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Exploring the Links Between Substance Use and Mental Health

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Exploring the Links Between Substance Use and Mental Health

SECTION I
AN DISCUSSION PAPER

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SECTION II
A ROUND TABLE

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EXPLORING THE LINKS
BETWEEN SUBSTANCE USE
AND MENTAL HEALTH

SECTION
I

A Discussion Paper

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EXPLORING THE LINKS BETWEEN
SUBSTANCE USE AND MENTAL HEALTH:
A DISCUSSION PAPER

EXECUTIVE SUMMARY

The history of linkages between mental health and substance use is ancient. The influence of substance use on the mind is well recorded in religious and medical history. Whether used to relieve pain, enhance pleasure, reduce anxiety or for worship, throughout history humans have sought to alter their state of consciousness by using either natural or synthetic drugs. Form, frequency, circumstance and results of substance use have always been influenced by the individual state of mind.

This Discussion Paper is the final part of a project initiated by the Mental Health Division and Alcohol and Other Drugs Programs of Health Canada. The project includes an annotated bibliography on the links between substance use and mental health, followed by a detailed analysis of the cited literature. This third and final piece is a discussion paper on issues identified in the literature search. Issues associated with linkages between substance use and mental health are discussed and recommendations made to improve health promotion and treatment.

ISSUES ASSOCIATED WITH LINKAGES BETWEEN SUBSTANCE USE AND MENTAL HEALTH ARE DISCUSSED AND RECOMMENDATIONS MADE TO IMPROVE HEALTH PROMOTION AND TREATMENT.

To illustrate these linkages simply, the authors use a model placing mental health and substance use on continua which include common protective and risk factors.

Current approaches and challenges in prevention and health promotion are discussed. Treatment issues such as dual disorders and philosophical differences between the mental health and addictions fields are also included.

The paper presents and discusses six broad recommendations:

1. The overall philosophical approach should be reoriented towards strengthening protective factors in individuals, families and communities, and away from problems and risk factors.

2. Prevention and health promotion efforts in both areas should be combined and revitalized.

3. Practitioners and policy makers within both care systems should consider combining efforts to avoid duplication of services.

4. Social and health policies in both areas must acknowledge the negative impacts produced by stresses of unemployment, poverty and insecurity.

5. A refocusing of priorities and approach to research are needed.

6. In areas of potential co-operation and collaboration, measures to generate dialogue and information sharing should be fostered.

FOREWORD

Exploring the Links Between Substance Use and Mental Health: A Discussion Paper is the final part of a project initiated by the Mental Health Division and Alcohol and Other Drugs Programs of Health Canada. The project includes an annotated bibliography on the subject, followed by a detailed analysis of the cited literature[1]. This paper discusses linkages between substance use and mental health, and suggests changes to improve programs and services in health promotion and treatment. It reflects the authors' research and analysis as well as the results of a Round Table Discussion involving Canadian researchers, policy makers, and practitioners held in Ottawa in March, 1995[2].

Discussion issues focus on current knowledge, attitudes, beliefs and actions of health service providers, users, academics, researchers and the public as illustrated in published literature.

The authors have tried to present the links between substance use and mental health in ways that stimulate discussion and promote a clearer understanding of the subject. Their collective experience covers clinical, educational and research areas of mental health and substance use. Although issues in this document are presented logically and impartially, the reader's experience and values may lead to varying interpretations.

Vocabulary used in substance use and mental health must be defined clearly, as terms are typically broad in scope and subject to different interpretations. In this Paper, relevant terms are defined in order to clarify use and meaning.

Within the project's timeframe, a close scrutiny of every article cited was not possible. Acceptance of the editorial integrity of the books, journals and reports used was often the basis of selection.

Literature published in both fields concentrates on isolating risk factors to determine their influence on substance use and mental health problems. The authors think this overemphasizes problems and single-factor relationships and consequently neglects multiple interactive influences and health protection and promotion.

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1 The *Annotated Bibliography* and *Detailed Analysis* are available from Health Canada.

2 See Appendix I

Finally, while the authors recognize that links between substance use and mental health include complex neurological and biological factors that influence an individual's susceptibility or resistance to problems in both areas, discussion in this paper focuses on other factors.

INTRODUCTION

> "I am convinced that people are best able to avoid or outgrow destructive habits through being provided with honest information as best we can discern it, through respect for variations in how individuals and cultural groups prefer to conduct their lives, through recognition of people's capacity to choose, to adapt, and to grow, and through the creation of a society that offers those prone to unhealthy involvements reasonable alternatives for accomplishment and self-respect."
>
> Stanton Peele, *Diseasing of America*

Religious and medical history record the ancient linkages between mental health and substance use. Whether sustances were used to relieve pain, enhance pleasure, reduce anxiety or communicate with deities, it has always been known that the individual state of mind influenced form, frequency, circumstance and outcome of drug use. Throughout history humans have sought to alter their state of consciousness, and have discovered that either natural or synthetic drugs can help.

To avoid complication and confusion, it is important to distinguish between the mind and the brain and how each relates to mental health. In this paper, the term *mind* refers to a process, not a place. Mental problems and disorders may have their origin in a genetic defect or chemical malfunction within the brain, but the processes are not currently understood.

Substance use normally has a direct effect on some part of the brain. Brain function may be affected immediately by the presence of a particular substance, or chronic effects occur from repeated use. Interruptions to information processing, perception, equilibrium or other brain functions may be temporary or sustained.

Mental health, however, is not simply the absence of a brain disorder; it is a unique state involving biological, psychological and socio-cultural factors. This discussion of mental health and substance use considers issues of the mind and well-being, as well as brain functioning.[3]

MENTAL HEALTH, HOWEVER, IS NOT SIMPLY THE ABSENCE OF A BRAIN DISORDER; IT IS A UNIQUE STATE INVOLVING BIOLOGICAL, PSYCHOLOGICAL AND SOCIO-CULTURAL FACTORS.

[3] The work of Richard Restak referred to in the Bibliography elaborates on the distinctions between mind and brain.

Historical Evolution

Naturally occurring intoxicants or analgesics are used by people around the world for medicinal, social, recreational or spiritual reasons. Drugs such as psilocybin in mushrooms or mescaline in peyote cactus have been used in religious ceremonies of aboriginal peoples of the southwestern United States for centuries. Medicinal and recreational use of opium and its derivatives have a centuries old history in the Far East, as does coca in South America. Distilled spirits have always been used for medicinal, as well as social and recreational purposes. The spread of tobacco in Europe began with Columbus' discovery of tobacco use by natives on his first trip to the Americas. Chemical compounds to alter mental states can be found in the histories of all civilizations.

The history of mental illness and its treatment is also ancient. Three thousand years ago priests in Egypt treated depression within a theological rather than a medical framework, and syndromes now classified as schizophrenia were reported. Greek physicians in the fourth and fifth centuries B.C. used *mania* and *melancholia* as terms differentiated from *dementia* (Restak, 1988; Rowe, 1989). People with depression or mania in the Middle Ages were thought to be possessed by evil spirits and were burned at the stake. This was actually believed to be an act of mercy. That mood disorders had natural causes was recognized during the Renaissance period, but humane treatment for these and other mental disorders did not begin until much later (Restak, 1988).

THREE THOUSAND YEARS AGO PRIESTS IN EGYPT TREATED DEPRESSION WITHIN A THEOLOGICAL RATHER THAN A MEDICAL FRAMEWORK

Reports on the extent substance use and mental health problems are linked vary by period and culture; and whether such problems warranted punishment or treatment is vague. According to Blackwell (cited in Riley, 1993), the treatment of addicted individuals in institutions and asylums run by medical superintendents before the 19th century suggests the disease model of alcoholism was already being postulated by members of the "medical profession". However, treatment received in institutions differed little from that received in prisons, and both would appear cruel by modern standards. Asylums and institutions in North America that were opened in the 19th century for progressive and humane treatment had, by the mid-1950s, become inhumane warehouses for those whose treatment had little or no success.

The 20th Century

The inability to understand or treat problematic substance use and mental health problems effectively at the beginning of the century probably contributed to treatment in both fields evolving differently.

Until very recently, mental health problems have been defined by psychiatry and treated in hospital or clinic-based settings. Substance use problems, especially alcohol, have been treated in specialized non-psychiatric settings with a combination of medical, behavioral and psycho-social models. "Recovered addicts" often assume responsibility for many aspects of a treatment program. Since the mid-1930s, Alcoholics Anonymous has evolved into a successful support form, using a self-help and mutual aid model of care. Other programs, including treatment for compulsive gambling, have adopted and adapted this model.

Both the discovery of effective neuroleptic drugs in the mid-1950s and de-institutionalization policies that began in the early 1960s resulted in fewer inpatient hospital days for mental disorders. However, adequate community-based care did not follow de-institutionalization. Health reform policies of the 1990s may help remedy this problem.

Modern treatment for major mood disorders usually combines anti-depressant drugs and psychotherapy; in severe cases electro-convulsive therapy (ECT) may be used. Schizophrenia can also be treated with medication, primarily for symptomatic relief, but much remains to be learned about this disorder. Other disorders such as anxiety or panic are now treated with greater success due to more sophisticated medication and psychotherapeutic methods. Personality disorders remain the area least amenable to available treatment interventions. Problematic substance users are considered by many to belong within this category.

Equally important in treating mental disorders and less severe mental problems is the development of various therapies practiced by psychiatrists, psychologists, psychiatric social workers and other psychotherapists. These include behavior therapy, cognitive therapy, crisis intervention, marital or family therapy, group therapy and interpersonal therapy. All have been valuable to the successful treatment of psychiatric, psychological and substance use problems.

Alcohol use and its relationship to depression is a major concern for health professionals. Links between suicide, depression, alcohol and other substance use are also a widely recognized problem. Other mental disorders including schizophrenia, anxiety and personality disorders have been associated with substance use. Substance use may be either a predisposing or a precipitating factor (Rowe, 1989). The extent of substance use as a causal agent for mental disorder continues to be debated. However, anyone working with or living with chronic substance users knows that anxiety, depression, impulse control problems, and paranoid and antisocial behavior are associated with substance use.

ALCOHOL USE AND ITS RELATIONSHIP TO DEPRESSION IS A MAJOR CONCERN FOR HEALTH PROFESSIONALS.

Some treatment programs for substance use problems have always functioned within psychiatric facilities. This is because the psychiatric diagnostic system classifies many forms of substance use as problematic in themselves, or part of the clinical symptoms of other disorders. Multiple diagnosis also identifies some problematic substance users as psychiatric patients. There are health professionals working in psychiatric facilities who have an interest and training in addictions, and in some regions treatment services are combined to save resources and funding.

Some problematic substance users are treated in general hospitals where their cases are often hidden under obscure diagnosis to prevent the stigma of being classified as an *Alcoholic* or *Substance Abuser*, or to avoid being sent to an addictions treatment facility. This exemplifies our conflicting attitudes about the legitimacy of non-hospital based treatment services, and about substance use as a health-related problem.

This issue of stigma has been present throughout the development of both fields. Punitive attitudes have resulted in fewer quality resources being allocated to substance use and mental illness treatment programs and facilities than to providing care for more sympathetic conditions such as cancer or heart disease.

Mental health in the sense of *well-being* rather than absence of mental illness is a relatively new concept. Recorded medical history traditionally only identified individuals suffering various emotional and mental disturbances. The medical field has frequently used the quantified method of morbidity and mortality statistics to determine priorities for research treatment and prevention programs. Conducting research on determinants of health rather than "illness" was considered too subjective and qualitative. Because interest in prevention has increased over the past 25 years and traditional medical care costs are becoming unmanageable, alternatives are now being seriously considered. We know more about *substance use problems* and *mental health problems* than about health promotion or how people become and stay healthy. Little is known about responsible substance use and how it can be taught. There is even some debate whether the term "responsible substance use" should be used for any reason.

WE KNOW MORE ABOUT SUBSTANCE USE PROBLEMS AND MENTAL HEALTH PROBLEMS THAN ABOUT HEALTH PROMOTION OR HOW PEOPLE BECOME AND STAY HEALTHY.

Laws and customs must be considered in the relationship between substance use and mental health. An example of this is the extent a person can be excused for violent behavior while under the influence of alcohol. This remains a matter of debate before Canadian courts. The age of majority for tobacco and alcohol use in Canada has been altered

several times over the past 25 years to reflect changing attitudes about these substances and their use by young people. Certain religions forbid the use of specific drugs and have influenced cultural attitudes and legislation related to these substances in some countries.

Customs and laws are seldom consistent or logical concerning drugs and mental health. Science and public opinion frequently differ, and disagreement exists within the substance use and mental health fields. Health scientists and community groups disagree on the kind or amount of substance use that may be beneficial or detrimental to mental health. These issues are complex and emotional. Freedom of choice for individuals, community standards of behavior, scientific theory versus scientific fact and religious and cultural diversity all lead to inconsistent and confusing attitudes and practices.

The 20th century has seen substantial changes in our understanding of substance use and mental health. The role of genetics and biochemical influences in both fields is better understood. Treatment of disorders in both areas has been humanized. Laws against drinking and driving, and psychiatric certification for individuals considered a danger to themselves or others, are examples of legislation introduced to protect citizens. The victims of mental disorders and substance use problems are provided safe and secure treatment facilities staffed by well-qualified professionals using sound treatment methods that promote positive outcomes. Most importantly, care services have moved toward prevention rather than just concentrating on illness, and are seeking to promote responsible substance use and positive mental health. Yet, much remains to be learned.

MOST IMPORTANTLY, CARE SERVICES HAVE MOVED TOWARD PREVENTION RATHER THAN JUST CONCENTRATING ON ILLNESS.

Substance use and mental health are linked, with overlaps in public opinion, public policy, promotion, prevention and treatment issues, and it is important to examine them together. However, before the links between the two are considered, issues unique to each field must be understood.

SUBSTANCE USE

Substance use (see Appendix I: Definitions) is a general term covering a range of health promotion/prevention and ill health/treatment issues. There is little agreement among interested parties as to where certain kinds of drugs or drug users fall under this umbrella. Should someone be criminally charged for driving under the influence of a prescription drug? Should the health care system pay for someone to stop smoking? Is an occasional alcoholic beverage used to reduce stress always a bad practice? Few health practitioners agree in responding to these questions and even less consensus would be found within the general population.

In addition to differing philosophies and values, there is the problem of terminology. Researchers, treatment and prevention specialists and the general public use, define and understand **differently** terms such as: *abstinence, abuse, addiction, alcoholism, dependence, dual disorder, impairment, social drinking, problem drinking, tolerance, light user, moderate user, heavy user* or *withdrawal.*

The following substance use issues were identified by reviewing literature, discussing the author's clinical and academic experience and considering the policies and practices noted by workers in the field:

- **Substances tend to get lumped together** under the common heading of "alcohol and drugs" when being considered as a problem. This is somewhat of a misnomer since alcohol, tobacco and prescription or over-the-counter medications, although drugs, are thought of and treated differently from illicit or "hard" drugs.

- **The term *drug use* usually implies something negative.** When discussing drug use, the general perception is that we mean illicit drug use or problematic alcohol use. Tobacco, prescription or over-the-counter drugs are only included under special circumstances. This perception is prevalent in Canada and very hard to change.

WHEN DISCUSSING DRUG USE, THE GENERAL PERCEPTION IS THAT WE MEAN ILLICIT DRUG USE OR PROBLEMATIC ALCOHOL USE.

- **Substance abuse involves more than amount or frequency of use.** Use and abuse are often treated as synonyms, especially in reference to adolescents. However, some researchers have found significant differences between abstainers, exploratory users, occasional users, regular users, overusers and abusers.

- Factors in the **initiation of substance use** and in the **continuation and escalation of use** may be very different. Peers may play a major role in initial use, but less in continued use.

- **Risk factors vary among substances**. Socio-economic class is highly related to smoking, but less so to other drugs. Deviant behavior is more closely associated with illicit drug use than with alcohol.

- **Addiction is often used as a general term in reference to any perceived problematic behavior.** Biological cravings for substances such as alcohol or cocaine and compulsive behavior such as gambling are both referred to as addictions. This makes the usage of the term "addiction" meaningless.

- The **substance use field**, in general, **concentrates on the problem end of a drug use continuum**, dealing with the minority who experience serious health and lifestyle problems associated with substance use. Little attention is paid by researchers or drug educators to less serious users, responsible users or even abstainers.

- The vast majority of Canadians **use licit drugs (such as alcool and medications) without experiencing significant problems.** The substance use field needs a better understanding of why people who use drugs responsibly do not experience significant problems.

- **Conflicting attitudes** exist about people with certain drug-related problems such as alcohol. These individuals are viewed as victims of a disease by some, and as perpetrators of a self-inflicted problem by others.

- **Tobacco may be a *gateway* drug**. Alcohol and illicit drug use are far higher among smokers than nonsmokers.

- **Tobacco addiction is not viewed as a disease** by the general public. It is viewed as a bad habit that could be stopped with enough will power.

TOBACCO ADDICTION IS NOT VIEWED AS A DISEASE BY THE GENERAL PUBLIC.

- There is little agreement on defining or discussing responsible substance use, especially with young people. The authors believe that the **positive or beneficial effects of responsible substance use should be recognized and taught**.

- In spite of health education campaigns and published material, **not enough is known by the general public about substance use**.

- **Prevention programs often lack a theoretical base and have generally been poorly implemented**, and because of this, some policy makers think that drug education in public schools does not work. Results are expected in a few months or years rather than the more realistic timeframe of a generation.

- Public drug education **focuses almost exclusively on illicit drug use** and consequently on the negative aspects of drug use. Because most Canadians use drugs responsibly, drug education must be realistic and balanced in order to be credible.

- The substance use field **has taken responsibility** for the **education and treatment of gambling addiction**, but not for other process addictions such as eating disorders.

MENTAL HEALTH

Mental health is a general term even more ambiguous than *substance use*, with little agreement on definition or use. Does the individual or society define mental health? Does mental health mean being *normal*, *well-adjusted* or *content*? Is mental health the opposite of mental illness?

Terms such as *depression*, *mania*, *psychotherapy*, *psychology* and *schizophrenia* have a clinical as well as a general meaning. *Well-being*, *self-esteem*, *stress management* and *coping* are equally confusing.

The following mental health or mental illness issues were identified by reviewing the literature, discussing the authors' clinical and academic experience and considering the policies and practices noted by workers in the field.

- *Mental health field* usually refers to the practice of **psychological and psychiatric services for emotional problems and mental disorders.** Mental health promotion or the components of psychological well-being are more academic issues than public health issues.

- Mental health is usually viewed as **opposite to or as a euphemism for mental illness**. What constitutes mental health is not well understood, so concentration is focused on what is known about mental illness.

MENTAL HEALTH IS USUALLY VIEWED AS OPPOSITE TO OR AS A EUPHEMISM FOR MENTAL ILLNESS.

- **Characteristics defining optimal mental health are not well understood or studied**. Funding agencies are principally interested in problems people have and the determinants of these problems. Issues like happiness, contentment or compassion as positive human states are seldom research topics.

- Risk factors **dominate mental health literature.** Most often represented were violence (especially family violence), depression, stress and unemployment.

- Protective factors **are not well represented in mental health literature**, although studies have been made of well-being, coping, hardiness, resiliency and support systems or networks.

- There is **a significant lack of services for individuals who experience mental distress** but are not diagnosed with a mental disorder. Examples are victims of social injustice, racism and discrimination.

- **Very few prevention programs** exist for **mental disorders** and **mental distress.**

- **Anyone with a diagnosed mental disorder is stigmatized.** It is viewed as a shameful weakness of character.

- **People with mental health problems are often portrayed as dangerous by the popular media.** A distorted view of the "psychotic killer" as the norm for those afflicted with mental health problems contributes to public fear.

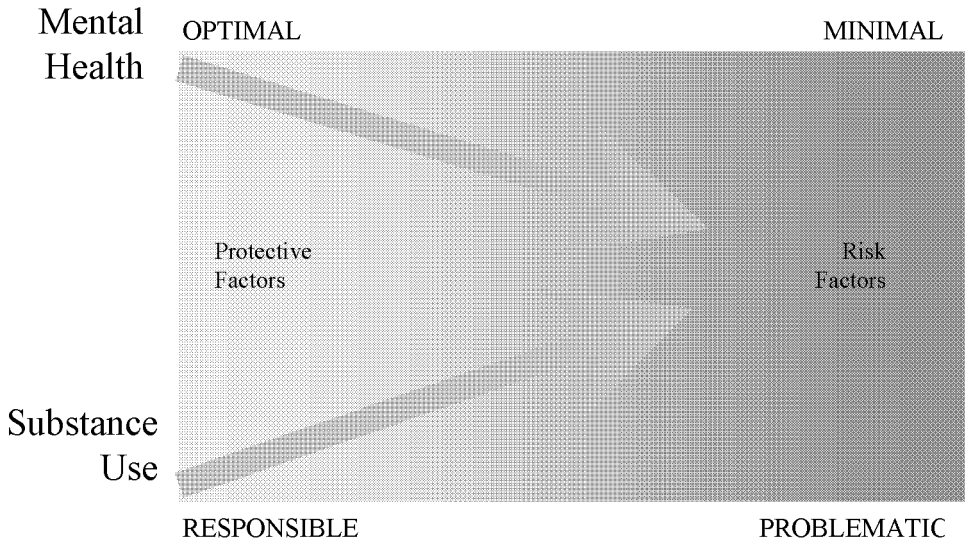
- **Mental health promotion or mental disorder prevention is the least understood and least developed aspect of the mental health field.** What promotes mental health in children, adolescents, adults, immigrants from developing countries, the unemployed, farmers, refugees, aboriginal people, street kids or university students is often understood in terms of a single variable, targeted as significant in an isolated piece of research.

LINKS BETWEEN SUBSTANCE USE AND MENTAL HEALTH

In reviewing mental health and substance use literature, it becomes obvious that there is a variety of links between them and that a system to classify them is needed. Two types of linkage relationships are suggested. First, there is an overall relationship, since mental health problems often occur in conjunction with substance use problems. The literature also suggests that mental health problems can act as risk factors for substance use problems and vice versa. This type of linkage indicates that when people begin to have problems in one area, they may be affected in the other. As well, individuals who are able to cope or who have a sense of well-being are less likely to experience substance use problems.

The second broad category of links is the presence of common risk and protective factors for both substance use and mental health problems. These factors place people at risk for either substance use or mental health problems, or both. Poverty, difficulties at school, isolation and family problems are included in this category. Much of the literature reviewed focuses on these risk factors. On the other hand, there appear to be common protective factors as well. Whatever promotes responsible substance use promotes good mental health equally.

The following model is offered as a graphic simplification of these complex issues.



In the model, substance use and mental health are placed along two continua moving from optimal functioning and responsible substance use towards problematic substance use or minimal mental health (see Appendix I for definitions of these terms).

It suggests a connection between the mental health and substance use continua. As the two continua move from health toward ill health, they come closer together. This does not suggest that the two always co-exist, but that they probably co-exist or have common roots.

The model suggests that common risk and protective factors become more similar as individuals move towards the problematic end of the continuum. If a classification system existed for healthy behavior, these continua might be closer at both ends.

The implied intersection of the continua represents the overlapping issues of dual disorders. The direction of causality is, however, a complex issue. Most studies are correlational and cannot determine with certainty how substance use contributes to the mental health continuum, or vice versa. Consequently, it is virtually impossible to establish clear causation between risk factors and outcome.

COMMON PROTECTIVE AND RISK FACTORS

Opportunities for education and work, universal health care and equity legislation promote and protect the health and well-being of Canadians. Adverse conditions such as poverty, illiteracy, violence and discrimination are barriers to good health and place people at risk. In the *Annotated Bibliography and Detailed Analysis,* the authors found evidence of the conditions that link substance use and mental health and promote or inhibit health and well-being. The relationships were analyzed using the above model.

OPPORTUNITIES FOR EDUCATION AND WORK, UNIVERSAL HEALTH CARE AND EQUITY LEGISLATION PROMOTE AND PROTECT THE HEALTH AND WELL-BEING OF CANADIANS.

This model of a triangular relationship between substance use and mental health only intersects at the problem end. Between the non-problematic and problematic ends are identifiable protective and risk factors influencing the pull toward optimal mental health and responsible drug use at one end or mental disorders and problematic drug use at the other. As noted above, the triangular shape is due to a classification system providing more information about common linkages at the problematic end of the continua than the non-problematic.

Risk and protective factors are seldom mutually exclusive. For example, high self-esteem seems to be a protective factor while low self-esteem increases risk. The importance of factors may change with time and circumstance, and protective factors become a risk. For example,

strong family ties that protect and comfort a person at one point in life, may become overbearing and stressful when trying to establish a more independent life. A protective factor for one person may be a risk factor for another. A drink of alcohol that eases tension in one person can release hostility in another. Many of the studies cited in the *Annotated Bibliography,* however, show the variables to be correlated. A description of some common variables found in the literature follows. These factors are mentioned briefly and not discussed in detail.

Socio-Cultural / Community

The literature reviewed links **school performance** to both substance use and mental health among youth. High academic achievement, social bonding and learned coping skills influence school performance positively, while feelings of alienation and stress impact negatively. Drug use may serve as a coping strategy, but seldom has a positive influence on school performance. This relationship clearly exists, but it is not well understood. For example, does school failure come first or does drug use precede school problems or perhaps even cause them? Not everyone who does poorly in school will automatically abuse drugs. The relationship may also differ for male and female students.

Social norms and expectations about drug use are influenced by cultural beliefs concerning appropriate behavior and by social learning. These cultural beliefs may stem from the broad social system we live in or may be more specific to particular subgroups or subcultures within that system. These norms and expectations may have both positive and negative consequences for an individual or a group in terms of drug use and mental health. For example, in our society moderate alcohol use is quite acceptable and is portrayed extensively by the media as having positive consequences. For others (perhaps religious or ethnic groups), any use of alcohol is unacceptable.

Cultural expectations about substance use in Canada are often ambiguous. Canadians frequently belong to a number of groups with conflicting expectations. In addition, contradictory messages can be received through the media and from close friends and family. Drunkenness, for example, is condemned in some circumstances and condoned in others.

Poverty and socio-economic status are well linked to substance use, especially tobacco use. However, as with all correlational studies, causation cannot be assumed. Poverty surely does not cause smoking, nor does smoking cause poverty. Although the relationship is not well

Protective Factors	<——————————>	Risk Factors

SCHOOL PERFORMANCE

- Alienation
- Social Bonding
- Academic Performance
- Stress and Coping

SOCIAL NORMS AND EXPECTATION ABOUT DRUG USE

- Cultural Beliefs Concerning Appropriate Behaviour
- Social Learning

SOCIO-ECONOMIC STATUS

- Particularly Linked to Tobacco Use

understood, it is interesting to note that smoking is also linked to mental health problems and other drug use. Poverty and socio-economic challenges seem to act as risk factors for both areas. Poverty is increasingly recognized as a central health risk factor, while reducing poverty is strongly linked to mental health and to population health overall.

POVERTY AND SOCIO-ECONOMIC CHALLENGES SEEM TO ACT AS RISK FACTORS FOR BOTH AREAS.

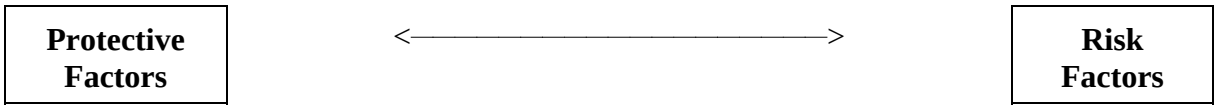
Family and Peers

Parents are usually the most influential factor in the lives of young people, helping to determine how they will cope with life as adults. No single success formula is applicable to every family or every child within a family. Raising children is a lot of work and few parents consider themselves to be experts, but parents can clearly have a very positive or negative effect on their children's development. Their values, attitudes and behaviors are observed and mimicked or rejected. Some mental health practices and substance use attitudes and behaviors can actually be taught, such as how comfort is obtained in times of stress.

Children who live in families characterized by internal violence or a history of mental illness or substance abuse are at high risk for many problems that often develop cumulatively and in an interactive fashion. These problems seem to have two sources. First, living in a family with

problems leads to greatly increased stress levels for all family members. Second, children in these circumstances typically do not have the number or quality of necessary coping skills to deal with this increased stress. As a result, they are at risk of using substances to deal with stress, or developing mental health problems. However, it must be recognized that the development of more serious forms of mental disorders (e.g. schizophrenia) have nothing to do with parental influence. Also, not all children from violent families experience problems. The diverse factors that contribute to resiliency in these children, and the phenomenon of resiliency itself, need to be examined more closely.

Peer relationships are also very important in the psycho-social development of young people. These provide social support and sometimes a buffer or escape from family or other stresses. Yet, they can as easily have a negative influence as a positive one if they create dissonance in youngsters in relation to family or community values. Peer relationships are particularly important in providing modeling and



FAMILY INFLUENCES

- Parental Support and Control
- Family Cohesion and Adaptibility
- Parent/Child Relationship
- Coping with Stress
- Parental Attitudes Toward Drug Use
- Family History of Drug Use
- Conflict Resolution Approaches
- Family Violence

PEER INFLUENCES

- Peer Relationship Patterns
- Social Support
- Peer Pressure
- Peer Drug Use
- Extent of Social Networks

reinforcement of values and norms. It is clear that individuals whose peer groups do not value substance use and who have norms that do not involve problematic substance use, tend to drink and use drugs less frequently and in lower amounts. Peer influence has been researched extensively in relation to both substance use and mental health variables such as self-esteem. The role of peers may be subtle or covert, and fills the social or psychological needs to feel accepted and normal, and to experience camaraderie.

Intra-Individual Factors

Psychological factors influencing mental health and substance use are even more complex and difficult to isolate and measure than environmental factors. The fact that these always occur in conjunction with other factors and in various contexts, makes them difficult to describe with certainty.

Self-esteem is one of the most extensively studied, but least understood factors influencing the lives of Canadians. Even the definitions used for the concept vary across studies. In spite of this, the literature is clear in listing low self-esteem as a risk factor for both substance use and mental health problems. High self-esteem, however, does not necessarily protect us from experiencing serious problems. Self-confidence, self-image, success and interpersonal relations all exert influences that cannot be easily isolated and studied, although each contributes significantly to self-esteem.

Self-efficacy and locus of control are closely interrelated concepts. Both imply having a strong sense of personal power and control over one's life, and both may protect and promote well-being and be antithetical to problematic drug use. Yet, at different times of life and in different contexts, both can vary. Personal power and control have been used extensively in substance abuse treatment. The research suggests that people who learn to cope appropriately in high risk situations will be less likely to use drugs in ways that cause problems.

Expectations and sensation seeking strongly influence both initial and continuing risk behaviors, especially substance use. Drug use can be highly reinforcing. If use produces pleasurable feelings or stress reduction, it will likely continue, further reinforcing the expectations. In the case of process addictions such as eating disorders or gambling, this seems especially true. Most people expect positive outcomes from alcohol use, such as increased social comfort and spontaneity, relaxation or playfulness.

Stress and perceived stress are significantly related to mental health and substance use. No single variable has received more attention, both as a rationale for substance use and as a consequence of mental health or substance use problems. While difficult to quantify, stress and perceived stress can have a powerful influence. At its worst, stress can trigger depression or anger which may be directed outwardly or inwardly. Stress can be episodic or experienced daily, and cumulative effects of stress can produce devastating physical and psychological distress. It is therefore not surprising that substance use frequently occurs as a form of self-medication related to stress.

Stress is linked to substance use and mental health but it may be a person's ability to *cope* with stress, rather than stress *per se*, that is the truly important factor. Ability to cope, to survive or even thrive in the face of significant adversity or risk, is a major protective factor associated with resilience. People possessing positive coping skills tend to have lower overall stress levels than those with poor coping skills. Coping therefore becomes the critical variable. This is particularly significant

STRESS IS LINKED TO SUBSTANCE USE AND MENTAL HEALTH BUT IT MAY BE A PERSON'S ABILITY TO COPE WITH STRESS, RATHER THAN STRESS PER SE, THAT IS THE TRULY IMPORTANT FACTOR.

Protective Factors <——————————————> **Risk Factors**

- Self-esteem
- Self-efficacy
- Locus of Control
- Drug-related Experiences
- Stress and Coping Skills
- Loneliness

PERSONAL CHARACTERISTICS

- Sensation Seeking
- Tolerance for Deviance/Disreagrd for Social Mores
- Lack of Conventionality/Rebelliouness
- Impulsiveness
- Boredom Susceptibility
- Disinhibition

when trying to prevent problems and foster resiliency. When looking at the relationship between stress coping skill (an attribute of mental health) and substance use, it is important to distinguish between non-problematic substance use as a coping mechanism and problematic use as self-medication.

Loneliness is another intra-individual factor that has implications for both fields. It can predispose and reinforce drug use behavior and can lead to depression and despair. Paradoxically, lonely people may use alcohol to increase sociability, but with increased use sociability decreases and loneliness increases. It should be noted that loneliness, like stress, can be a matter of perception. Individuals' perception of their sociability and social connections may place them more at risk than the number of social contacts or supports. For example, loneliness can exist in a long-term marriage or in a crowd, and not just when one is physically isolated. However, social rejection resulting in loneliness is also a reality for some and not just a perception. In whatever form, loneliness can be debilitating to the point of hopelessness and, like stress, is prone to being self-medicated.

IN WHATEVER FORM, LONELINESS CAN BE DEBILITATING TO THE POINT OF HOPELESSNESS AND, LIKE STRESS, IS PRONE TO BEING SELF-MEDICATED.

The list of psychological attributes, tendencies and personality factors linking substance use to mental health is longer than can be addressed here. The above are a range of examples only. In varying degrees, attributes such as sensation seeking, tolerance for deviance, disregard for social mores, rebelliousness, impulsiveness or intolerance of boredom can result in either problematic substance use or mental health problems, or both.

POPULATION SPECIFIC FACTORS

Published literature over the past 10 years increasingly recognizes the divergent and unique characteristics of population groups whose needs are little known or poorly met by existing health care services. In the literature examined, these groups include women, seniors, aboriginal peoples, marginal youth, and cultural and ethnic minorities. Also included are ill-defined groups usually identified as "immigrants". This definition encompasses a wide range of meanings and groups and must be used cautiously.

Women

The literature on women's substance use and mental health tends to concentrate on depression, aging and life stages, childhood victimization,

alcohol use and issues associated with work and gender roles. In addition, for women — especially young women — concern about body image and personal appearance are often related to smoking and eating disorders. Employment related issues of equal opportunities and pay, job satisfaction, security and harassment and multiple work and family roles for women may produce anxiety or depression. It is also suggested that they can be contributing factors in self-medication with alcohol or prescription drugs. Research, however, lends more weight to the role of *relationships* than to these factors in determining substance use patterns. For older women who frequently outlive their partners and close friends, loneliness and isolation play a role in both substance abuse and mental distress. Establishing and maintaining friendships and social networks are particularly important for women as a protective factor in both areas.

Another major area of particular concern related to mental health and problematic substance use for women (and also for men, though the incidence is lower), is having been physically or sexually abused. A history of abuse is clearly a factor in both mental distress and substance addiction. Its brief mention here does not reflect the profound role abuse can play in either addiction or mental distress later in life.

Seniors

Compared with younger people, seniors generally experience more physical disability, poorer health, lower socio-economic status, more social isolation, increased sensory deficits and stress from life events such as the death of a long-time spouse or friend. Not surprisingly, seniors have higher rates of prescription drug use and polypharmacy than younger age groups. Emotional problems are often manifested in anxiety, depression, and possibly problematic substance use. In some cases using medication to sleep or cope with other health-related issues leads to an unintentional cycle of drug misuse and abuse.

Aboriginal Peoples

Among Canada's aboriginal peoples, multiple mental health and substance use problems are profound. Suicide is the most extreme manifestation of these problems. The suicide rate is much higher on Reserves than in the general population and has been linked to drug use, low self-esteem, isolation, a history of child abuse and lack of educational opportunities or meaningful employment. These same

conditions contribute to frequently reported family violence, drug abuse, depression and anxiety. Increased empowerment of aboriginal peoples within their own communities could serve as a positive mechanism to protect and enhance health and well-being.

INCREASED EMPOWERMENT OF ABORIGINAL PEOPLES WITHIN THEIR OWN COMMUNITIES COULD SERVE AS A POSITIVE MECHANISM TO PROTECT AND ENHANCE HEALTH AND WELL-BEING.

Other Minorities

Although it is recognized that numerous Canadian minority groups have not been well-served by either mental health or addictions services, these groups often lack a representative or unifying voice to articulate their concerns. They may be first generation Canadians or Landed Immigrants from developing countries, new Canadians with neither French nor English as a first language or simply people perceived as "different". While issues unique to these groups are not well represented in published literature, many people are working with a wide range of individuals and families who fall under this heading. Much remains to be understood by both mental health and addictions organizations so that this population, which forms an important part of the Canadian social fabric, can be better served.

COMPULSIVE GAMBLING

This is a relatively new area for consideration when discussing linkages between substance use and mental health. Although not a substance, compulsive gambling can be considered a process addiction, which seems to have characteristics similar to other addictions. Research evidence to date suggests that compulsive or pathological gambling may progress in stages similar to those in alcoholism. Yet no national consensus exists as to whether gambling should be treated as an addiction.

Research also suggests that compulsive gamblers have a higher coincidence of mental distress and may differ cognitively from non-compulsive gamblers, thus linking compulsive gambling and emotional health. Social and psychological factors are of special concern because many provinces are establishing casino gambling to increase revenues. Although addiction services in several provinces have begun to offer compulsive gambling treatment programs, it may be several years before we understand the scope of this problem, effective treatment and prevention.

HEALTH PROMOTION AND PREVENTION PROGRAMS

Health promotion and prevention in the context of this discussion includes the whole spectrum of policies and program strategies aimed at reducing risk, enhancing protective factors and promoting healthy choices and actions at both the individual and systems levels.

PROMOTING RESPONSIBLE SUBSTANCE USE AND PREVENTING PROBLEMATIC SUBSTANCE USE OR ABUSE

School-based

In schools, prevention programs have evolved from "scare tactics", through fact-based programs, to recent approaches combining cognitive elements with developing life skills such as problem solving, assertiveness and peer refusal skills. Multiple teaching approaches are employed such as peer-led groups and theatrical performances. That health promotion is broader than classroom instruction and that the school is part of the community is increasingly recognized.

Unfortunately, school-based programs are inconsistently implemented across provinces, districts and even schools. As with health education in general, there is little program revitalization and teacher preparation. Few programs except smoking have demonstrated significant results in altering attitudes or behavior. Research suggests that program goals are often unrealistic and that poor implementation prevents a thorough analysis of program impacts.

RESEARCH SUGGESTS THAT PROGRAM GOALS ARE OFTEN UNREALISTIC AND THAT POOR IMPLEMENTATION PREVENTS A THOROUGH ANALYSIS OF PROGRAM IMPACTS.

Community-based

Community-based programs have emerged mostly in the last decade. With the advent of the Healthy Communities ideal, there is a growing consensus that health promotion is better accomplished through *process* (e.g. community development) than through any one program. Traditionally, community-based initiatives in substance abuse prevention have included parent education or empowerment, efforts to provide drug free leisure activities and social marketing or public awareness

campaigns. As with most voluntary programs or initiatives, participation has been a challenge, especially where parents are involved.

PROMOTING OPTIMAL MENTAL HEALTH AND PREVENTING MENTAL HEALTH PROBLEMS

Three general approaches have been implemented in Canada. *Skills-based mental health promotion programs* most frequently target children (e.g. *In Living Colour*, Ontario Division of the Canadian Mental Health Association). Typically, these programs are designed to increase social competence, problem solving and coping skills. Self-image, communication and self-management skills have also been the content of programs for children. As with substance abuse programs, implementation and delivery is sporadic at best and comprehensive evaluation is seldom demanded.

Mental health promotion suffers the same stigma as mental health — the emphasis has been on preventing mental *disorders* rather than stressing mental and emotional health as a goal for everyone. The literature shows a number of *social marketing* efforts directed at changing the image of mental health, but work remains to be done to remove the stigma, and to help the general public realize the importance of mental health in everyday life.

A third genre of mental health promotion in the literature is that of *community empowerment*. Programs fostering empowerment in decision making have been successful with institutionalized senior citizens. The process of empowerment lends itself naturally to promoting mental health. This concept is not unique to mental health promotion, but is a tenet of community development and organization around health and social issues.

THE PROCESS OF EMPOWERMENT LENDS ITSELF NATURALLY TO PROMOTING MENTAL HEALTH.

The prevention of substance abuse and mental illness have much in common. Unfortunately, that common ground includes financial constraints to develop, implement and evaluate all prevention programming. However, valid and reliable programs fostering general health, family well-being, risk reduction, lifestyle enhancement, bonding, commitment and nurturing would promote both optimal mental health and responsible drug-related attitudes and use. Families, schools and communities provide natural settings for programs. As these links are examined, populations at risk and needing special attention should become obvious.

PUBLIC HEALTH POLICY AND LEGISLATION AS HEALTH PROMOTION

Health promotion includes not only encouraging voluntary individual or collective change, but also fostering social and economic conditions conducive to health, and discouraging certain behaviors. Research suggests that legislative controls on price and availability of substances have impacted more on public behavior than have educational programs. The distinct relationship between social and economic conditions and mental health or substance use problems suggests that social policy resulting in opportunities for meaningful employment and income and safe housing may play a key role in determining the health of Canadians. While fostering life skills and protective attributes such as resiliency are important, reducing the human and financial costs of substance abuse cannot be ensured without building favourable social conditions.

TREATMENT ISSUES

Treatment programs in substance abuse and mental illness have evolved differently, although substance abuse treatment was at times provided in psychiatric or general hospitals. Both areas have struggled to provide the most humane treatment possible, but public opinion about substance use and mental disorders has been ambivalent. In some cases a punitive attitude has affected public policy, resulting in the desire to remove substance use and mental disorder problems from public sight. Neither area has ever gained sufficient public sympathy to provide the first class services expected by Canadians for the treatment of physical health problems.

SUBSTANCE ABUSE TREATMENT

Several outstanding issues have plagued the addiction treatment field. Foremost is what type of substance use constitutes abuse and consequently calls for treatment intervention. This issue is of paramount importance and little progress will be made in substance use treatment if the focus remains only on the most obvious and severe forms of abuse. The rhetoric defining almost any substance use as abusive is equally restrictive: the term *drug-free society* falls into this category. The overemphasis on particular drugs, reinforcing the myth that drugs themselves are the problem, is a related issue. Drugs are neutral, neither inherently good nor evil; how they are used and the consequences of use create the problem. The belief that a person is either an addict or not, and there is no in-between, is also problematic. A corollary is that a person once addicted is always an addict. This all-or-nothing label is not applied to someone who is obese or clinically depressed. Many ex-smokers consume volumes of tobacco smoke passively without restarting their habit.

DRUGS ARE NEUTRAL, NEITHER INHERENTLY GOOD NOR EVIL; HOW THEY ARE USED AND THE CONSEQUENCES OF USE CREATE THE PROBLEM.

No single treatment modality works for everyone. However, few treatment programs provide choices because of philosophy, staff training and budget. Moreover, what constitutes *successful* treatment is very debatable: if abstinence is the only goal and measure of success, few persons will succeed in early treatment. To stop smoking, for example, usually requires many attempts.

Finally, the role of self-help is of major importance, but where does it fit into a treatment regime? Is it necessary for a successful recovery? Who benefits most from participating in a self-help experience, and who might not benefit?

There are no simple answers to these questions and issues, but a healthy debate — lacking at present — should be ongoing in the literature and among service providers.

THERE ARE NO SIMPLE ANSWERS TO THESE QUESTIONS AND ISSUES, BUT A HEALTHY DEBATE — LACKING AT PRESENT — SHOULD BE ONGOING IN THE LITERATURE AND AMONG SERVICE PROVIDERS.

We raise several new issues and considerations that need to become part of current and future substance abuse treatment:

- It is important to recognize that treatment is only one of the factors that contribute to or influence outcome. Psycho-social events and conditions before, during and after treatment may be far more influential than the actual treatment. Minimizing negative outcomes or applying the harm reduction theory are probably more realistic in evaluating treatment than simply whether or not a person continues to use a drug.

- The field should clearly state that substance use falls along a continuum requiring multiple strategies of intervention. At one end, promoting healthy behaviors must incorporate both education and policy approaches. In terms of cost effectiveness, far more effort should be placed on the least problematic end of the continuum, where the most people will benefit. The least effort should be applied to the chronic and most severely disabled end of intervention, since it represents only about five percent of the population and may be the least tractable to change. For this group, more supportive programming is needed. In some cases, for instance with the highest risk groups, harm reduction strategies such as needle exchange programs may be the most appropriate. This exploration of treatment along a continuum has been mainly conducted with alcohol; less is known about its application to other drugs.

- More effort should be placed on effectively serving specific population groups. It is important to know what treatment works or does not work with different groups.

- Most clients in addiction treatment today are polydrug users. Should each of these drugs be treated equally? Should attempts be made, for example, to encourage or force clients to stop smoking while in treatment for other drugs?

MENTAL DISORDER TREATMENT

The mental health field concentrates its efforts at the minimal mental health end of the continuum. In fact, the Canadian health care system spends most of its resources on those with the greatest impairment. This is not only short-sighted, it is ineffective. For this reason, all

provinces are reforming their health care from institution-based to community-based systems. This may or may not change the mental health field.

"Stigma" is at the heart of mental health issues. Mental illness makes the general public feel uncomfortable and is perceived as a weakness, possibly a dangerous weakness, of character. We are still close to the "dark ages" in our understanding of mental disorder or mental health. Consequently, the special group of health care workers who treat mental health problems often work in isolation, and are themselves stigmatized. Working with the mentally disordered, especially the chronic mentally ill, is one of the least "glamorous" of all of medical specialties and is one of the most underfunded of all community services.

Psychiatric diagnosis and psychotherapeutic interventions remain on the outer edge of health care in spite of enormous gains in our understanding of the mind and brain. At the same time there is still so far to go in our understanding of the nature and nurture influences on human behavior.

From a treatment perspective, we have created two systems of care — a public system for the serious and chronically disordered and a private system for those less impaired. The *Psychiatric Diagnostic and Statistical Manual* (DSM-IV) is the standard by which symptoms are categorized to provide some common ground for considering treatment for people with similar profiles. The Manual includes many substance use- related categories. Those with less severe or ill-defined symptoms ranging from stress to existential depression are usually looked after by private practice psychotherapists and counsellors with varying degrees of training and experience.

DUAL DISORDERS

The overlap between mental health issues addressed within a substance abuse treatment program, and vice-versa, is significant. Problematic substance use goes hand-in-hand with numerous mental health problems. Anxiety, mood disorders and even psychotic episodes may be associated with certain substance use related experiences.

The idea of dual disorders suggests two distinct problems in one person. The fact that it concerns a single person must not be lost in analyzing separate issues of drug and mental health problems. The individual sees only one problem and will probably seek help for the most pressing issue. Therefore the onus is on the two services to help

THE FACT THAT IT CONCERNS A SINGLE PERSON MUST NOT BE LOST IN ANALYZING SEPARATE ISSUES OF DRUG AND MENTAL HEALTH PROBLEMS.

that person understand how a mental health problem is aggravated by substance use or vice versa.

A staff not trained to treat or even recognize dual disorders is inadequately trained. Those whose lives involve violence need different professional help from those with psychosis, whether drug induced or otherwise. Recognizing dual diagnosis here becomes a critical issue.

This is a controversial subject that requires much attention from health workers in both fields. Co-morbidity and dual diagnosis, although familiar terms in psychiatry, are not normally associated with substance abuse and mental disorder. Dual disorder isn't a new term either, but there are few well-established programs to address it. Terminology remains vague and many theories and treatment methodologies are in a state of infancy. Although pioneers are breaking new ground, there is still much scepticism. "Turf protection" exists in both the mental health and substance use systems. Only time will resolve some of the disputed issues.

"TURF PROTECTION" EXISTS IN BOTH THE MENTAL HEALTH AND SUBSTANCE USE SYSTEMS. ONLY TIME WILL RESOLVE SOME OF THE DISPUTED ISSUES.

Substance abusers are presently recognized to be at risk for mental health problems and may possess diagnosable symptoms that predispose, reinforce, or result from that substance use. Equally, people with a diagnosable mental disorder or even milder mental health problem are at risk or may already experience substance use problems. The issue is who are these individuals, what is the relationship between the two problems, and what can or should be done about it. In order to prevent these people from becoming chronically addicted or mentally ill, should the danger of combining even moderate alcohol use with milder forms of mental health problems be explained? This philosophy is stronger in drug dependency services than in mental health services, and has not been addressed at all in dual disorder reports.

Persons with bipolar disorder, antisocial personality and schizophrenia are most at risk for substance use problems, either through self-medication or because of unsatisfactory life experiences. Symptoms of mental illness are difficult to disentangle from symptoms of intoxication, dependence and withdrawal from drugs, particularly alcohol.

Because the prevalence of dual disorders is very high among the identified psychiatric disorders, special attention is needed. Those who deal with this population group require time to test theories and treatment modalities and to establish clinical trials to determine optimal interventions and possible preventive action. Workers in both the substance abuse and mental health fields can assist each other in this endeavour.

CONCLUSIONS AND RECOMMENDATIONS

In this paper, the authors have tried to broadly identify some of the issues that arise from examining possible linkages and relationships between substance use and mental health. These relationships are complex and multifaceted and exist at many levels. We have looked at the two domains as psychological and philosophical concepts, as professional fields with distinct infrastructures, and as an array of programs ranging from health promotion to treatment. This section summarizes the issues discussed, and offers several recommendations.

Perhaps the obvious has been stated: that mental health and substance abuse are not easily compartmentalized, nor should they be thought of as singular states. Both exist on dynamic continua, and overlaps occur in many ways. Substance use and mental health share common environmental, psycho-social and psychological bases. Focus has tended to gravitate toward the "problem" end of the continua; in fact both areas are often defined in the context of problems. In both domains, most resources have been allocated to treating the most severe problems.

Substance use and mental health, both as concepts and as fields, have experienced stigmatization. This has been particularly true in the case of mental health, defined in the public eye principally in terms of mental disorders. The general attitude towards substance use is ambivalent. Rhetoric calling for a "drug free" Canada characterizes drugs and drug use as innately harmful. We have discussed the stigmatization issue — that neither field enjoys the same sympathy or support given to physical health.

SUBSTANCE USE AND MENTAL HEALTH, BOTH AS CONCEPTS AND AS FIELDS, HAVE EXPERIENCED STIGMATIZATION.

The review and analysis of literature conducted for this project confirms that a considerable amount is known about the factors underlying substance abuse and mental disorder, and that many of the same factors predicting substance abuse or addiction also predict mental distress. However, very little research exists on the behavioral and psycho-social determinants of mental well-being, or of healthful attitudes and behaviors toward substances, particularly concerning the possible roles certain substance use may play in supporting or fostering mental well-being. Focusing on risk factors and causes of dysfunction and dissecting

problems into their determinants, rather than constructing scenarios conducive to health, further entrenches a negative, problem-centred view.

In terms of prevention and health promotion, we have suggested that while the current status of programs differs between the fields, both share the quandary of health promotion in general, that of poor implementation and evaluation. As well, the key role of the physical, social and economic environment in determining illness or health is apparent in both cases. Addressing stresses produced by poverty, inadequate or unsafe housing, unemployment and lack of hope are central in addressing both substance use and mental health programs. Educational or awareness programs are not sufficient: healthy social policy and commitment to equity and opportunity are needed.

EDUCATIONAL OR AWARENESS PROGRAMS ARE NOT SUFFICIENT: HEALTHY SOCIAL POLICY AND COMMITMENT TO EQUITY AND OPPORTUNITY ARE NEEDED.

Contextual issues pertaining to different population groups have been considered. Clearly, concepts and even determinants of mental health and responsible substance use differ among the many Canadian cultures. The factors contributing to health or distress differ with gender and age. All this makes the discussion of links and relationships between mental health and substance use more complex.

Finally, issues salient to treatment in both areas have been raised, particularly the need to clearly recognize and address the overlap between mental distress and disorders and addiction.

How then to address these issues? Keeping in mind the overall observations, six broad recommendations are offered to help shift the focus toward increased recognition and utilization of the many links and commonalities between the two fields. Within each recommendation, more specific actions are urged where appropriate. These recommendations stem from both the review and analysis of literature and from a National Round Table Discussion by professionals and practitioners in both fields, held in conjunction with this project (see Section II). The recommendations fall into five categories: Focus, Programs, Policy, Research, and Dialogue and Information Sharing.

FOCUS

1. **The overall philosophical approach should be reoriented towards strengthening protective factors in individuals, families and communities, and away from problems and risk factors.** To date, most of the focus in both areas has been on the need to address problems that people encounter, rather than to look at their strengths and try to capitalize on these. The suggested shift in focus moves from:

- **treatment to prevention,**
- illness to health,
- drugs *per se* to contexts of use,
- risk factors to protective factors,
- **determinants of illness to determinants of health and quality of life.**

This recommendation is neither unique nor new in the health field. Such a trend has been part of the health reform dialogue and implementation across the country. However, it needs to become operational, and only by placing it central on the agenda can it find its way into program and policy decisions.

PROGRAMS

2. **Prevention and health promotion efforts in both areas should be combined and revitalized.** With an increased focus on protective factors and on the determinants of well-being comes an increased interest in promoting that well-being. Community-based efforts are badly needed to destigmatize mental health and increase public understanding and dialogue. The multiple consequences of intolerance and social injustice caused by stigmatization may require a national campaign to remedy.

Community, both physical and social, appears to play a significant role in preventing and solving problems. How is a sense of community developed and fostered? What are the impacts of an enhanced sense of community on mental health and substance use outcomes for individuals and families? This is another challenge to be addressed in prevention and health promotion.

Health promotion programs for schools, families and communities need revitalization and careful implementation and assessment. Traditionally, agencies and organizations interested in prevention and health promotion in the two fields have worked separately. Yet the wellness factors in both areas largely overlap. Programs to promote mental health and reduce harmful self-medication should be developed and implemented. It could be argued that a good mental health promotion program is also a good substance abuse prevention program.

PROGRAMS TO PROMOTE MENTAL HEALTH AND REDUCE HARMFUL SELF-MEDICATION SHOULD BE DEVELOPED AND IMPLEMENTED.

Most importantly, the two fields should combine in advocacy and support for stable and consistent implementation, maintenance and periodic revitalization of efforts. New initiatives should move from a reductionist approach, reducing determinants of mental distress or

substance use to risk factors, towards an expansionist approach that looks holistically at factors creating wellness. In doing so, attention must be given to the differing needs of various cultures and population groups.

3. **Practitioners and policy makers within both care systems should consider ways to combine efforts and avoid duplication of services.** Bringing together two care systems that have evolved separately with different goals, philosophies and modalities presents many challenges. Yet it makes little sense to treat mental illness and addiction as isolated problems or to shuffle people from service to service. On the other hand, neither field is equipped to simply absorb the other, nor would it be appropriate to do so. A wholesome dialogue on training, structure, "turfs", and accountability would be particularly beneficial at this time. Certificate programs could be created by universities and community colleges to prepare people at all levels with the competencies and skills needed to take a leadership role in collaborating and bringing these two fields together.

BRINGING TOGETHER TWO CARE SYSTEMS THAT HAVE EVOLVED SEPARATELY WITH DIFFERENT GOALS, PHILOSOPHIES AND MODALITIES PRESENTS MANY CHALLENGES.

POLICY

4. **Social and health policies that acknowledge the negative impacts of unemployment, poverty and insecurity must be in place, especially at a time of severe fiscal constraint and harsh economic climate.** Currently it appears that layoffs and cutbacks in human resources are a prime tool in deficit reduction. In this way, economic policy is at odds with health policy. Problems in both substance use and mental health are substantially aggravated by unemployment, poverty and insecurity. Health and social policy must recognize that these forces add not only human costs, but economic ones as well, and can work against the intentions of fiscal restraint. Moreover, healthy social policy and socially conscious health policy address the central environmental determinants of health in ways that programs fostering skills and behavior change cannot.

RESEARCH

5. **A refocusing of priorities and approach to research is needed.** In particular, more research focusing on protective factors in substance use, and issues surrounding optimal mental health would provide a more balanced understanding of both areas. Research that examines substance use as other than a problem should be encouraged.

Co-operative and collaborative research should underlay any pilot projects exploring linkage areas. Well-designed and well-funded longitudinal Canadian research is essential, both in substance use and mental health, separately and in areas of clear linkages. A greater emphasis should be placed on qualitative and participatory research in contrast to traditional quantitative methods. This is particularly important if we are going to increase our understanding and ability to address substance use and mental health within their cultural and social contexts. Finally, an emphasis should be placed on generating applied research initiatives and research topics addressing needs that have been determined through open consultation and dialogue. Hence, an increase in contracted research on specific topics is needed, in contrast to grant research on topics of importance to individual researchers.

Dialogue and Information Sharing

6. **Measures that generate dialogue and information sharing in areas of potential co-operation and collaboration between the two fields should be fostered.** For example, Health Canada could sponsor a series of substance use and mental health monographs covering links in philosophy, theory, promotion, prevention and treatment, emphasizing the Canadian context. Readable reviews and synopses of relevant research and demonstrated success stories in promotion, prevention and treatment should be included. Professional health associations could be asked to sponsor workshops and conferences addressing specific linkage issues. Examples of topics are contemplating alternatives to the disease model and clarifying the boundaries of dual disorder. Stakeholders from all perspectives should be invited to collaborate and contribute toward common language, common goals and successful intervention strategies. Mechanisms need to be developed to encourage sharing of programs and research. In analyzing literature for this project, it became apparent that Canadian research and activities on mental health and substance use produce a lot of information that goes unreported and is difficult to access. This must be remedied.

MECHANISMS NEED TO BE DEVELOPED TO ENCOURAGE SHARING OF PROGRAMS AND RESEARCH.

These initiatives would help break down barriers between the mental health and substance use fields, develop trust and pool creativity and leadership.

Identifying and taking advantage of links between mental health and substance use fields for the benefit of Canadians presents many challenges. The issues are complex and the two areas are meshed in multidimensional ways. Continuing to operate more or less independently

of one another and focusing on problems, risk and treatment issues may seem easier, but considering the fundamental importance of mental health to the well-being of all Canadians and the reality of substance use in a myriad of forms as part of Canadian culture, ways to address both issues with optimism, vitality, and creativity must be found. To look for avenues of collaboration and co-operation becomes an obvious course of action. Faced with today's social and economic realities, challenging entrenched views and methods, and finding creative new approaches, becomes not only timely but essential.

Appendix

DEFINITIONS

The following are selected substance use definitions for this Discussion Paper:

Addiction according to Peele (1983) exists when a person's attachment to a sensation or an object lessens his/her appreciation of and ability to deal with other things because of an increasing dependence on the experience associated with the sensation or object.

Harm Reduction implies reducing the harm associated with use of the substance. This may include reducing consumption levels, but also implies reducing other harmful health or social consequences, such as reducing the risk of infection through needle exchange programs.

Problematic Substance Use is the contextually inappropriate and improper use of any substance that results in seriously harmful outcomes or potentially serious harmful outcomes for the individual or others.

Process Addiction implies compulsive engagement in a process (such as eating or gambling) that produces health or economic problems and/or becomes uncontrollable and creates discomfort on withdrawal.

Responsible Substance Use is the contextually appropriate and proper use of any substance. In some cases this is subjectively defined by individual or community standards; in other cases this is objectively defined by laws.

Substance Use includes the use of any of a range of substances including tobacco, alcohol, non-prescription or prescription drugs, illicit drugs, solvents and inhalants. This use may range from abstinence, to occasional or regular use, to frequent heavy use, to substance abuse. *Drug Use* may be used as an alternate phrase.

Substance Abuse as defined in the World Health Organization's Lexicon of Alcohol and Drug terms, is: "a maladaptive pattern of use indicated by ... continued use despite knowledge of having a persistent or recurrent social, occupational, psychological or physical problem that is caused or exacerbated by the use [or by] recurrent use in situations in which it is physically hazardous" (p.4).

The selected mental health definitions relevant for this Discussion Paper are found in *The Mental Health of Canadians: Striking a Balance* (1988):

Mental Disorder is a recognized, medically diagnosable illness that results in the significant impairment of an individual's cognitive, affective or relational abilities (p.8).

Mental Health Problem is a disruption in the interactions between the individual, the group and the environment (p.8).

Minimal Mental Health is individual, group, and environmental factors (in) conflict, producing subjective distress; impairment or underdevelopment of mental abilities; failure to achieve goals; destructive behaviors; and entrenchment of inequities (p.9).

Optimal Mental Health is when individual, group, and environmental factors work together effectively, ensuring subjective well-being; optimal development and use of mental abilities; achievement of goals consistent with justice; and conditions of fundamental equality (p.9).

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EXPLORING THE LINKS
BETWEEN SUBSTANCE USE
AND MENTAL HEALTH

SECTION
II

A Round Table

March 22-24, 1995
Minto Place Suite Hotel, Ottawa

ACKNOWLEDGEMENTS

Health Canada would like to thank all those who participated in the round table held in Ottawa, March 22 to 24, 1995. We appreciate the sincere and constructive sharing of insights and experiences. We thank those who gave us their expertise in particular areas of service and interest; we thank the "consumers" who shared their personal stories.

Our thanks to Pat Allan, Aurelia Beach, Heather Black, Lorraine Cantlie, Maureen Crocken, Michael Egilson, Pauline Fisher, Alayne Hamilton, David Hodgins, Murray Kelly, Michel Landry, Stephen Lurie, Ross Norman, Philip Perry, Tom Payette, Margaret Render, Helen Ross, Kellie Schriver, Murray Sillito, Rajpal Singh, and Herb Thompson.

We are especially grateful to Louise Nadeau who facilitated the session so capably, and with such good humour.

We are also grateful to Colleen Hood, Gillian Leigh, Colin Mangham, and Don McGuire from the Atlantic Health Promotion Research Centre who shared the findings of their indepth search of mental health and substance use literature.

And finally, special thanks are due to the Health Canada team that organized the event: Virginia Carver, Natacha Joubert, Lyn Taylor, and Ivy Williams.

A complete list of participants with addresses and contact numbers is included as Appendix A.

CONTENTS

INTRODUCTION

The round table *"Exploring the Links Between Mental Health and Substance Use"* took place in Ottawa from March 22 to 24, 1995. It was part of a Health Canada project to develop increased awareness and understanding of issues common to mental health and substance use. The project was designed to develop a more integrated and comprehensive approach to mental health and substance use policies, research, services and programs. The following publications, available from Health Canada, resulted from the project:

- *Mental Health and Substance Use: An Annotated Bibliography;*
- *Detailed Analysis of Literature Pertaining to Substance Use and Mental Health;*
- *Links Between Substance Use and Mental Health: A Discussion Paper.*

In order to compare how the information from the literature search is consistent with the concerns and needs of the mental health and substance use sectors, the round table brought together people with expertise and hands-on experience in both fields. Researchers, policy makers, programmers, counsellors and consumers from prevention, health promotion and treatment services from both fields participated.

Specific objectives were: to discuss and analyse the literature search findings; to learn what is or is not working in clinical and community practices across the country; to share concerns and hopes for the future; and to explore collaborative, multi-disciplinary and innovative approaches for dealing with emerging issues.

The key issues identified in the literature search and analysis were the basis for discussions. Highlights of the Round Table are reflected in the Discussion Paper referred to above.

The following is a report on the proceedings. The list of participants, agenda and issues identified for discussion are attached as Appendices.

INTRODUCTORY AND OVERVIEWS

On the first evening, the facilitator welcomed participants and reviewed the purpose of the round table.

Participants then introduced themselves, describing their involvement in mental health or substance abuse issues. After the introductions, Colin Mangham, from the Atlantic Health Research Centre, provided an overview of the project and the challenge of studying the very broad areas of mental health and substance abuse.

COMMON RISK AND PROTECTIVE FACTORS
FOR
MENTAL HEALTH AND SUBSTANCE USE

WHAT THE LITERATURE TELLS US

Colleen Hood and Don McGuire presented the following findings from their review of the literature:

- Terms such as "substance use", "abuse", "self esteem", "mental health" and "mental illness" are defined inconsistently in the literature. The same words refer to different concepts in different studies.

- The majority of studies are correlational and thus only suggest a relationship. Causal inferences and conclusions cannot be made.

- "Longitudinal" studies vary in length from anything between three months and ten years.

- The literature focuses on factors which put people at risk for mental health and substance use problems. However, the majority of people do not experience such problems.

- Early stages of problems tend to go untreated. Interventions are not introduced until the consequences are severe.

EARLY STAGES OF PROBLEMS TEND TO GO UNTREATED. INTERVENTIONS ARE NOT INTRODUCED UNTIL THE CONSEQUENCES ARE SEVERE.

- Gender differences include higher rates of alcohol disorders among men and more frequent prevalence of depression among women.

- Contextual factors such as social and economic circumstances contribute to the levels of disability and prognosis.

- Mental health and substance use problems sometimes occur together. Examples are depression and heavy alcohol consumption; depression and smoking.

- Some mental health problems act as risk factors for substance use problems and vice versa. Examples are low self-efficacy, anxiety and use of tranquilizers.

- External factors such as family violence, sexual abuse and poverty appear to act as risk factors for both mental health and substance use problems.

- Common protective factors include self-esteem, coping skills, hardiness and social supports.

Risk Factors

The authors listed the following risk factors under three broad categories. They reminded participants that the literature suggests risk and protective factors are at opposite ends of the same continuum.

Socio-cultural-community influences

- **School performance** including factors such as alienation, social bonding, academic performance, stress and coping.
- Social norms and expectations about drug use, influenced by factors such as cultural beliefs about appropriate behaviours, and social learning.
- **Socio-economic status**

Family and peer influences

- **Family issues:** parental support and control; family cohesion; adaptability; parent/child relationships; coping with stress; parental attitudes towards drug use; perceived parental drug use; family history of drug and alcohol use; conflict resolution approaches; family violence.

- **Peer influences:** peer relationship patterns; social support; peer pressure and influence; extent of peer networks; peer drug use.

Intra-individual factors

- Self-esteem

- Self-efficacy (e.g. Marlatt's relapse prevention model)

- Locus of control (internal vs. external; global vs. specific)

- Drug related expectancies

- Stress and coping skills

- Loneliness

- Personality characteristics: sensation seeking; tolerance for deviance; disregard for social mores; lack of conventionality; rebelliousness; independence; impulsiveness; susceptibility to boredom; disinhibition.

The presenters posed the following three questions for consideration:

1. Research tends to look at people outside their context. How does the information presented in the literature apply to individuals within the context of their experiences and environments?

2. Many studies look at risk and protective factors for mental health and substance use in isolation. How do we cope with all the factors and variables which influence mental health and substance use?

3. How do we avoid emphasis on negative risk factors and interventions after problems develop? How do we focus more on health promotion and prevention? How do we help people to adopt and maintain healthy lifestyles?

WHAT EXPERIENCE TELLS US

After the presentation, participants considered the information in relation to their everyday experiences. To focus the discussion, only the health promotion and prevention end of the continuum was considered in discussing risk and protective factors. The broad population was considered, rather than only people with mental illness or problems with substance abuse. Clinical and treatment issues were dealt with on the second day of the proceedings.

Common Protective Factors

Participants identified the following as protective factors:

- **"Attitude towards life"** was considered a primary protective factor by several participants. Children need to view themselves as competent and capable of control. Parents must teach children to meet challenges and accept that problems happen in life. Children who are able to take action at an early age are better protected.

PARENTS MUST TEACH CHILDREN TO MEET CHALLENGES AND ACCEPT THAT PROBLEMS HAPPEN IN LIFE. CHILDREN WHO ARE ABLE TO TAKE ACTION AT AN EARLY AGE ARE BETTER PROTECTED.

- **Families**, as clearly indicated in the literature review, play a crucial role and can be a very strong protective factor. As the primary source of values and role models for children, every effort must be made to ensure that they are "healthy". It is also families that bear the burden in times of adversity or crisis.

- **Values** were identified as an important protective factor. People, especially children, need clearly defined values, role models and examples of appropriate behaviour. However, several participants noted that values cannot be applied universally.

Values are usually discussed from the point of view of a dominant culture and this is not always appropriate. For example, solutions to problems in Aboriginal communities need to reflect their cultures and realities. Mediterranean and some European cultures do not have the same perceptions of social drinking and problem drinking as does North America.

- **Higher income** and **education** were also identified by many participants as important determinants of overall health.

- **Supportive, caring communities** play a protective role. The community can be a protective factor by helping people to develop links and avoid isolation. Community centre programs can impart a sense of belonging. One participant described a program in Saskatchewan which matches single young mothers to "coaches" who provide daily support to nurture self-esteem, offer financial advice and help them feel part of the community.

THE COMMUNITY CAN BE A PROTECTIVE FACTOR BY HELPING PEOPLE TO DEVELOP LINKS AND AVOID ISOLATION.

- **Information** was viewed as an essential protective factor. People need reliable information to make healthy choices. However, the necessary information base is not always there.

Common Risk Factors

Discussion then moved on to risk factors. While participants acknowledged the impact of alcohol and other drug use on people with severe mental disorders, much of the discussion was limited to links between less severe mental health problems and substance use. Several common risk factors were listed:

1. **Genetic and biological vulnerabilities**, such as Fetal Alcohol Syndrome; family history of substance abuse or mental health problems such as schizophrenia.

2. **Psychosocial and economic vulnerabilities** such as physical, emotional or sexual family violence; isolation; disruption of the extended family structure (especially for Aboriginal peoples and immigrants); loss of culture, language and traditional identity; poverty and loss of hope.

3. **Professional practices and availability of services** such as misidentifying substance abuse symptoms as signs of aging; "medicalizing" psychosocial issues, especially for seniors and women; dependence on medication caused by overprescription; inadequate and/or inappropriate interventions; lack of available or accessible culturally appropriate programs.

4. Negative attitudes such as "sermonizing" in some health messages; the stigma associated with mental health and substance use problems; negative attitudes towards socio-cultural differences.

Cautions

Despite general consensus on the importance of increasing focus on protective factors and prevention, the group expressed a number of concerns and cautions.

One difficulty associated with a health promotion approach is **finding ways to reach the people who most need help**. Several participants observed that education and services are most accessible to those who need them least. Information must be accessible to all groups, including the mentally challenged or those with serious mental disorders. Participants agreed that during a crisis, when people are forced to seek help, is the best time to introduce prevention messages and educate people.

Limited resources are another problem identified by participants. Most resources are currently going to people with serious mental illnesses. Many felt that resources should be shifted toward prevention, but some resistance was encountered. Some participants worried about the potential unfairness of taking resources away from "people with a legitimate claim to health care," especially at a time of dwindling resources. Financial considerations also have an impact on research activities: most of the literature is comprised of correlational studies because researchers lack the funds to conduct longitudinal studies.

Delegates raised the issue of the "sick role" created by the "**disease industry**". Such an approach can harm people's resiliency and their ability to develop coping mechanisms. One delegate observed that specialists contribute to the problem and must modify their approach.

The **stigma and ostracism** associated with mental illness, substance abuse and depression discourage people from getting help early.

Participants concluded that there needs to be a **multiplicity of interventions**. There must be policy interventions with the majority and more individualized interventions for people with problematic mental illness and substance use. The same approach cannot be used to prevent mental health and substance use problems as to treat those with serious problems.

MOVING TOWARDS NEW APPROACHES: IMPLICATIONS FOR RESEARCH, POLICY, PROGRAMS AND SERVICE DELIVERY

The facilitator then asked participants to consider the points raised in discussing health promotion and prevention in the areas of research, policy, programs and service delivery.

Research

Participants made the following points regarding research:

- Research should include participatory components so people can be "partners" rather than "subjects".

- Research should focus on the long-term effectiveness of existing programs and services. For example, we need to know more about the effectiveness of school programs and their delivery mechanisms; more research is needed on the effectiveness of self-help and mutual aid programs.

- Programs should be evaluated by independent researchers. Researchers could help program and service providers assimilate evaluation components into programs.
- Strategies for effective dissemination of research findings need to be developed. Much beneficial research does not appear in professional journals.

- Researchers and service deliverers with similar interests should form information networks and build on what is already done, rather than work in isolation.

- Research results should be available to the community for use as a strategic planning tool.

- Information about the determinants of mental health and substance use problems such as housing and unemployment needs to be made more available.

- Very little information is available about the effectiveness of services and programs among Aboriginal communities. New ways of doing research are needed, with Aboriginal communities participating in planning and implementation.

NEW WAYS OF DOING RESEARCH ARE NEEDED, WITH ABORIGINAL COMMUNITIES PARTICIPATING IN PLANNING AND IMPLEMENTATION.

- The differences in delivering programs and services in rural and urban areas need to be studied. Many programs that work in large communities cannot be transferred effectively to smaller ones.

- Research should look at the role of the community as a protective or a risk factor. Environmental interventions and corresponding policy implications should be studied to see whether they are more effective than interventions at the individual level. For example, how do responsible municipal policies on alcohol affect community health.

- Communities and individuals need to be tracked long-term over 30 to 50 years.

- Social support is an important area for research, but personal satisfaction with one's social support is more important than objective markers.

- Research should look at how important relationships with confidants, and other protective factors such as self-esteem and problem solving, are developed.

- Research should look at how to generalize effective demonstration projects and make them more accessible.

- There is a need to look at the duplication of programs and lack of information-sharing among researchers and service providers.

- More qualitative as opposed to quantitative research is needed.

Policy and programs

In discussing policy and program implications, participants made the following observations:

- Policies and programs should meet the needs of the client, not the health care provider. Health professionals have historically directed mental health and substance use policies.

  "We need to reposition health as a prime goal of our culture," said one participant. We need to involve consumers of services and their families in the planning and delivery of the services.

POLICIES AND PROGRAMS SHOULD MEET THE NEEDS OF THE CLIENT, NOT THE HEALTH CARE PROVIDER.

  There was agreement that a client-centred health promotion model would not only be more effective, but would cost less. The role of professionals should shift toward transferring skills and control to the individual. Research is needed to validate the effectiveness of such a shift.

  Policies should encourage the integration of treatment and prevention for greater effectiveness.

- Policies should focus on "gatekeepers" and their role in the promotion of mental health and the prevention of substance use problems.

General practitioners, for example, could act as "gatekeepers" and ask questions about isolation, drinking patterns, etc. This would allow them to make suggestions to avert crises.

"Gatekeepers" need to be more aware of the broad determinants of health. The criminal justice and education systems need to be involved in mental health and substance use policy making. Barriers should be broken down between the areas of spousal abuse, mental health, and substance use.

- Instead of "passing the buck" between provincial and federal jurisdictions, strategies should be developed to look at joint problem solving, joint resourcing, and joint training.

INSTEAD OF "PASSING THE BUCK" BETWEEN PROVINCIAL AND FEDERAL JURISDICTIONS, STRATEGIES SHOULD BE DEVELOPED TO LOOK AT JOINT PROBLEM SOLVING, JOINT RESOURCING, AND JOINT TRAINING.

- Rather than merging mental health and substance use programs and services, a partnership model should be developed. Resources could be pooled to strengthen and share programs and services with similar goals.

- Funding should encourage partnerships at national, provincial and local levels, but mechanisms are needed to help groups maintain their identities.

- The federal government should encourage good public policy for effective programs and spending. Little of the health care budget is allocated to mental health and substance use. This must be addressed. Of the mental health budget, 80 percent is spent on hospitalization. Financial cutbacks especially affect programs with the smallest budgets.

- Policies should be based on fact, but prevention and health promotion decisions are often political. Many inconsistencies exist; policies affecting alcohol use and illegal drugs are an example. With the public more involved in the development of programs, constituents can advocate political changes while prevention and health promotion professionals focus on programs and service delivery.

DUAL DISORDERS AND TREATMENT ISSUES

The final day's discussion focused on dual disorder and treatment issues.

WHAT THE LITERATURE TELLS US

Gillian Leigh from Cape Breton Regional Hospital opened with a presentation of findings from the literature review.

For the presentation, the term "dual disorder" was used to describe concurrent substance use and mental health problems. The literature divides individuals with dual disorders into four subgroups: a) severe persistent mental illness accompanied by an addiction; b) addiction to alcohol or to other drugs and symptoms of mental illness; c) substance induced organic mental disorder and a current substance use problem; and d) dual disorder "by history", a current substance use problem and a past mental illness problem or visa versa.

The literature identifies several key components of treatment. These include: complete detoxication; comprehensive assessment; provisional diagnosis with periodic review; flexible approaches to treatment; abstinence as a goal but not as a condition for treatment; open-ended treatment; concurrent treatment for both problems; and post-treatment care, including case management, self-help and family involvement.

The literature review also identified the following issues:

- Diagnosis (incidence) depends on the population studied.
- There is a lack of outcome research.
- There is a lack of studies which compare different treatment approaches.
- The literature concentrates on the most severely affected clients.
- Gender issues are not addressed.
- Cultural issues are not addressed.
- It is difficult to decide on how to ensure that the different needs of special populations are taken into account.
- A philosophical rift between addictions and mental health services affects treatment delivery.

- Studies on interaction and maintenance (what factors maintain substance use for a person with a mental illness) are lacking.

WHAT EXPERIENCE TELLS US

In the discussion following the presentation, participants agreed on the following three points:

- Mental health and the addictions specialists need to collaborate more to provide effective treatment of dual disorders;

- Programs and services need to be more client-centred, user friendly and accessible; and

- The role of communities in helping clients with dual disorders needs to be more recognized.

As one participant noted: "With good psycho-social interventions, good work with families, education about illness, and help to develop coping skills, you can reduce the relapse rate and the symptoms and improve the quality of life of affected people. It works!"

Participants identified current problems and obstacles preventing change:

- **Different legislation** governing provision of services in the mental health and addictions fields, **competition for dollars and conflicting professional practices** all discourage collaboration.

- There is a **lack of integration** between and within the two fields. Appropriate services are difficult to access, especially when moving between the two systems.

- There is a **lack of information** about availability of services. "How do you access the system when you don't know the system?" asked a delegate.

- Because people with dual disorders are often **difficult clients** to serve, some services set up to help them tend to **drift away from their mandate**. Participants noted that psychiatrists were often reluctant to work with substance use problems or personality disorders.

- Many people with dual disorders are **reluctant** to come forward for treatment because treatment services can be very threatening for them. Service providers tend to label and judge people coming for help; they strip clients of their confidentiality and send them back and forth between the two fields. Also, many clients associated with mental health services fear being stigmatized.

MANY PEOPLE WITH DUAL DISORDERS ARE RELUCTANT TO COME FORWARD FOR TREATMENT BECAUSE TREATMENT SERVICES CAN BE VERY THREATENING FOR THEM.

- Some programs and services are **insensitive to clients' needs**. One participant said that despite good intentions, service providers tend to impose their ideas and do not respect the role that substance use can play as a coping strategy for people with dual disorders. "You cannot take it away without replacing it".

ONE PARTICIPANT SAID THAT DESPITE GOOD INTENTIONS, SERVICE PROVIDERS TEND TO IMPOSE THEIR IDEAS AND DO NOT RESPECT THE ROLE THAT SUBSTANCE USE CAN PLAY AS A COPING STRATEGY FOR PEOPLE WITH DUAL DISORDERS.

- **Language** used to describe clients and client groups can sometimes be insensitive or inaccurate. For example, some participants strongly objected to the terms "dual disorder" and "case management" which they felt were dehumanizing. A Calgary treatment program has changed its perspective by replacing the term "dual disorder" with "special needs". Another example of the inappropriate use of language is the use of the term "immigrant" to define both refugees and voluntary immigrants, two groups with blurred outlines and very different needs. "It will make our services more effective if we can clarify our use of words."

- Some treatment services centre on **providers** rather than clients. Some addiction counsellors are not flexible in their approach. The focus is on assessing and labelling the client instead of giving immediate attention and help.

- **Geographic distances**, especially in isolated communities, and inconvenient hours make services inaccessible to many.

- **Lack of trust** on the part of clients prevents many people from accessing community-based services. "People with severe mental illness have been ignored and let down by the system. It takes them a long time to develop trust".

- **Lack of confidentiality**, especially in smaller communities, discourages use of community-based services.

- There is a **lack of understanding about the special training and educational needs** of health workers. Service providers and "gatekeepers" for people with dual diagnoses have special training needs. In Aboriginal communities, ethnic or cultural groups and among immigrants, frontline health workers often lack the necessary background to deal with the specific problems encountered. However, specialization can lead to a concentration on one aspect of the client's functioning, not the whole person.

In the diagnosis of mental health and substance use problems, there was consensus that biological factors should be integrated into a diagnosis, but "level of functioning" was the most important. "Risk factors make the most sense if defined in terms of something we can act on".

A "stress vulnerability" model was proposed as a diagnostic tool. This model would consider vulnerabilities such as genetic, perinatal, and experiential factors. The fewer vulnerabilities an individual has, the higher the expected ability to cope with stresses.

One participant shared an example of a program which discusses risk factors and vulnerabilities with adolescents. In this case, knowledge changes risk factors into protective factors. "Knowledge promotes choice".

MOVING TOWARDS NEW APPROACHES: IMPLICATIONS FOR RESEARCH, POLICY, PROGRAMS AND SERVICE DELIVERY

There was general consensus that successful treatment is based on values such as tolerance, dignity, and respect. Programs and service providers must be non-judgmental and accountable to their clients. Services should be easily accessible and based on individual needs.

The focus needs to be on long-term, flexible services that promote a harm reduction approach. Substance use, in particular tobacco use, can serve as a survival tool or a coping method. Treatment must free people from these "crutches", and allow them time to heal.

Participants provided the following suggestions on system changes to achieve the directions described above. Some current practices based on the values and principles were described to demonstrate how they work in practice.

Improved Collaboration

- **Develop and fund demonstration projects:** participants favoured demonstration projects to show how the two fields can collaborate to develop and deliver programs for substance use problems and mental health disorders.

- **Provide training:** participants supported secondment between the two fields, and into the community, to expand treatment professionals' experience in both areas. They suggested that dual disorders should be included in the curriculum for both fields. One participant stressed more specifically the need for "holistic training".

  People must learn from the client groups they serve. In the Yukon, for example, curricula for social work and education are designed in collaboration with First Nations. Consumers should share their stories with health workers as part of the training process.

One participant described an example of a "mentor" training program in Manitoba. Specialists in addictions treatment have trained staff at local hospitals in substance use assessments and referrals. Although this has increased the workload of the hospital staff, it has also made it easier for them to treat their patients.

Another participant described a travelling training program launched in Sudbury following a conference on dual disorders. This program has helped people from both fields to collaborate and to realize how much the two fields have in common.

- **Work in partnerships:** the group stressed the importance of putting together teams not driven by any one discipline. Suggestions included external steering committees, councils in charge of operations, case management teams and affiliations between organizations.

  One participant described how case management teams have successfully been put together in New Brunswick. These teams demonstrate how people from both fields can work together while still retaining their uniqueness.

- **Develop a common vision:** one participant said that a common vision might help treatment professionals rise above their territorial perspective. Another participant encouraged the field to look ahead rather than seeking all the answers in the literature.

Client-Centred Services

- **Make programs attractive and non-threatening:** respect clients' need for confidentiality; invite people to casually inquire; focus on the positive side of treatment instead of on the problems; take advantage of teaching opportunities. Treatment programs should help people see their problem themselves rather than be told.

TREATMENT PROGRAMS SHOULD HELP PEOPLE SEE THEIR PROBLEM THEMSELVES RATHER THAN BE TOLD.

- **Focus on clients' needs:** adapt hours to clients' needs; give them the help they need first instead of assessing them; design a specific approach for each client. "Let's ask our clients how we can serve them," one participant said.

Community Services

- **Work to improve attitudes:** loss of confidentiality has to be compensated by a greater acceptance of mentally ill or addicted people.

- **Strengthen community services and follow-up** when people with dual disorders return to the community. Strong community services

can play a crucial role by making information and resources accessible to persons with dual disorders. Participants emphasized the importance of frontline health service providers as "generalists". "Social workers *are* able to take on people with mental health or substance use problems. We must demystify the notion that you need to have a specialty to deliver services." Participants emphasized the importance of education, support and training, especially for families.

- Community services need **links with more formal systems** to address problems such as housing, poverty, mental health and addictions.

COMMUNITY SERVICES NEED LINKS WITH MORE FORMAL SYSTEMS TO ADDRESS PROBLEMS SUCH AS HOUSING, POVERTY, MENTAL HEALTH AND ADDICTIONS.

Success Stories

Participants then highlighted activities across the country incorporating the approaches described above.

The Achievement Centre in **Calgary** provides services to street youths. Many different services are involved, and the Centre is guided by a Council that emphasizes values instead of labels. Four hundred kids enthusiastically take part in the program.

A participant from **Saskatchewan** talked about a program for individuals with dual disorders. The program is managed by a non-governmental organization (NGO) and offers client-centred services based on individual needs. The most common need is housing. As a consequence, a large house with individual apartments was bought for clients, who may stay as long as they choose. Clients have access to community resources such as the YMCA/YWCA. The goal for clients is abstinence, but it is not mandatory.

A similar housing program in the **Yukon** has reduced repeat hospital stays. Auxiliary workers provide support as needed. Many have no formal training, but have worked with disabled individuals, and are able to teach life skills.

In **New Brunswick**, downsizing a psychiatric hospital has led to development of an effective community-based program which takes a multi-disciplinary approach, uses case managers and support workers. The primary values and goals are respect and dignity of all involved, including consumers, their families and staff. Abstinence is not the goal; success is defined by the individual. Relapses are expected and coaches help people through them. The program is cost-effective, rehospitalization rates have been lowered, people are happier and have fewer relapses.

A participant from **Calgary** described a project for young people who have been rejected by many other placements. Modest homes were

bought and the young people were asked to carve their initials into the buildings. They were also told that if anything went wrong, they wouldn't be told to leave — the caregivers would leave. This project required money to launch, but the cost to the system is now $92.00 per day rather than $600.00.

Another participant from **Calgary** spoke of a successful dual diagnosis program, where staff have general and special skills. Staff expect to develop areas of interest that facilitate a link with other organizations. Links have been created at an administrative level and between frontline workers.

In **Ottawa** a broad spectrum of services are delivered by a community health centre. Programs include crisis, education, self-help and volunteer components. The "gatekeepers" are outreach nurses and 31 cultural interpreters bridging the mainstream and a multi-cultural community. Generalists are supported by counsellors, representatives of Children's Aid Society and psychiatric hospitals, mental health and employment counsellors, acupuncturists and experts in women's abuse. The organization collaborates with many other organizations including the United Way and several churches.

In **Edmonton** "we train specialists who act as generalists for specific problems". The approach is cross-disciplinary and based on the particular knowledge needed to help individual clients.

CONCLUSION

The round table provided an opportunity for researchers, policy makers, practitioners and consumers to spend two days exchanging ideas on how the substance use and mental health fields can work together. Although the two fields have evolved independently, they both focus on illness and risk factors, rather than on health and protective factors. To better serve clients, it was agreed that the fields need to collaborate to remove organizational barriers and policy and funding conflicts, and to provide community managed, integrated and more prevention focused services.

To reach these goals will require a shift in philosophy and changes in attitudes, expectations and behaviours of policy makers, program developers, service providers, clients and their families. Key changes would include: training professionals in both fields; emphasizing health promotion and problem prevention; developing partnerships between professionals and clients to plan and provide services which recognize diversity as well as the interdependence of individuals, families and communities; promoting independence, control and self-esteem; and enabling people to live and access services in their communities.

APPENDIX A

LIST OF PARTICIPANTS

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APPENDIX B

AGENDA

Wednesday, March 22, 1995 ***Salon Vanier***

6:30 — 7:00	Welcoming Reception
7:00 — 8:00	Dinner
8:00 — 9:30	**Opening Session**: Introductions and Overview

Thursday, March 23, 1995 ***Salon Vanier***

8:30 — 9:00	Continental Breakfast
9:00 — 10:00	**Common Risk and Protective Factors for Mental Health and Substance Use.** Presentation on Findings of Literature Search by the team from Dalhousie University
10:00 — 10:30	Refreshment Break
10:30 — 12:30	**Discussion — Reframing the Theory in Reality.** Does this information differ from your experiences, and if so, how? What are the key issues for you? What are the success stories? What are the obstacles?
12:30 — 1:30	Lunch (Salon Leger A)
1:30 — 2:30	**Moving Towards New Approaches: Implications for promotion and prevention (research, policy, programs)** How can we develop new concepts of health promotion and prevention taking the commonalities into account?
2:30 — 3:00	Refreshment Break
3:00 — 4:30	**Summary and Future Directions**

Evening	Dinner on your own. (We will be organizing a sign-up sheet for participants who are interested in getting together for dinner at a local restaurant.)

Friday, March 24, 1995 ***Salon Vanier***

8:30 — 9:00	Continental Breakfast
9:00 — 10:00	**Dual Disorders and Treatment Issues**. Presentation on Findings of Literature Search by the team from Dalhousie University
10:00 — 10:30	Refreshment Break
10:30 — 12:30	**Discussion — Reframing the Theory in Reality.** Does this information differ from your experiences, and if so, how? What are the key issues for you? What are the success stories? What are the obstacles?
12:30 — 1:00	Lunch (Salon Vanier)
1:00 — 2:30	**Moving Towards New Approaches: Implications for treatment (research, policy, programs).** How can we develop new concepts in treatment, taking into account the commonalities?
2:30 — 2:45	Refreshment Break
2:45 — 3:30	**Summary and Future Directions**

APPENDIX C

ISSUES FOR DISCUSSION

Issues in Health Promotion and Prevention

- Most prevention programs address risk factors. Yet in many cases there is little evidence that changing risk factors changes outcome. A stronger theoretical basis is needed.
- What directions should we take in health promotion and prevention?
- What are the settings in which we want to work? Are poorly implemented and maintained school health programs a problem, even where curricula are mandated?
- Are our prevention resources and approaches getting stale? In what ways do they need rejuvenation? How could we work together?
- Almost all non-biological risk factors in substance abuse are related to mental health. Yet activities in treatment, and especially in prevention, are compartmentalized. Would it make more sense to promote mental health, rather than to have isolated programs addressing specific issues?
- The literature focuses on risk factors, leaving protective factors to be inferred. Does this overemphasize risk?
- Can we take for granted that risk and protective factors for mental health and substance abuse are similar, or are there other dimensions such as resiliency?

Dual Disorders and Treatment Issues

- What are the implications of dual disorders for substance abuse treatment?
- Treatments reported in the literature almost entirely follow the disease model of addiction for dual disorder clients. What are the implications?
- What constitutes use and abuse of substances in mental health treatment?

- The psychiatric approach appears to dominate dual disorder literature. What are the implications? Is this true in practice, or just in literature?

Social Attitudes and Norms

- Most literature negatively views substance use, without acknowledgement of positive aspects. Does substance use have no positive role in mental health? How might this issue be addressed? What do we do with data on the protective aspects of alcohol?

- Mental health is portrayed negatively in the literature. Do we change the perception or change the name? From what past lessons of substance abuse can mental health benefit? What data on resiliency can profit substance abuse?

Future Directions

- By all accounts we face an era of unprecedented funding cuts and economic turmoil. Yet the fallout of unemployment and economic hardship is likely to increase the demand for services.

  Are there ways to pool resources? Is this desirable? Are services duplicated? How do you envision the future?

- What areas have potential for collaboration between mental health and substance use? In what areas is there conflict? What benefits and conflicts among different interest groups (MDs, psychologists, social workers, ex-addicts, counsellors) do you foresee?

Miscellaneous

- Compared to the U.S., most information on Canadian programs, evaluations and reports is never published. Is there adequate publication and circulation of information so that others may benefit? How can this problem be solved? (Clearinghouses?)

- Where, if at all, do process addictions fit into the mental health/substance use fields?