Toronto: "It is important to screen mental health clients for alcohol misuse because the combination is so prevalent. Also, be alert to the possibility that mental health problems can exist with alcohol dependence."

Diagnosis is complicated by the fact that the signs and symptoms

of alcohol dependence and alcohol withdrawal can mimic psychiatric disorders. Depressive symptoms and mood instability are common in people who use alcohol and other alcohol, so those people may often be misdiagnosed or diagnosed too early with a mood disorder, when in fact their mood symptoms are being driven by their use of alcohol or other drugs. Clinicians advise that when it is questionable whether an individual has a mood disorder, it is important to observe them over a period of abstinence to get a better sense of whether the mood disorder is separate from the substance use or whether it is driven by it.

Are drinking patterns related to specific mental health problems?

Conventional wisdom suggests that people with social anxiety may initially use social drinking as a coping mechanism, and then find the alcohol use spiraling into alcohol dependence. However, the opposite can also be true. U.S. researchers have found that both long-term alcohol misuse and alcohol withdrawal can significantly increase anxiety levels. As well, having an anxiety disorder increases the risk for drinking relapse after alcohol treatment. A 2007 Canadian study that examined associations between depression and alcohol consumption in men and women found that binge drinking was strongly related to major clinical depression, particularly in women.

Do co-occurring problems complicate treatment?

Symptoms can interfere with the person's ability to participate in a treatment program or type of program. For example, a person who is psychotic and experiencing perceptual disturbances on an ongoing basis will not do well in a residential addiction treatment facility. Similarly, a person with social anxiety may be ill-suited to living in a dormitory-type environment with communal dining.

Treatment for individuals who use alcohol to self-medicate may be challenging. For example, women who have experienced trauma such as sexual abuse may use alcohol to escape the emotional and psychological consequences. During treatment for the alcohol use problem, either the trauma recovery work or becoming sober can trigger the trauma symptoms they were trying to cope with through

alcohol. With the alcohol coping mechanism gone, women often experience an increase in trauma symptoms, which, in turn, jeopardizes their abstinence.

What is the best treatment approach for co-occurring mental health and alcohol use problems?

Historically, the problem has been that many alcohol treatment programs exclude people with mental health problems and that mental health programs refuse treatment to people with active alcohol use. Persisting differences in treatment philosophy may hinder access to appropriate treatment and supports. For example, some 12-step addiction recovery programs may be wary of people taking required medications for their mental health problem because they are drugs. Some mental health programs require abstinence and do not recognize that relapse is common during recovery.

A lack of integrated services in addiction and mental health means that many people living with co-occurring mental health and alcohol use problems, as well as other substance use problems, receive inadequate and uncoordinated care, bounce between the substance use and mental health systems, have high rates of emergency department visits and hospitalizations and have poorer treatment compliance and outcomes. However, comprehensive, co-ordinated and integrated treatment that uses evidence-based approaches can improve outcomes for individuals with concurrent disorders. Early identification and treatment allow services to provide prompt assessment, treatment and support and potentially reduce the duration of untreated illness. If a person has schizophrenia and an alcohol use problem, the mental health disorder requires medication treatment and ongoing supportive therapy and the alcohol use problem may be treated using substance use management principles, such as behavioural management.

Are there any medications used for alcohol problems or mental health problems that can be used to treat both problems?

The current options for the pharmacological treatment of alcohol dependence are naltrexone, acamprosate and disulfiram (see pp. 8–9). There are currently very limited options for medications that are helpful for both mental health and alcohol use problems. Despite the high rates of concurrent disorders, very few controlled treatment studies have been conducted in people with co-existing alcohol dependence and psychiatric disorders. There is some data suggesting a modest benefit with antidepressant medication for the treatment of depression and alcohol dependence, however, it is recommended that treatment for depression be combined with alcohol-specific interventions. Many clinicians agree that medication should not be the mainstay of treatment for a person with alcohol dependence but that it should be used in conjunction with psychosocial rehabilitation.

Other medications used in the treatment of mental health disorders (e.g., topiramate, carbamazepine, valproate) are being studied for the treatment of alcohol dependence. The most promising evidence to date is for topiramate, although the studies have included only people with alcohol dependence.

Has the rise in treatments for concurrent disorders increased the risk of negative drug interactions? If so, how can clinicians avoid such problems?

Although the potential for interactions between medications used in the treatment of mental health disorders is significant, the reality is that often more than one medication is needed. Often these combinations can be managed by carefully evaluating and adjusting each medication. Fortunately, the medications currently used in the treatment of alcohol dependence, particularly acamprosate, are associated with fewer interactions. Clinicians should always check for the possibility of interactions whenever a new medication is added to a pharmacotherapy regimen. Pharmacists are a great resource to help with this. It is also important to consider the potential for drug interactions with alcohol among clients with mental health problems. This risk varies depending on the mental health medication. It is important for clinicians to discuss the level of risk with clients. If clients are simply told that they should not drink while taking the medication, they may choose to stop the medication instead.

Sources: *Best Practices: Concurrent Mental Health and Substance Use Disorders,* Health Canada, 2002; Beth Sproule, advanced practice pharmacist, Centre for Addiction and Mental Health (CAMH), Toronto; Carol Edwards, advanced practice nurse, Addictions Program, CAMH; "Comorbidity of alcoholism and psychiatric disorders: An overview," *Alcohol Research and Health,* 2002; "Follow-up study of anxiety disorder and alcohol dependence in comorbid alcoholism treatment patients," *Alcoholism: Clinical and Experimental Research*, 2005; Dr. Paul Casola, consulting psychiatrist, Salvation Army Harbour Light Centre, Toronto; "Prevalence of Co-occurring Substance Use and Other Mental Disorders in the Canadian Population," *Canadian Journal of Psychiatry*, 2008; "Use of health care services by patients with co-occurring severe mental illness and substance use disorders," *Mental Health and Substance Use: Dual Diagnosis*, 2008.

DO YOU HAVE THE KNOW-HOW TO HELP CLIENTS WITH CO-OCCURRING DISORDERS?

Basic skills

- ability to accurately screen and assess for major mental illnesses
- ability to accurately screen and assess for substance use disorders
- familiarity with motivational interviewing and other client engagement tools
- knowledge of how to access both mental health and substance use systems
- familiarity with local resources and referral sources, especially those with specialized programs for individuals with co-occurring disorders

Advanced skills

- knowledge and experience with the substance use/addiction recovery process, including the disease concept and the 12-step model
- familiarity with substance intoxication and withdrawal symptoms and the detoxification process
- knowledge of stages of change and models of recovery ability to conduct a mental status examination, including risk assessments
- ability to develop differential diagnoses, and familiarity with criteria and terminology in the *Diagnostic and Statistical Manual of Mental Disorders*
- ability to use cognitive-behavioural therapy concepts and techniques
- familiarity with psychotropic medications and psychopharmacological management of mental illness and addiction
- access to ongoing clinical supervision by experienced and qualified clinicians
- attitudinal and philosophical support for the special needs of clients with co-occurring disorders

Adapted from "Double trouble: Helping clients with co-occurring disorders," by John K. Smith, *Social Work Today*, 2007, v. 7:3.

Conceiving risk, bearing responsibility: FASD as social construction

Sociologist Elizabeth Armstrong has written a provocative book. *Conceiving Risk, Bearing Responsibility: Fetal Alcohol Syndrome and the Diagnosis of Moral Disorder* offers a compelling and important critique of how complex health-related problems such as fetal alcohol syndrome become medicalized. It also challenges questionable prevention guidelines that stigmatize women and ignore the social and structural determinants of women's drinking. In the book, originally published in 2003, Armstrong builds this critique by analyzing historical medical literature, drawing insight from in-depth interviews with doctors and evaluating U.S. epidemiological data.

Conceiving risk. In a very readable way, Armstrong traces the history of the construction of alcohol's effects on fetal development, from the 19th-century debates on heredity and eugenics, through its construction during prohibition, to modern individualized, medicalized conceptions. All along, she illustrates how this has not been a progressive, cumulative evolution of medical knowledge, but one very much influenced by sociocultural forces and historical context, including moral preoccupations and concerns about women's societal roles. Today we recognize alcohol as a teratogen; yet we still do not have answers on the exact relationship between fetal development, alcohol use and a wide range of determinants of pregnant women's health, such as malnutrition and social and environmental stressors. Exaggeration of risk still often characterizes our prevention responses, and health and morality become so intertwined in these responses that pregnant women who have even a single drink are still considered to be at risk and face reproach.

Bearing responsibility. In Canada we are making significant strides in increasing fetal alcohol spectrum disorder (FASD) diagnostic capacity to ground our understanding of risk and prevalence. Yet this initiative is beset with the concerns identified by Armstrong and current women's health researchers of reinforcing a false maternal/fetal conflict of interest and decontextualizing women's alcohol use pre-, during and post-pregnancy. Diagnosis is done in the child health system without linkage to the health needs of birth mothers, who most commonly have lost custody by the time children are of an age to be diagnosed. We continue to ignore how issues of poverty, violence, isolation and fear of losing custody can characterize women's lives and interact with alcohol use to create adverse outcomes for mothers and their children. Women of childbearing years with alcohol problems, pregnant women who drink and birth mothers of children with FASD continue to face opprobrium, while comprehensive, welcoming, respectful health care is lacking and structural inequities go unaddressed.

The diagnosis of moral disorder. Armstrong poses important questions regarding our approach to maternal drinking: How do we construct the risk of alcohol use in pregnancy and justify our warnings to women? Why do we continue to characterize people with alcohol/substance use problems as lacking self-control and expect cessation of use, all the while ignoring the roots of these problems? How does the medical model serve to enforce social control? How can we make our policy responses more grounded in evidence and less punitive? And in Armstrong's words, "How might we close the gap between the uncertainty of our medical knowledge about the relationship between alcohol and reproduction and the need to take action at a societal level to prevent adverse birth outcomes?" (p. 219). Armstrong's fascinating critique needs to be widely considered, discussed and acted upon.

Conceiving Risk, Bearing Responsibility: Fetal Alcohol Syndrome and the Diagnosis of Moral Disorder. Elizabeth Armstrong. Johns Hopkins University Press, Baltimore, 2008, 296 pp., $25US.

Nancy Poole is a research associate with the British Columbia Centre of Excellence for Women's Health.

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SHEILA LACROIX

Youth and Alcohol

Binge drinking: Extent of the problem

Binge drinking by teens and young adults is a concern. To find out the extent of the problem in your region, visit the Canadian Centre on Substance Abuse web site (www.ccsa.ca), which offers various reports on its Statistics pages. Select "Statistics" from the main menu and follow links to student surveys from across Canada.

The National Institute on Alcohol Abuse and Alcoholism (www.niaaa.nih.gov) has two resources about young people's drinking. See Alcohol Alert no. 59 – *Underage Drinking: A Major Public Health Challenge*, for a referenced research summary that covers key issues. Also see the NIAAA journal, *Alcohol Research and Health,* vol. 28:4, 2004/05, Focus on Young Adult Drinking. Some articles focus on risks and other factors in the adolescent years. The article "Alcohol and the Adolescent Brain" covers a topic that is difficult to research.

The Centre for Addiction Research of British Columbia (www.carbc.ca) offers the *Alcohol Reality Check,* an online resource for screening, raising awareness and intervening in risky drinking. The Youth Package includes low-risk drinking recommendations for youth; the 7-question Risky Drinking Checkup, scoring aid and screening guide and a take-home results form, which summarizes the checkup results and offers recommendations and local resources. To locate, use the search engine on the CARBC site.

The Centre for Addiction and Mental Health (www.camh.net) provides full access to *First Contact: Brief Treatment for Young Substance Users,* which is a component of the larger package, Youth Drugs and Mental Health. This resource provides a brief, first-step intervention for youth, aged 14–25, who misuse alcohol and/or other drugs. It provides motivational interviewing and cognitive-behavioural and harm reduction approaches. The resource was developed for group settings but can be used in individual counselling.

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Message in a bottle: Wet shelters embody true harm reduction approach

DR. TOMISLAV SVOBODA

In the winter of 1996, Eugene Upper, Kompani Mirsalah-Aldin and Irwin Hardy froze to death on three separate nights in the streets of Toronto. A coalition of poverty and housing activists led by street nurse Cathy Crowe and human rights lawyer Peter Rosenthal advocated for an inquest. A coroner's inquest determined that in addition to homelessness, uncontrolled heavy alcohol use and severe mental illness were implicated in the deaths. The jury recommended that a 24-hour in-shelter harm reduction program including in-shelter provision of alcohol be implemented in the shelter system. A 12-hour municipally run shelter was designated as the program site. Front-line staff led by Arthur Manuel developed the Annex Harm Reduction Program within this shelter, which included an in-shelter drinking program despite senior administration statements that such a program was neither necessary nor feasible.

The program aimed to provide shelter for homeless men who avoided shelters or who were repeatedly barred from other shelters due to difficult behaviours related to alcohol use, severe mental illness and other factors. From the front-line perspective, these were individuals who were not being helped by numerous hospitalizations, incarcerations, court appearances and police pickups.

Annex staff adopted a harm reduction approach in the strict sense, supporting clients in their use of alcohol in a variety of ways, including serving alcohol as part of a managed alcohol program and storing alcohol for clients, building staff-client relationships and accepting difficult behaviours in a supportive shelter environment.

Two shelter-based programs in Canada have now adopted the Annex model. These managed alcohol programs in Ottawa and Hamilton, Ontario, serve alcohol up to 11 hourly drinks a day as an alternative to drinking beverage and non-beverage alcohol on the street. The drinking programs are part of more comprehensive programs that include multidisciplinary health care, social work, shelter, meals and other supports.

Despite being embraced by front-line advocates as providing ongoing benefits to clients, shelter-managed alcohol programs continue to be highly controversial and are subject to ongoing criticism by community leaders and commentators. During a recent Toronto City Council budget review, Annex staff were questioned about providing alcohol and cigarettes to clients. In 2004, city council had requested that staff report back on harm reduction alternatives to providing alcohol to shelter clients.

Although numerous studies have evaluated harm reduction as an approach to assist homeless opiate-dependent individuals, there has been little discussion in the medical or addiction literature about this approach for those pejoratively called "skid row alcoholics." The plight of the homeless sub-population these programs serve, although well known, is not well described in the scientific literature, making this population more vulnerable to misconceptions in public and professional debates. Front-line service providers recognize them as "frequent flyers"; they have been called "million-dollar men," reflecting their intense use of emergency rooms, ambulances, prisons and other services that do not address their underlying problems.

Various interrelated moral and empirical imperatives motivate the shelter-based managed-alcohol programs, including removing class-based application of law; not denying services because of alcohol use; reducing harms by removing clients from dangerous environments and providing services otherwise not available; and applying interventions appropriate to the stages of change. In our society, if you are poor and without a home it is illegal to drink; but if you have financial means and a home you can drink as much as you want. Without shelter-based managed-alcohol programs, a poor person without a home is subjected to a state of prohibition; drinking is forbidden in parks, shelters or hospitals. A person will be denied access to emergency shelter, hospital care and other social services if he or she wishes to drink while using these services.

Good data suggest that applying action- or maintenance-oriented approaches to those who are in pre-contemplation will fail; yet these misapplied approaches underlie policies that link shelter, hospital and financial assistance care to successful abstinence. The managed-alcohol shelter programs have been described as "safe drinking sites," leveraging empirical understanding from the heavily studied "safe injection sites" that are increasingly showing benefit over abstinence-based approaches.

With the expectation that the first three imperatives and argument by analogy would not be sufficient to dissuade unfair bias against these programs, studies were conducted to determine whether managed-alcohol programs provide greater benefit than the usual abstinence-based care. A preliminary study conducted by Joyce Burnstein at Toronto Public Health suggested that deaths among clients who stayed at Seaton House, Toronto's largest shelter for men where the Annex program resides, dropped after starting the program. Three peer-reviewed studies have shown benefits from managed-alcohol–type programs: Thornquist and colleagues in *Academic Emergency Medicine* in 2002; Podymow and colleagues in the *Canadian Medical Association Journal* in 2006; and a 2006 University of Toronto PhD dissertation on the Annex program all found large drops in emergency room visits, detox unit visits and police interactions and incarcerations and increased time spent in shelter out of harm's way for those enrolled in managed-alcohol programs.

Many questions remain unanswered, and managed drinking programs continue to be controversial. For now, in the minds of many front-line care providers and hardened alcohol-dependent individuals, these programs are a better alternative to a life filled with mouthwash, rubbing alcohol, street assaults and blackouts, ambulance pickups and incarcerations.

Dr. Tomislav Svoboda helped to develop the Annex program. He is a community medicine specialist and clinical director at Seaton House and an associate scientist at the Centre for Research on Inner City Health at St. Michael's Hospital in Toronto.

CANADA

Western Canadian Youth and Family Addictions Conference
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e-mail info@asap-bc.org
www.asap-bc.org

Alberta FASD Conference: "Promising Practices, Promising Futures"
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e-mail Amanda.Amyotte@gov.ab.ca
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Growing Home: 2nd National Conference on Housing and Homelessness in Canada
February 18–20, Calgary, Alberta
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tel 403 220-2459
fax 403 282-7269
e-mail nhc2009@ucalgary.ca
www.nhc2009.ca

Ontario Harm Reduction Distribution Program Provincial Harm Reduction Conference
February 22–24, Toronto, Ontario
toll-free tel 1 866 316-2217
e-mail cathyc@ohrdp.ca
www.ohrdp.ca/conference-2009.html

Expanding Our Horizons: "Moving Mental Health and Wellness Promotion into the Mainstream" International Conference
March 4–6, Toronto, Ontario
Contact: Clifford Beers Foundation, 5 Castle Way, Stafford, ST16 1BS, United Kingdom
e-mail michael_murray@charity.demon.co.uk
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3rd International Conference on Fetal Alcohol Spectrum Disorder
March 11–14, Victoria, British Columbia
Contact: University of British Columbia, Interprofessional Continuing Education, 2194 Health Sciences Mall, Rm. 105, Vancouver, BC V6T 1Z3
toll-free tel 1 877 328-7744
fax 604 822-4835
e-mail ipcdereg@interchange.ubc.ca
www.interprofessional.ubc.ca/FASD09.htm

Society of Behavioral Medicine 30th Annual Meeting
April 22–25, Montreal, Quebec
Contact: Society of Behavioral Medicine, 555 East Wells St., Ste. 1100, Milwaukee, WI 53202-3823
tel 414 918-3156
fax 414 276-3349
e-mail info@sbm.org
www.sbm.org/meeting/2009/

Embracing the Future of Addictions Treatment: An International Conference on Addictions and Mental Health
April 23–24, Toronto, Ontario
Contact: Salvation Army Toronto Harbour Light
tel 416 321-3910, ext. 283
e-mail tlscott@harbourlight.org

31st Annual Substance Abuse Librarians and Information Specialists Conference
May 5–8, Halifax, Nova Scotia
Contact: SALIS, P.O. Box 9513, Berkeley, CA 94709-0513 USA
tel 902 424-7214
e-mail Ruth.Hart@gov.ns.ca
http://salis.org/conference/conference.html

2nd Annual Canadian Network for Innovation in Education International Conference 2009
May 10–13, Ottawa, Ontario
Contact: Crystal Mohr, Canadian Healthcare Association, 17 York St., Ottawa, ON K1N 9J6
tel 613 241-8005, ext. 226
fax 613 241-5055
e-mail cmohr@cha.ca
www.cha.ca

Risky Business: From Prevention to Advanced Trauma Care
May 14–15, Montreal, Quebec
Contact: Christianne Levesque-Quintal or Josee Maurice, McGill University Health Centre, Trauma Program, 1650 Cedar Ave., Montreal, QC H3G 1A4
tel 514 934-1934, ext. 44412 or 48420
fax 514 934-8215
e-mail trauma.program@muhc.mcgill.ca
www.medicine.mcgill.ca/traumaprogram/

10th National Conference on Collaborative Mental Health Care
May 28–30, Hamilton, Ontario
tel 905 667-4861
e-mail sari.acherman@hamiltonfht.ca
www.shared-care.ca

Canadian Psychological Association Annual Convention
June 11–13, Montreal, Quebec
Contact: CPA, 141 Laurier Ave. W., Ste. 702, Ottawa, ON K1P 5J3
tel 613 237-2144, ext. 323
toll free 1 888 472-0657
fax 613 237-1674
e-mail convention@cpa.ca
www.cpa.ca/convention/

50th Annual Institute on Addiction Studies
July 12–16, Barrie, Ontario
Contact: Addiction Studies Forum, Box 322, Virgil, ON L0S 1T0
toll-free tel 1 866 278-3568
toll-free fax 1 888 898-8033
e-mail info@addictionstudies.ca
www.addictionstudies.ca

117th Annual Convention of the American Psychological Association
August 6–9, Toronto, Ontario
Contact: APA, 750 First Street, N.E., Washington, DC 20002-4242
tel 202-336-5500
e-mail convention@apa.org
www.apa.org/convention09/

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

Annual Meeting of the International Society of Addiction Medicine
September 23–27, Calgary, Alberta
e-mail office@isamweb.com
www.isamweb.org

UNITED STATES

International Neuropsychological Society Annual Conference
February 11–14, Atlanta, Georgia
Contact: International Neuropsychological Society, 700 Ackerman Rd., Ste. 625, Columbus, OH 43202
tel 614 263-4200
fax 614 263-4366
www.the-ins.org/meetings

American Association for Geriatric Psychiatry 2009 Annual Meeting
March 5–8, 2009, Honolulu, Hawaii
Contact: AAGP, 7910 Woodmont Ave., Ste. 1050, Bethesda, MD 20814
tel 301 654-7850, ext.111
e-mail meetinginfo@AAGPonline.org
www.aagpmeeting.org

110th Annual Meeting of the American Society for Clinical Pharmacology and Therapeutics
March 18–21, National Harbor, Maryland
Contact: ASCPT, 528 North Washington St., Alexandria, VA 22314
tel 703 836-6981
fax 703 836-5223
e-mail meetings@ascpt.org
www.ascpt.org/annualmeeting2009/index.cfm

6th International Conference on Positive Behavior Support
March 26–28, Jacksonville, Florida
Contact: Association for Positive Behavior Support, P.O Box 328, Bloomsburg, PA 17815
tel 813 974-8295
e-mail ialvarez@fmhi.usf.edu
www.apbs.org/conference/jacksonville/index1.aspx

Society for Research in Child Development Biennial Meeting
April 2–4, Denver, Colorado
Contact: Society for Research in Child Development, 2950 S. State St., Ste. 401, Ann Arbor, MI 48104
tel 734 926-0600
fax 734 926-0601
e-mail info@srcd.org
www.srcd.org

Society for Social Work Leadership in Health Care 44th Annual Conference
April 22–25, New Orleans, Louisiana
Contact: SSWLHC, 100 N. 20th St,, 4th fl., Philadelphia, PA 19103
toll-free tel 1 866 237-9542
e-mail lgroff@fernley.com
www.sswlhc.org/html/conference.php

2009 Conference of the European Opiate Addiction Treatment Association and the American Association for the Treatment of Opioid Dependence
April 25–29, New York City, New York
www.europad.org

15th Annual Mayo Clinic Nicotine Dependence Conference: "A Focus on Mental Illness and Substance Abuse"
April 28–30, Rochester, Minnesota
e-mail cme@mayo.edu
www.mayo.edu/pmts/mc8000-mc8099/mc8000-60.pdf

American Society of Addiction Medicine 40th Annual Conference
April 30–May 3, New Orleans, Louisiana
Contact: ASAM, 4601 N. Park Ave., Upper Arcade, Ste. 101, Chevy Chase, MD 20815
tel 301 656-3920
fax 301 656-3815
e-mail@asam.org
www.asam.org/AnnualMeeting.html

2009 National Association of Addiction Treatment Providers Annual Addiction Treatment Leadership Conference
May 16–19, West Palm Beach, Florida
Contact: NAATP, 313 W. Liberty St., Ste.129, Lancaster, PA 17603-2748
tel 717 392-8480
fax 717 392-8481
e-mail rhunsicker@naatp.org
www.naatp.org/conferences/annualconference.php

American Psychiatric Association 162nd Annual Meeting
May 16–21, San Francisco, California
Contact: APA, Office to Coordinate Annual Meetings, 1400 K St., N.W., Washington, DC 20005
toll-free tel 888 357-7924
fax 202 789-8882
e-mail apa@psych.org
www.psych.org

Association for Psychological Science 21st Annual Convention
May 21–24, San Francisco, California
Contact: APS, 1133 15th St. N.W., Ste. 1000, Washington, DC 20005
tel 202 293-9300
fax 202 293-9350
www.psychologicalscience.org/convention

International Child and Youth Care Conference
May 26–29, Fort Lauderdale, Florida
Contact: Juan Carlos Sánchez, conference manager, P.O. Box 11858, Fort Lauderdale FL 33339
tel 954 397-2830
fax 954 366-1540
e-mail jsanchez@icycc2009.com
www.icycc2009.com

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 ebgeller@temple.edu
www.cpdd.vcu.edu/

ABROAD

3rd Annual Conference of the International Society for the Study of Drug Policy
March 2–3, Vienna, Austria
fax 61 2 9385 0222
e-mail Alison.ritter@unsw.edu.au
www.issdp.org

14th World Conference on Tobacco OR Health
March 8–12, Mumbai, India
Contact: Salaam Bombay Foundation, 46, Maker Chambers III, Nariman Point, Mumbai
tel 022 645 23 837
e-mail secretariat@14wctoh.org
www.14wctoh.org/contact.asp

World Psychiatric Association International Congress
April 1–4, Florence, Italy
Contact: Newtours S.p.A., Via Augusto Righi 8, 50019 Osmannoro, Sesto Fiorentino, Florence, Italy
tel 39 055 33611
fax 39 055 3033895
e-mail info@wpa2009florence.org
www.wpa2009florence.org/

International Harm Reduction Conference
April 19–23, Bangkok, Thailand
Contact: Contact Harm Reduction 2009, Conference Consortium, 34 Bloomsbury St., London WC1B 3QJ UK
tel 44 207 462 6997
fax 44 0 207 462 6999
e-mail info@ihraconferences.com
www.ihraconferences.net

Society for Research on Nicotine and Tobacco 15th Annual Meeting
April 27–30, Dublin, Ireland
Contact: SRNT, 2810 Crossroads Dr., Ste. 3800, Madison, WI 53718 USA
tel 608 443-2462
fax 608 443-2474 or 608 443-2478
e-mail meetings@srnt.org
www.srnt.org/meeting/future/future.html

12th European Federation of Therapeutic Communities Conference
June 2–5, The Hague, The Netherlands
e-mail eftcinfo@parnassiabavogroep.nl
www.eftc-bepartofthesolution.eu/

16th Congress of the International Society for the Psychological Treatments of the Schizophrenias and Other Psychoses
June 15–19, Copenhagen, Denmark
Contact: International Conference Services, P.O. Box 41, Strandvejen 171, DK-2900 Hellerup, Copenhagen, Denmark
tel 47 2310 3777
e-mail ISPS2009@ics.dk
www.isps2009.ics.dk/

World Psychiatric Association 2nd Thematic Conference on Legal and Forensic Psychiatry
June 16–20, Madrid, Spain
e-mail forensicpsychiatry2009@gmail.com
www.worldpsychiatricassociation.org

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