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It is not difficult to understand why individuals who experience these profound and frightening changes will often seek to keep them secret, deny that anything is happening, or avoid people and situations where they may be discovered. The feedback they receive when they express hallucinations or delusions is disbelief. Ill persons, therefore, feels misunderstood and rejected, and ceases to share their thoughts as a result.

These intense internal experiences trigger other feelings of panic, fear, and anxiety – natural reactions under the circumstances. These feelings can further amplify their extreme emotional state. The psychological burden may be intense: most of it kept inside, its existence denied. The pain of schizophrenia is further accentuated by the persons’ awareness of the anguish and suffering they are causing their family and friends. Those who suffer from schizophrenia require a lot of understanding, patience, and reassurance that they will not be abandoned.

As the symptoms of schizophrenia become noticeable, the ill person will likely experience a sense of alarm and fear. Obviously, the sooner the symptoms are recognized and diagnosed, the sooner the person will benefit from medical help. Once you’ve confronted the disorder and the fear that goes along with it, you’re on your way to recovery.

DEFINING POSITIVE AND NEGATIVE SYMPTOMS

Understanding the terminology used by medical professionals can help you in your efforts to deal with this illness. The symptoms of schizophrenia are classified into two categories: positive symptoms and negative symptoms. They are described for you below:

POSITIVE SYMPTOMS

Hallucinations are thought to be a result of over-sharpening of the senses and of the brain’s inability to interpret and respond appropriately to incoming messages. Persons with schizophrenia may hear voices or
energy, they may not be able to do much more than sleep and pick at meals. Persons with schizophrenia can be experiencing life without any real interest in it.

Blunted feelings or blunted affect refers to a flattening of the emotions. Because facial expressions and hand gestures may be limited or nonexistent, individuals with schizophrenia seem unable to feel or show any emotion at all. This does not mean that the individuals do not feel emotions and are not receptive to kindness and consideration. They may be feeling very emotional but cannot express it outwardly. Blunted affect may become a stronger symptom as the disease progresses.

Depression involves feelings of helplessness and hopelessness, and may stem in part from realizing that schizophrenia has changed their life; that the feeling experienced in the psychotic state is an illusion, and that the future looks bleak. Often, persons believe that they have behaved badly, destroyed relationships, and are unloved.

Depressed feelings are very painful and may lead to talk of, or attempts at, suicide. Social withdrawal may occur as a result of depression; a feeling of relative safety in being alone; being caught up in one’s own feelings, and/or fearing that one cannot manage the company of others. People with schizophrenia frequently lack an interest in socializing, or at least the ability to demonstrate/express this interest.

EARLY WARNING SIGNS OF ONSET

One of the difficulties in reading the early warning signs of schizophrenia is the easy confusion with some typical adolescent behaviors. Schizophrenia can begin to affect an individual during the teen years, a time when many rapid physical, social, emotional, and behavioral changes normally occur. There is no easy method to tell the difference. It’s a matter of degree. Family members tell of different experiences. Some sensed early on that their child, spouse, or sibling was not merely going through a phase, a moody period, or reaction to the abuse of drugs or alcohol. Others did not feel their relative’s behaviour had been extraordinary. If you have any concerns, the best course of action is to seek the advice of a trained mental health specialist.
Early onset cases often tend to have a gradual, insidious onset of illness, rather than an abrupt onset. There is often a long period of gradual deterioration in functioning over months or years, referred to as the prodrome, which precedes the onset of overt psychotic symptoms (e.g., delusions, hallucinations, grossly disorganized thinking, and generally being out of touch with reality). The prodrome may be characterized by apathy, withdrawal, speaking less, declining interests and school performance, loss of contact with friends, loss of initiative, bizarre or occult interests/preoccupations, odd behaviours or rituals, neglect of hygiene/grooming, and disorganized thinking manifested as difficulty concentrating or engaging in coherent conversation.

The use of drugs or alcohol may act as a trigger (for an illness that was inevitably going to develop at some point in time) or can signify the adolescent’s way of dealing with his/her symptoms (to relieve or mask them). Psychosis that is purely drug or alcohol induced should resolve within days or weeks of not using these substances.

Other possible signs include unruly, attention-deficit/delinquent-like behaviour, or aggression.

The prodrome may resemble depression, and it may be difficult to distinguish schizophrenia at this early stage, especially since an adolescent becoming ill with schizophrenia may feel depressed. It is more likely, however, that the ill individual’s mood can be described as blunted or flat rather than sad, and there may seem to be an inability to experience or express appropriate emotion at all.

**TREATMENT**

Acute psychotic episodes, particularly first episodes, usually require hospitalization for a few weeks for assessment and stabilization. Further treatment can be provided on an outpatient basis in a hospital clinic staffed by a psychiatrist and a nurse. Ill individuals whose course of illness has stabilized, and for whom a medication regime has been established, may be able to receive their treatment from a non-hospital based psychiatrist, family doctor or pediatrician, but many people require re-admissions to hospital for acute psychotic episodes, especially in the first few years.
Sometimes an ill person does not recognize their illness, and refuses treatment. Your province has mental health legislation that will enable you to get help for your ill relative. Consult your provincial Schizophrenia Society, and a mental health or legal professional with expertise in these matters. (See section on Legal Issues, Mental Health Legislation, p. 170 for more information.)

The issues regarding medication treatment for adolescents are much the same as for adults. Certain factors are of added importance in adolescents, such as the need to optimize cognitive (intellectual) functioning (alertness, concentration, memory etc.) as much as possible to facilitate the continuance of academic studies. Certain side effects, such as weight gain and acne, are particularly problematic for adolescents, and may lead to non-compliance with treatment. Compliance is generally a major problem for adolescents, and often requires extra effort on the part of parents to help ensure that their child takes the medication.

A supportive, empathic and stable doctor-patient relationship is naturally important in ensuring compliance with medication, as adolescents with schizophrenia are frequently mistrustful and guarded, if not overtly paranoid, and lack insight about the need for treatment. Once stabilized, the doctor, nurse or other therapist can engage the adolescent in ongoing supportive counselling, talking about day-to-day events and stresses, encouraging the adolescent to verbalize thoughts and feelings and develop better reality-testing and problem-solving abilities. More intensive, introspective, analytically-oriented psychotherapy is generally not applied, as such therapy can be too stressful and disorganizing for individuals with schizophrenia.

COPING WITH YOUR TEENAGER’S ILLNESS

Families usually need a lot of emotional and practical support while coming to terms with their loved one’s illness, and steering their way through the turbulent first few years. In many cases the first few years
A diagnosis that confirms schizophrenia may be heart-breaking for you and your family. Remember there are many others like you, who have experienced the feelings that burden you. Seek consolation and support at this difficult time. It will help you cope, and you will learn valuable lessons to help the person with schizophrenia.

SEEKING MEDICAL ATTENTION

Family members will likely be the first to recognize the need to get medical attention for he/she affected loved one. Take the initiative. Ask your family doctor for an assessment if mental illness is suspected. It is important to realize that your relative may be genuinely unaware of the abnormality of his/her symptoms — remember that ill persons believe that the hallucinations, delusions, or other symptoms are real. They may, therefore, resist any suggestion to see a physician. Even if ill persons are aware that something is wrong with them, their confusion and fear about the problem may convince them to deny its existence or abnormality.

Efforts to have your relative agree to visit a doctor will likely be more successful when made without reference to strange behaviour (e.g., “You’ve been acting really weird lately”, or any reference to the feelings of others; “Your behaviour has been upsetting this family”). Encouraging the ill person to seek medical attention based on symptoms such as insomnia, lack of energy, or sadness will more likely be perceived as helpful and non-threatening. If your relative agrees to see a doctor, ask the receptionist for a double booking (most appointments are only 10 or 15 minutes long) so that you will not feel rushed. Then, after you have arranged the appointment, send the doctor a letter outlining your concerns as clearly as possible. In addition to assisting the doctor, this will help you be clear about what has been happening. The following is a sample letter:
THE NEED FOR PUBLIC EDUCATION

Recognizing and accepting that a problem exists, and seeking help are the first steps to receiving treatment for schizophrenia. But how is a person to know that what he/she is experiencing is not something to run and hide from – but rather something that should be treated, sooner rather than later? If and when they do seek medical assistance, how can people suffering symptoms of schizophrenia be sure they will get an appropriate response? The best answer is increased public education and awareness, and better training of health professionals. Public education should be targeted to: authoritative figures in an adolescent’s world; to the medical care system; to families with a history of schizophrenia (whose children are at greater risk of developing the disorder); to young people who exhibit symptoms of alcohol or substance abuse, and to the general public. Family physicians should have specific training to help them detect mental illness in its early stages. Emergency care units and mental health units of hospitals should have specific training not only recognizing the early symptoms of schizophrenia, but also minimizing the trauma of a first episode of psychosis for the ill person.

Often times the onset of illness comes at a young age (between ages of fifteen and twenty-five). Young people are typically still dependent on parents, teachers, athletic coaches, guidance counsellors, clergy, youth agencies and others for direction in their lives. These people can be influential in a young person’s life, and it is very important that they receive information on mental illness, and the early signs of its onset. Awareness will improve the chance of recognition, and once suspected, a teacher or other figure of authority and influence may help the ill person to accept the problem and seek treatment. If the ill person has a good relationship with a teacher or family doctor, wherein he/she trusts the professional, and feels treated with respect and concern, then there is a good chance that this figure of authority will be one of the first points of contact for the youth. It is essential that such individuals be educated about the warning signs of mental illness, and about taking a distressed young person’s complaints seriously. The person with schizophrenia is more likely to seek help voluntarily with the help of someone knowledgeable about mental illness with whom he/she enjoys a healthy interpersonal relationship.10
schizophrenia need lots of human contact, reassurance, encouragement, counselling, and support to accept their illness.

One of the advantages of having an educated public is that it is easier for the ill person and his/her family to engage the support of their community. If schools and teachers understand the illness, then they can help the young ill person as he/she tries to continue studies. If work environments have a good awareness of mental illness, they are more likely to support an ill person who tries to continue his/her career pursuits. Community support is key to reintegration of the ill individual, and should be engaged as soon as the ill individual is stable – it is **counter-productive** to prevent an ill person from doing activities he/she is capable of until a firm diagnosis is made (since that can take one or more years). Families will also need hands-on support from their community. They may require respite services, and are likely to need the help and understanding of other relatives and friends. People generally want to be helpful to those in need, and public education fosters the attitude of the general public to assist and appropriately to schizophrenia, while removing the stigma attached to it.

THE NEED FOR PATIENT AND FAMILY EDUCATION

In 1998 an early intervention survey performed by the Canadian Mental Health Association, British Columbia Division, found that the majority of people with mental illness received either minimal or no information about their diagnosis, or about the treatment and support available to them. The findings cited several problems with education for ill people: inability to process or accept the information at an acute stage of illness; lack of opportunities for education beyond the hospital environment; reluctance of professionals to diagnose based on a first experience; delivery of information failing to successfully and accurately communicate to the recipient (invoking unnecessary fear and serious misunderstandings), and failure of communication to be fitting and sensitive to the recipient (invoking fear, demoralization, or denial). The study also found that one of the best sources of information was peer-based education, because it provided knowledge in a less threatening manner, and enabled people with mental illness to share experiences with other people in similar situations. It is imperative that ill individuals receive sufficient and appropriate
Evaluations show a twenty-five percent improvement in functioning at the twelve-month follow-up in patients cared for under the EPICCC program as compared to pre-EPPIC patients.

The Centre’s core services include:

- The Youth Access Team (mobile crisis assessment and treatment team)
- Outpatient case management (OCM)
- An inpatient unit
- A group program
- Cognitively-oriented psychotherapy of early psychosis (COPE)
- Family work
- PACE clinic (the Personal Assessment and Crisis Evaluation clinic)
- Other sub-programs related to the treatment of psychosis

The **Youth Access Team** is a multidisciplinary mobile crisis assessment and treatment team. It is available 24 hours-a-day, seven days-a-week. YAT serves ill people experiencing a first episode of psychosis between the ages of fifteen and twenty-nine years. It provides crisis intervention in as little as an hour (for urgent referrals), in a manner that minimizes the stress to the ill individual. It will carry out assessments in an environment that is comfortable for the ill youth, such as home, school, or doctor’s office. The team provides intensive treatment, making daily visits (if necessary) to establish a relationship that the young ill person trusts, and to engage him/her in treatment. This approach allows the individual to recover as quickly as possible in familiar, supportive surroundings, with minimal disruption to regular activities. YAT also offers support and information to both ill individuals and their families. As the ill person begins to stabilize, the team will introduce the ill person to the full range of services of EPPIC. YAT provides information on psychosis to professionals in the community and to the general public. The team also plays a key role in forming close links with other service providers.
also responsible for ensuring the ill person has access to appropriate services when the three year period of case management expires.

Like EPPIC and the UK program, EPP subscribes to the usage of low doses of medication, and addresses persistent positive symptoms by changing medications. The psychiatrist tries to engage the family when deciding on choice of medication, asking for their help in background information and history of experience with medication. This helps promote family understanding and support of the treatment plan.

EPP offers cognitive-behavioural therapy (CBT) to ill individuals in order to help them adapt to the diagnosis, to treat depression and anxiety, to address low self-esteem and demoralization, and to reduce vulnerability to relapses. Recent research has demonstrated that CBT can also treat psychosis. EPP also offers CBT (in conjunction with antipsychotic therapy) for treatment of positive symptoms of schizophrenia.

The program offers family interventions, including: working with individual families; educating families about psychosis; offering strategies for coping with schizophrenia; training family members how to communicate with the ill person, how to problem-solve, and how to deal with a crisis, as well as offering support groups for families. EPP also offers group programs that deal with psychosis education, recovery, social anxiety, healthy living, alcohol and/or substance use, and coping with positive symptoms.

EPP recognizes the need for public education on early intervention. It offers education to mental health agencies, family physicians, and schools and colleges in the Calgary community on how to recognize early signs of psychosis, and how to access treatment.

EPP works in affiliation with the PRIME Clinic (Prevention through Risk Identification Management and Education). PRIME is a research clinic that studies mental and emotional problems. It offers intervention to individuals between the ages of fourteen and forty-five who sense that something is not quite right with their health. These people who are experiencing prodromal symptoms are offered an opportunity to discuss their concerns, and undergo a detailed assessment. They may also participate in studies the clinic undertakes.
The goals of PRIME are:

• To identify people at risk for developing psychosis
• To identify individuals in the prodromal stage of psychosis
• To delay or prevent the transition from prodromal stage to full-blown psychosis, and
• To decrease chronic illness by offering targeted treatment to those people considered at risk

EPP and PRIME together create a best practice in early intervention for schizophrenia. They are located at the Foothills Medical Centre, 1403-29 Street NW, Calgary, Alberta, T2N 2T9, and can be reached by telephone at 403-944-4836 or by fax at 403-944-4008. Further information on EPP can also be obtained from their website: www.eppic.org.au.

EARLY PSYCHOSIS PROGRAM, HALIFAX

In 1995, Dr. Lili Kopala, an expert in first episode schizophrenia, established the Early Psychosis Program in affiliation with the Nova Scotia Hospital and Dalhousie University. The program is designed to enhance detection of early psychosis and optimize the treatment during its earliest stages. There is a strong research component to the program, with emphasis on how to optimize functioning for people with schizophrenia. The clinical component provides specialized consultation services to mental health practitioners throughout the Atlantic Provinces; clinical consultation and treatment to ill people and their families in Halifax, and education for professionals, families, and the community. For more information on this program, contact the Department of Psychiatry, Dalhousie University, 5909 Veterans Memorial Lane, Queen Elizabeth II Health Sciences Centre, 9th Floor, Lane Building, Halifax, Nova Scotia B3H 2E2. Their phone number is 902-473-4254 and fax number is 902-473-4596.
PREVENTION AND EARLY INTERVENTION PROGRAM FOR PSYCHOSIS (PEPP), LONDON

Based in the London Health Sciences Centre of London, Ontario and affiliated with the University of Western Ontario, PEPP provides comprehensive assessment and treatment for individuals experiencing a first episode of psychosis. Using a modified assertive case management model, the program services ill people between the ages of sixteen and fifty. A clinician is available by phone to handle immediate problems. Appointments with a trained mental health professional can be arranged within twenty-four to forty-eight hours for exploration and assessment of the ill person’s situation, either in the clinic, or at the ill person’s home. If signs of psychosis (or risk for imminent psychosis) present themselves, a multidisciplinary team of health practitioners will carry out a complete assessment. PEPP is specially designed to suit the needs of youth, and is committed to working in partnership with the families of ill individuals. Hospital admissions are avoided whenever possible. Treatment plans are created on an individual case basis, and consist of safe and effective newer antipsychotic medications combined with psychological and psychosocial interventions. Each individual is carefully monitored by a case manager. Results of the PEPP program confirm those of the EPPIC program in Australia – that individuals receiving optimum treatment within six months of onset of psychosis have better recovery than those whose treatment was delayed for six months or more.

PEPP recognizes the need to educate the public on early intervention. Their community outreach initiative involves media advertising, strengthening links with community agencies and family physicians, and other interventions designed to facilitate early detection and treatment.

PEPP’s clinical service is integrated with a research program. Research is focused on the advancement of knowledge about the nature of psychotic disorders, the impact of psychosis on ill people and their families, and the development and evaluation of new approaches to treatment and prevention. Experts in the fields of psychiatry, psychology, epidemiology, economics, neurosciences, nursing, and health services contribute to research projects. One of PEPP’s research projects is the evaluation of the effect of its outreach program on the length of time to treatment response, the likelihood of relapse, and the level of improvement in community functioning and quality of life for the ill individual.
EMERGENCY PLANNING

Contributing families recommend strongly that you have an emergency plan in place for crisis episodes. For example:

• Keep a list of phone numbers handy for: the police, the doctor, the psychiatrist, and an emergency centre for psychiatric admissions. Find out if there is a Crisis Hotline in your region

• Ask the ill person’s doctor or psychiatrist (ahead of time) which hospital (if necessary) to go to in case of an emergency

• Know which family members, friends, and caregivers the ill individual might trust most in an emergency

• Find out whom you can phone for support at any time of the day or night

• If applicable, decide who will take care of other children

• Consider explaining the situation ahead of time to your local police department to make them aware of your circumstances, and get their advice on emergency response

• Know that the crisis situation may be less frightening to the ill person if the emergency procedure has been explained and is anticipated

In crisis situations, you expect the ill individual to be admitted, if not voluntarily, then involuntarily. However, this may not be the case. He/she may refuse to be admitted, and the medical examination may not result in an assessment that would support involuntary admission. If you are not able to be at the hospital, it is possible that the person may be allowed to leave before you are notified. If he/she is not admitted involuntarily, yet admission is recommended, families who have been through the experience strongly suggest that you consider telling your family member that returning home is not an option. Without the alternative of returning home, the hospital may appear to be a safe haven to the ill person.

It isn’t always easy to make decisions during a crisis. If you’ve already experienced a crisis, make plans so you will be prepared in case it happens again.
shower regularly. How can we work out an agreement that you will shower daily?”

• Be forgetful. Say something like, “I forgot the milk. Can you get it please?”

• Encourage the ill person to take responsibility. For example, leave instructions about starting dinner in case you are late getting home that night. And then be late.

• Try to teach the ill person how to deal with stress in a socially acceptable manner. For example, if he/she is in a public place and begin to feel panicky, they can go to a washroom until the feeling has passed.

• Remember that family members are often the only friends the ill person has. So try to be a friend; talk as a friend would. “I’d really like to see this movie. Would you come with me tonight?”

• If you are a member of a church, encourage someone from the congregation to befriend the ill person. (Look for someone from his/her age group.)

• Always try to put yourself in the person’s shoes. Respect his/her feelings. Saying “Don’t be silly. There’s nothing to be afraid of”, will get you nowhere. Allow the ill person to feel frightened by saying something like, “It’s all right if you feel afraid. Just sit here by me for awhile”

• Respect the person’s concerns about his/her illness. Often, those who have schizophrenia ask their families not to go public – that is, not to become a public speaker or to give interviews on behalf of their support group. Although some families may feel they have a lot to offer in terms of helping others, they may decide (for the time being) to abide by the ill individual’s wishes. Others, although fully sympathetic with the ill person, may decide otherwise.

“…A good family environment can be a major factor in improving the chance of stabilizing the disease and preventing serious relapses.”

– Dr. Ian Falloon, et al.
MEDICATION

Medication is the cornerstone of treatment for schizophrenia. Once the acute stage of a psychotic episode has passed, most people with schizophrenia will take medicine indefinitely. This is because vulnerability to psychosis doesn’t go away, even though some or all of the symptoms do. For example, without regular medication, the chance of a relapse in 2 years is 80-90%. By contrast, the 2-year relapse rate is cut in half if a person with schizophrenia does nothing except take antipsychotic medication as prescribed. Relapse rates are even further reduced by adding other treatment measures (as described in the Psychosocial Treatment section). Thus, medication has a preventive role in the long run, as well as a symptom-relief role in the short run.

First-generation medicines were introduced between 1955 and 1980. They were used to alleviate the positive symptoms (hallucinations and delusions) of schizophrenia. Second-generation medicines have been available since 1990. They work equally well on positive symptoms, and have a documented advantage in relieving negative symptoms. It remains to be seen whether the new medicines are better for cognitive symptoms, such as memory loss and concentration problems.

Clozapine – a second-generation antipsychotic – was developed to act on a variety of neurotransmitter receptors. Risperidone was developed specifically to block serotonin and dopamine receptors equally. Olanzapine and quetiapine were developed to act like clozapine. Because they are less potent at the dopamine receptor, they tend to have fewer side effects associated with the blockage of dopamine, e.g., tremor, stiff muscles, and agitation. Unfortunately, they have their own undesirable effects, such as a tendency to gain weight. This can be more of a health hazard than stiffness and tremors. There are many kinds of antipsychotic medicines in use today. Each drug has two names: the generic or chemical name (first column below), and the brand name used by the pharmaceutical company that manufactures it (second column below). The table below lists the antipsychotic medicines currently available in Canada.
with schizophrenia, the stigma already attached to the illness, coupled with the lack of self-confidence that comes from being overweight, can seriously impact their quality of life.

Social isolation in turn can lead to increased inactivity, especially when coupled with low socio-economic status. The less active a person is, the more prone he/she is to gaining weight.

Causes of Weight Gain

Typical causes of weight gain include:
- Poor dietary habits
- Lack of exercise
- Age
- Gender
- Substance abuse, and
- Antipsychotics and other psychotropic medications

POOR DIETARY HABITS:
- Eating on the run and snacking (especially in the evening) are big contributors to an unbalanced and unhealthy diet. This problem is made worse if the snack foods are empty calorie foods (foods that do not provide good nutrients and energy for the body).
- Eating lots of fatty and sugary foods like biscuits, sweets, cakes, muffins, and chips can lead to fluctuations in blood sugar. These can give you mood swings or make you feel tired, irritable, or depressed. The same can happen if you regularly skip meals.
- Eating too many simple carbohydrates produces a high sugar level in the body, which turns into fat. Simple carbohydrates include breads, starches (potatoes, rice, etc.), fruit juices, cereals.
- Not eating three healthy meals a day, with a proper daily balance of protein, grains, vegetables, and fruit will likely lead to snacking, and eating inappropriate foods. Not taking the time to plan and eat a well balanced diet will likely lead to forming the poor dietary habits listed above.
Lack of Exercise

Health and fitness go hand in hand. If you are fit, you will be in better condition to face life, both mentally and physically. By contrast, if we do not look after ourselves – both our physical and mental health – we will likely suffer physical health problems that can also affect our mental and emotional well being.

People with schizophrenia are particularly prone to physical inactivity. Feelings of fatigue, depression, or anxiety can drain one’s energy, making it difficult to be motivated to exercise. The problem is, however, that the more inactive one is, the more tired and less vibrant a person tends to feel.

Age

As people get older, there is a tendency to want to slow down, or not feel as strong or able to be physically active. Again, the problem is that the more inactive the body is, the more likely it is to feel stiff, sore, or tired. Physical movement is necessary to maintain good blood circulation to all the body’s hundreds of parts. Poor circulation, and lack of use of muscles, leads to stiffness and soreness. While activities may have to be modified as one ages (e.g., a fast paced walk as opposed to running), it is just as important to exercise when you are older.

It is interesting to note that drug-induced weight gain (see section on medications below) is lower for people over sixty years of age than for younger adults.

Gender

There is some scientific evidence that suggests females who experience schizophrenia may have a higher risk of weight gain than males. For example, research led by Dr. Tony Cohn of the Centre for Addiction and Mental Health in Toronto shows that the prevalence of obesity for women with schizophrenia is three times that of the general population. Males with schizophrenia tend to be two times more obese than men without the disorder.
Smoking is probably the most common risk factor for heart disease.

Dyslipidemia (an abnormal amount of fatty acid) is a metabolic abnormality that causes injury to the arterial walls creating problems in how cholesterol is processed in the body.

Hypertension produces structural changes within arteries that narrow the arterial openings, which may lead to aneurysms (an excessive localized enlargement of an artery) and necrosis (the death of tissue caused by disease or injury). The effects of hypertension manifest themselves after several years, and are made worse by other risk factors such as dyslipidemia, smoking, diabetes, obesity, an inactive lifestyle, high amounts of salt in the diet, and stress. Hypertension tends to increase with age.

Atherosclerosis is a form of arteriosclerosis (thickening of the walls of the arteries; also known as hardening of the arteries), and is caused by the build-up of fatty deposits.

Examples of psychological factors that contribute to heart disease include stress, anxiety, depression, and hostility.

Medical science also looks at risk factors in terms of metabolic syndrome. Metabolic syndrome occurs when three of the following risk factors are present at the same time: abdominal obesity (for men, a waist measurement greater than forty inches, and for women a waist measurement greater than thirty-five inches); a high level of fatty acids; low HDL cholesterol; high blood pressure, and high fasting glucose. People with metabolic syndrome have a significantly increased risk of diabetes and coronary heart disease. There is a chart known as the Framingham chart that doctors can use to calculate a person’s ten-year risk for heart disease. The chart assesses risk based on the following risk factors: age, gender, systolic blood pressure, HDL cholesterol, smoking, and total cholesterol. A point system is used to evaluate each risk factor, and the total number of points then corresponds to a person’s percentage chance of having heart disease within the next ten years.
It is particularly important that people with schizophrenia pay attention to the risk factors of cardiovascular disease. Maintaining a healthy lifestyle is the best prevention against heart problems. People with schizophrenia should have regular medical check-ups to monitor for CVD risk factors.

Rare Side Effects

People with schizophrenia and their families may come across information on antipsychotic drugs that at first glance could be alarming. The Canadian Government (Health Canada) has made rulings that require some pharmaceutical companies to post warnings on their products to alert users to specific conditions or side effects that may occur during treatment. These rulings resulted from concerns relating to a history of cardiac problems with older antipsychotics, antihistamines and sertindole. The labels do not mean that patients will experience the condition, but rather that users should be educated about the potential side effects so as to recognize signs of onset, and/or to ensure they are regularly monitored by a physician. It is also possible to have a warning that pertains to particular patient populations (e.g., those of various ethnic origins) for which there may be potential side effects. One of these potential side effects is QTc prolongation.

Prolongation of the QTc interval is a condition that may be induced by drugs such as diuretics, quinolone antibiotics, and antipsychotics. The QTc interval is the length of time that it takes for the heart ventricles to electrically discharge and recharge. An electrocardiogram can be performed on a person to measure QTc interval, and test for prolongation. For women at rest their QTc count is typically less than four hundred and fifty, and for men it is four hundred and thirty. Some drugs can cause the QTc interval to increase. A clinically significant prolongation of the QTc interval would be an increase greater than a count of thirty. If the QTc interval is increased to greater than a count of five hundred, the person may be at risk of sudden death from arrhythmia (an irregular heart rhythm or ventricular fibrillation), or a condition known as torsade de pointes. Torsade de pointes is extremely rare and unpredictable, and can lead to sudden cardiac death. Most cases of torsade de pointes have occurred in patients...
BE PREPARED! It is important to discuss prevention and emergency treatment with a trained health professional. Both the ill person and family members should know how to respond to a situation involving low blood glucose levels. It is a good idea for the ill person to carry glucose tablets or hard candies on him/her at all times.

If the person experiences high blood glucose levels, it is important to call or visit his/her physician. High blood glucose levels can occur when food intake, activity, and medications are not in balance. They may also occur when the person is sick or experiencing more stress than normal. Signs that blood glucose levels are high include an increase in thirst; more frequent urination, and/or an increase in fatigue. The physician may have to adjust medication and/or insulin, recommend a change in diet; or suggest that physical activity be increased.

When the person with diabetes gets sick (e.g., with flu, colds, or any other illness), it is very important that he/she continues to take his/her diabetes medication. Also, he/she should talk to a pharmacist before taking any medication to treat the illness.

When you are sick, it is very important that you:

- Drink plenty of extra sugar-free fluids or water
- Replace solid food with fluids that have glucose if you can’t eat as much as normal – try to drink/eat ten grams of carbohydrate every hour
- Call your physician, or go to a hospital if you vomit more than twice in a twelve hour period, and
- Continue to take prescribed insulin – you may need to take more than usual depending on blood glucose levels

Other tips for people with diabetes:

- Don’t smoke
- Visit the dentist regularly, and
- Visit the eye specialist at least once every two years
It is important to remember that diabetes is a serious illness. It can, however, be controlled through proper management and treatment. Family members may need to pay extra attention to the physical well being of a person with schizophrenia who has diabetes. Diligence is required to ensure the ill person eats regularly and properly, and maintains a healthy lifestyle.

For more information on diabetes, call the Canadian Diabetes Association. Some of the above information was taken from their Web site: www.diabetes.ca

**SMOKING AND SCHIZOPHRENIA**

Tobacco smoking is a common habit for people with schizophrenia. Fifty to ninety percent of people with the disorder are smokers (as compared to twenty-five to thirty percent of the general population in the United States). More than sixty percent of excess deaths among people with schizophrenia are related to smoking.

One of the reasons smoking may be so popular with people who have schizophrenia is that smoking may lessen the negative symptoms of the illness, and improve the processing of auditory stimuli. This is due to the effect nicotine has on dopamine activity in the brain. Another reason that smoking may be so popular among people with schizophrenia is that it makes them feel more comfortable in social settings.

Smoking increases the metabolism of antipsychotic drugs, and ill individuals who smoke may need higher doses of medicine to control their illness. Higher doses of antipsychotics, however, lead to an increased susceptibility of weight gain, dyslipidemia, hypertension, and diabetes.

Studies show that people who are treated with old or typical antipsychotic drugs tend to smoke more than those who undergo newer or atypical antipsychotic therapy.

Smoking has very serious, and even deadly, consequences.
concern to the person experiencing them, and can also be a key reason for not complying with drug therapy. It is usually during the recovery phase that sex becomes an issue. For example, a sexual relationship that existed prior to the illness will often be put on hold during the acute phase. As symptoms of the illness abate, and the ill person begins to recover, interest in a romantic relationship may be revived. Interest in sexual activity may signal resumption of normal development, as the ill person regains his/her identity and is prepared to seek close relationships again. Successful resumption of sexual activity can help to facilitate the establishment of intimate adult relationships.

It is important to developmental recovery that people with schizophrenia be educated about sexual side effects that can occur and that they report them to their physician(s). Doctors should actively question patients about sexual side effects of medication. The impact of the side effect on ill persons should be explored. Treatment options should be openly discussed with ill individuals so that they understand the costs and benefits of potential solutions to the problem. It is possible, for example, that by reducing the dose of antipsychotic medication, the side effect may decrease. It may also be feasible to try different medications. This may be helpful since not all medications cause the same severity of sexual side effects, and ill individuals may be sensitive to side effects from some drugs more than others. It is most important that people with schizophrenia realize that there are ways of treating sexual side effects without ceasing drug treatment for their disorder.

Antipsychotic medications, along with the illness itself, can both affect sexual thoughts and activity. This intimate area of human functioning may be difficult for individuals to discuss, but being open about such concerns can not only greatly reduce them, but lead to solutions that improve quality of life.
• Assist the ill person to set realistic goals. Encourage him/her to gradually regain former skills and interests. Try new things as well, but work up to them gradually. If goals are unattainable or if you nag, stress can worsen the symptoms.

• Gradually increase independence when the ill person shows the ability to handle greater responsibility and is able to complete various types of chores. Set limits on how much abnormal behaviour is acceptable and firmly and consistently apply the consequences. As well, some re-learning may have to occur about the handling of money, cooking and housecleaning. If outside employment is too difficult, help the person learn how to use time constructively.

• Together learn how to cope with stress. Anticipate ups and downs and prepare accordingly. A person with schizophrenia needs to learn to deal with stress in a socially acceptable manner. Your positive role modeling will be most helpful.

• Encourage the ill individual to get out into the community. Allow him/her to participate in the selection of an appropriate activity when trying something new. If requested, go along the first time for moral support.

• Be good to yourself. Your good health is very important, even crucial, to the best functioning of your entire family. Let go of guilt and shame. Take comfort and gain strength from the positive things your family has experienced together.

• Establish realistic expectations and goals for yourself within your own life. Make sure you are allotting yourself time for extra-curricular activities, hobbies, physical exercise/sports, etc. You need time for yourself in order to rejuvenate and maintain the stamina necessary to help others.

• Value your own privacy. Keep up friendships and outside interests and lead as orderly a life as possible.

• Do not neglect other children. Brothers and sisters often secretly share the guilt and fear of their parents. They may worry that they too may become ill. When their concerns are neglected because of the ill child, they can become jealous or resentful. These children need your love and attention, too.
FINANCES

MANAGING MONEY

Many people with schizophrenia have trouble in handling money matters. This can present families with some awkward situations, some of which may be beyond an immediate solution.

Patients who are entitled to disability benefits can get help to apply for them while still in hospital. Disability benefits are paid on a monthly basis. Most recipients will need a good deal of help learning how to budget properly to meet basic needs such as rent, food, and transportation. They may find it difficult to make the money last for the whole month. When a substantial sum is available (for example, on receipt of a disability cheque), many tend to blow all or a large part on impulse spending, often foolishly, or to give their money away to friends — even to strangers. Families find that they are then called upon to pay for basic living expenses.

Behaviour of this sort, although not surprising for someone with few chances to enjoy life, is disconcerting for families, and requires that they exercise a good deal of patience. For the individual, managing money well is an important step toward the achievement of greater independence. By linking behaviour that demonstrates responsibility (e.g., successful completion of chores) to autonomy in handling money, you may be able to help the ill person learn to manage his/her finances. Here are some ideas on how to make life a little easier on the family while giving the ill person a sense of independence:

• Consider arranging for the disability cheque to be delivered to a parent or guardian
• Investigate the possibility of pre-paying landlords, utility companies etc. so that the ill person’s rent, heat, hydro, and phone bills are covered
• Your local grocer may be asked to create vouchers for the ill person, paid for by the family in advance, and redeemable on a weekly basis by the holder
• Arrange with a local restaurant to pay for meals on the ill person’s behalf
them with appropriate medications such as antidepressants, also makes a big difference in improving cognitive functioning.

Cognitive remedial therapy is a relatively new approach that is not widely available for routine use. This involves practicing various mental exercises, usually with the help of a computer. Other simple steps include the use of various memory aids (e.g., using a dosing box to take medications regularly, and a calendar to note down appointments), and generally maintaining an active structured routine.

Like many other things in life, the principle with cognition is use it or lose it.

In the small proportion of individuals who are prone to develop a progressive type of cognitive deterioration, prevention is more critical. Initiation of antipsychotic medications early, soon after the first symptoms of illness appear, may have some value in limiting the deterioration in later years. Strict adherence to the recommended dose of medication over a period of time is also essential in lessening the degree of deterioration. Keeping symptoms under control and avoiding relapses of illness is perhaps the best approach to prevent cognitive deterioration. It is important to note that the indiscriminate use of recreational (street) drugs can worsen cognitive functions in vulnerable individuals.

CURRENT LIMITATIONS

While a lot has been learned from research over the past two decades, several questions still remain unanswered. First of all, it is not known if there are certain cognitive disturbances that are unique to schizophrenia. Cognitive problems of different sorts are seen in a number of other disorders such as Alzheimer’s disease, and the type of difficulties that are specific to schizophrenia are yet to be clearly identified. Second, there is a continuing debate about the progression of cognitive problems: whether they get worse over a period of time or not. Third, there is a need to develop a method of identifying individuals who are more prone to develop cognitive problems than others. Having such a predictive strategy will help early recognition and possible prevention. Fourth, the areas of the brain that are
RESEARCH IN PROGRESS

Cognitive aspects of schizophrenia have become the most active area of research in the past five years. Researchers are working on identifying the exact nature of cognitive problems experienced by people with schizophrenia, and have developed appropriate tests to measure and monitor them. Functional imaging has been another active area of research. Scanning devices such as the MRI and PET imaging are being used to study the brain mechanisms involved in causing cognitive problems. Also, major pharmaceutical companies are actively investing in the development and testing of newer medications that are likely to offer greater benefits in improving cognitive problems. Psychologists, occupational therapists, and specialists in education are involved in developing various cognitive remedial strategies that can be incorporated into day treatment programs and daily routine.

CONCLUSION

Our efforts to understand schizophrenia seem to unfold as if we were peeling the layers of an onion. At first it appeared that positive symptoms were the only problem. Antipsychotic medications have been greatly helpful in controlling these symptoms. As these medications became widely available, the problem of negative symptoms became apparent. The new second generation antipsychotic drugs offer some hope that negative symptoms can also be conquered. Cognitive problems are the next ones to tackle in the ongoing battle with this devastating disorder. Solving them presents a significant challenge. Understanding the origins of cognition and brain mechanisms is likely to help us not only in dealing with schizophrenia, but also in unravelling the mysteries surrounding other mental illnesses.
Reducing Stress

Reducing the chance of being overstressed is like reducing the chance of being infected. You try to avoid possible sources of stress (just as you would avoid people who sneeze); you try to develop habits that counter the effects of stress (just as you would regularly wash your hands); you try to fortify your defenses against stress (just as you would eat a healthy diet with lots of vitamins), and you try to immunize yourself against stress (just as you would get a flu shot).

Avoiding stress means working part-time rather than full time, having a room of your own you can go to during a family party, and avoiding people who make you tense. Good counter stress habits are getting lots of sleep, good food, exercise, having friends you can talk to, and avoiding alcohol, drugs, and nicotine. You can fortify your defenses against stress, for example, by discussing what people have said and how you reacted to their comments, as well as how you might have misunderstood them and how you could have reacted. Developing good defenses are important issues to discuss with a therapist. Immunizing against stress means taking prescribed medications. Just like inoculations, they may hurt a little temporarily but what is gained far outstrips what might be suffered.

Providing Structure

While lots of sleep is good, lying in bed not sleeping is bad. It allows thoughts and worries to crowd out reality. A person with schizophrenia needs a tight schedule for every day. That does not mean running wildly around — rest periods can be built into the schedule. An appointment calendar serves as an organizer and memory tool; using it can also give the ill individual a sense of accomplishment at the end of each day.
A person who stays home all day might have a schedule something like this:

8:00AM  Wake up, shower, dress
9:00AM  Prepare and eat breakfast, (take medications)
9:30AM  Clean breakfast dishes and make bed
10:00AM Walk around the block, mail letter, buy newspaper
10:30AM Write in diary
11:00AM Read newspaper and rest
12:00PM Prepare a salad, eat it, wash up
12:30PM Listen to music
1:00PM  Do housework, sew, iron, clean
2:00PM  Write a letter, call a friend
2:30PM  Have a piece of fruit, relax
3:00PM  Watch TV
4:00PM  Read a book
5:00PM  Start preparing for supper, prepare vegetables, cook main dish, set the table
6:00PM  Supper (with family)
7:00PM  (Help) Clean up
7:30PM  TV
9:30PM  Call friends, talk to family
10:00PM Prepare for bed, take medications.
Moderating Stimulation

While too many stimuli cause stress, too few may encourage apathy and boredom. The task of the family and caregivers is to modulate the stimulation just enough. This is not easy but comes with practice. The person with schizophrenia should be urged to be active, but not so much that it becomes overwhelming. Generally, activities that involve fewer people are easier. A walk around the block together could be a start. Introducing something new now and again is good, but novelty is always stressful. It is important to establish a routine, then you can make slight variations on the routine, but not all at once.

Maintaining Support

This refers mainly to emotional support but may include financial support as well. No matter what the person with schizophrenia says or how he/she behaves, the family needs to maintain a supportive stance. This can be at a distance. The main support does not necessarily mean closeness. It means that the ill person knows that the family is always there for him/her no matter what. Ideally, this is accompanied by encouragement, praise, recognition of even minor accomplishments, and optimism.

If you notice behavioural changes in the ill person that you suspect may coincide with the onset of a relapse, bring it to the attention of a member of the treatment team immediately. Remember, relapse is a natural phase of the illness. With strength, courage, and lots of support, the ill person can recover again!

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clerical skills such as filing or typing while working on the Clubhouse’s weekly newsletter; research skills such as recording and reporting of information on member participation, attendance, and success stories; communication skills through reaching out to members who do not regularly attend the club; meal planning by working with the Centre’s food services section; store clerk by working in the Clubhouse canteen or thrift store; telephone operating skills by working with the switchboard at the club, and housekeeping (vacuuming, dusting, cleaning) by helping to keep the club clean and beautified.

Members have the opportunity to participate in recreation activities during evenings and weekends, and get involved in planning special occasion events.

**Housing Unit**

The primary objective of this unit is to help members obtain as independent a housing situation as they can maintain. Clubhouse staff work with members to access and maintain decent and affordable housing that suits their individual needs and capabilities. Housing may be sought in the community, or within a Clubhouse home or apartment. Fitzroy Centre operates several housing projects:

- **Longworth House** – a ten bedroom house that provides a home environment
- **Fitzroy Centre Apartment Complex** – a seventeen unit apartment complex located next to the Clubhouse. The individual apartment units allow occupants to live independently, while at the same time accessing support they need to live on their own
- **181 Kent Street Apartments** – an eight unit complex for members who require only occasional support to live independently; and
- **Rent Subsidy Apartment** – 15 independent apartments located around the city. Occupant members are provided a rent subsidy that is geared to their income

The Housing Unit also provides education to members in daily living skills, for example, financial management and budgeting, medication regimes, etc. It also maintains the reception area for the club, giving members the opportunity to learn how to greet visitors and direct
them to various areas of the club. The unit is also responsible for repairs to Clubhouse facilities and care of the grounds. Members can get involved in painting, minor plumbing, carpentry, and obtaining estimates for repairs that they can’t do themselves. They can also learn gardening and lawn maintenance.

**Employment Unit**

The philosophy of the Clubhouse concept is that members and staff run the Clubhouse facility together, with the members being the driving force of the program. They work alongside staff doing all the various jobs of the Housing Unit and Member Services Unit. They learn the life skills required for their job in the outside world, such as dressing neatly, being punctual, and interacting with fellow employees. The objective of the Fitzroy Centre’s Employment Unit is to assist members in their efforts to reach their highest potential in the areas of employment and education.

The supports and services provided by the unit include:

- **Employment and Education Counselling** – wherein members receive the help they need to set vocational and educational goals
- **Life Skills Instruction** – helps members learn and apply coping skills to better manage their life situations, and to overcome employment barriers that may be preventing them from working
- **Employment Skills Training** – offers training programs that prepare members for entry or re-entry into the work force, and organized job finding clubs for the members
- **Transitional Employment Placement (TEP)** – offers part-time entry-level jobs within the community. The employment unit arranges the placements, and members work in the positions for six to nine months. TEP provides members with the opportunity to develop their confidence and good working habits in the real world
- **Job Search and Marketing Supports** – this service is also known as Job Finding Clubs, and is offered during peak hiring times. Participating members receive assistance in all aspects of job searching (e.g., resume preparation, applications, contacting employers, job interviews, and follow-up). The unit has a Job Board which includes information received daily from Human Resources
and Development Canada, local newspapers, employers, and other sources. Members are also individually informed of available job opportunities. Another aspect of this service is advocacy. Clubhouse staff advocate for employment opportunities, and go out into the community to educate employers on the Centre’s programs and services.

- Education and Literacy – provides learning tools for members such as literacy tutoring, and interactive computer programs in math, writing, autoskills, typing, and reading. This service also organizes educational activities such as library trips, spelling bees, museum tours, and guest speakers. Staff provide support to members to help them achieve their educational goals, and offer assistance with referrals to educational institutions.

The diversity of the programs offered at Fitzroy Centre allows members to set and achieve their individual life goals. Studies have shown that people who are involved in a Clubhouse experience less frequency of relapse, and report an improvement in their quality of life.

For more information on Fitzroy Centre Clubhouse, call 902-566-5111.

Best Practice Example:

Potential Place 1130-10th Avenue S.W., Calgary, Alberta

Also based on the International Clubhouse model, and accredited accordingly, Potential Place is Calgary’s restorative environment for people struggling with severe and persistent mental illness. It is designed as a place of transition from institutionalization to independent living.

Potential Place’s primary goal is to help people with mental illness attain or regain the self-esteem, confidence, and social skills necessary to lead vocationally productive and socially satisfying lives. Through Clubhouse activities (see description above), and advocacy in the community, Potential Place works to dispel the stereotype beliefs about the mentally ill and their place in the real world. The Clubhouse’s core belief is that what people who have mental illness need is not isolation as full-time patients, but rather integration into the real world. They have a right to meaningful, gainful employment (or volunteer positions), decent housing, a supportive community, opportunities for education.
The team includes a Clinical Follow-up Facilitator who will assist clients to access the services they need in order to carry out the intervention strategies developed by the Mobile Crisis Team. The MCT may refer the client to a Brief Treatment Team (BTT) who responds to the client within one day. The BTT is a multidisciplinary team who provides time-limited, solution focused treatment to clients, addressing issues and events that lead up to the crisis.

The MCT may also refer a client to a Crisis Stabilization Unit (there is one location for girls, and another for boys). These units are for clients who are in extreme distress, and may need a few days to reintegrate into their environment following their crisis. The MCT also offers Home Based Crisis Intervention Services to help clients and their families get back to a functioning level after experiencing a crisis. These services are provided immediately, and include support and homemaker services. As well, the MCT may help to facilitate reconnections with educational services or schools following a crisis situation.

Generally speaking, crisis response systems offer a range of integrated services and providers to resolve the crisis using a minimal intrusion strategy. They act much like a hospital emergency room, performing an assessment, along with an initial response to stabilize the crisis. Their advantage comes from having mental health specialists readily available, with connections to other required services for follow-up. The team intervenes wherever the crisis is occurring, e.g., at home, a boarding house, or a police station. The idea is to provide the ill person with support in a calm, protected, and supervised setting other than a hospital. This is a short-term solution, which offers a supervised protective environment where physical and psychiatric assessment can be performed, daily living skills training and social activities are available, and counselling and treatment planning are accomplished.36

To find out if there is a CRS in your area, we suggest you contact your local Schizophrenia Society chapter, or regional branch of the Canadian Mental Health Association.
Best Practice Example:

Seneca House

Seneca House is a charitable organization funded by the Winnipeg Regional Health Authority. It is a place where adults with mental illness can go when they are experiencing emotional difficulties. The philosophy of Seneca House is that people who have experienced a mental health problem are best able to provide empathy and support to others in similar situations. All staff members have personal experience with mental illness. With their help, guests of Seneca House learn to cope with their distress.

Seneca House provides opportunities for respite and peer support through short-term residential stays of up to five nights (one per calendar month to a maximum of seven times per year) in a safe and comfortable home environment. Guests may use this time to explore their feelings, attitudes, beliefs, challenges, and choices and to learn about other community resources that can assist them in their recovery process. Seneca House provides round the clock trained staff, six private bedrooms that include a secure box for medication and valuables, meals, and laundry facilities – all at no cost to the client. It is open twenty-four hours a day, seven days a week.

Access to this service is (usually) through referral from a health service provider. The service is targeted to people who have used mental health services. Guests must be able to make a commitment to: refrain from harm or violence to self or others; to be abstinent from alcohol or street drugs during their stay; to administer their own medication without supervision; to attend to daily living tasks without assistance (or with assistance from an attendant who will accompany them to the home), and to respect the rights and needs of their fellow guests.

Staff at Seneca House are Peer Support Workers with training and experience in crisis intervention and suicide prevention. Using their personal experience with mental illness and recovery, they strive to address the self-identified needs of each guest.

Seneca House provides employment opportunities to people with mental illness who are ready and able to assist others with the
• Work with colleges, universities, and professional accreditation bodies to encourage the adoption of culturally sensitive training in the curriculum for health caregivers

Some key points:

• Immigration does not cause schizophrenia; however, the stress surrounding it can compound the problem

• A physician cannot accurately diagnose the ill individual unless the emotional symptoms the person has experienced are revealed, along with the physical ones

• It is incumbent upon you to help the ill person by making physicians and health caregivers aware of your family’s attitudes toward mental illness

• Although schizophrenia does not differentiate between races and cultures, drug treatment may affect some cultures differently than others

• Be sure to use all the federal and provincial government services, and ethno-specific community association programs available to you. They may be able to provide interpreters and other assistance you require to get diagnosis and treatment for the ill individual

• All of the other chapters in this book may also be of help to you. Please read them carefully to help you understand schizophrenia, and how it impacts you and the ill person in your family, and

• You are welcome at SSC and its affiliate organizations: please let us help you!

HELP FOR FAMILIES

CULTURAL INTERPRETATION SERVICES (CIS)

Hospitals and health care facilities across Canada are becoming more aware of their responsibility to provide interpretation services for patients who are not proficient in English or French. It is becoming widely recognized that language barriers result in poor quality care, which adds to the burden of costs to the health care system.
In 1911, the psychiatrist Eugen Bleuler invented the term schizophrenia to describe the disorder. (Schizophrenia comes from the Greek schizo meaning split, and phrenia which means mind.) What Bleuler was trying to convey by the term was the split between perception and reality. Today many psychiatrists regret the existence of the term because it is misunderstood.

Misunderstanding can cause serious and unnecessary grief. It is important that we all take responsibility for sharing our knowledge about schizophrenia with others: for their sake, for our sake, and most importantly, for the sake of those who have this disorder!
Schizophrenia is a complex illness. There are other genes on other chromosomes, as well as non-genetic factors, that probably play a part in the development of schizophrenia. In other words, it is not possible to simply look at a person’s DNA and tell if there is an increased risk for schizophrenia. While there is much work ahead to identify, and learn about, the genes and non-genetic factors that contribute to the disorder, the success of this recent finding is very encouraging.

Another exciting finding is the discovery of a genetic syndrome known as 22q Deletion Syndrome (22qDS). It is associated with a chromosomal abnormality, and occurs in approximately one in two thousand to one in four thousand births. This means 22qDS is more common than other conditions like Huntington’s disease and Duchenne muscular dystrophy. Approximately twenty-five percent of individuals with 22qDS develop schizophrenia, and up to two percent of individuals with schizophrenia may have 22qDS, indicating that 22qDS represents a genetic subtype of schizophrenia. The clinical signs and symptoms, structural brain findings, and cognitive profile of 22qDS schizophrenia are all similar to those in other forms of schizophrenia. What is different is that people with a 22qDS subtype of schizophrenia have physical features and learning difficulties associated with the genetic syndrome.

It is interesting to note that approximately ninety percent of 22qDS cases are sporadic. In other words, this genetic form of schizophrenia usually presents itself in an individual whose family has no history of the illness. The mechanism of how and why this sporadic deletion occurs is not known, but we do know that it is nothing the parents did or did not do that caused the deletion. It is a chance occurrence. In the other ten percent of cases, one of the parents has 22qDS and has passed it on to their child. Because the physical findings associated with 22qDS can be quite subtle and vary from one person to the next, often a parent does not know that they have 22qDS until their child is diagnosed.

22qDS, which is also known as velocardiofacial syndrome or DiGeorge syndrome, usually has several other associated features, which can include: learning difficulties, speech or palate problems, characteristic but subtle facial features, congenital heart and other birth defects, hypocalcemia (low calcium levels in the blood), and thrombocytopenia (low platelet levels in the blood). Because the physical features are
Some of the most recent and hopeful news in schizophrenia research is emerging from studies in the field of psychosocial rehabilitation. New studies challenge several long-held myths in psychiatry about the inability of people with schizophrenia to recover from their illness. It now appears that such myths, by maintaining an overall pessimism about outcomes, may significantly reduce ill people’s opportunities for improvement and/or recovery. In fact, the long-term perspective on schizophrenia should give everyone a renewed sense of hope and optimism. Clinicians who investigate the long-term course and prognosis (a forecast of the course of the disorder) of schizophrenia are now presenting a very different picture of the illness from the gloomy scenario painted just a few years ago. Rehabilitation programs have evolved dramatically to improve the quality of life and functional recovery of people with schizophrenia. New and better drug therapies continue to be produced. Also, studies show that schizophrenia is not a disorder that progresses with age. The longer a person is free from acute episodes, the better the chances for a full recovery. The importance of family input for treatment, and the benefits of good relationships between clinicians and families, are now well established. Families need and want education, information, coping and communication skills, emotional support, and to be treated as collaborators. For this reason, knowledgeable clinicians will make a special effort to solicit involvement of family members and caregivers. Clinicians, individuals with the disorder, and families should work together to identify needs and appropriate interventions to help the ill person. Everyone involved should be able to have realistic yet optimistic expectations about improvement and possible recovery.

**TREATMENT STRATEGIES**

Schizophrenia is a long-term disorder. According to research, the first few years of the illness may determine the outcome. In other words, it is very likely that the success of interventions in the first years following onset will significantly impact whether the ill person has a good recovery, or suffers from chronic relapses. Furthermore, the time between onset of psychosis and effective treatment is, according to contemporary thinking, a significant factor in recovery. Young people who experience prolonged psychotic symptoms are at risk of
schizophrenia and related disorders, where to get help, and how to minimize disruption within the family unit, and reduce stress in the ill person's day-to-day life. (This is important because a firm diagnosis may take up to one year. In the interim, the ill person needs medical attention, and the family needs information.)

In the second stage, families must deal with the diagnosis of schizophrenia, and the beginning of treatment. They need comprehensive information about the disorder, and about their role in the recovery process. They may also need some help dealing with their emotions and the distress caused by the diagnosis.

In the third stage, families need to learn how to cope with the stress imposed upon them as they help their ill family member through the recovery process. They may need professional resources to assist in some areas, and to offer coping strategies. They also require information during this phase about the treatment the ill individual is undergoing, about the appropriate level of care as recovery progresses, and about early warning signs of relapse.

In the fourth stage, families may need to review their understanding of psychosis. The ill person will need treatment for an acute episode, and the family will need to understand the long-term prognosis. More psychoeducation may be required to help the family. It is important that the family have access to ongoing community support by the time they reach this stage.

The goal of the family intervention program in Calgary is to meet the needs of families based on this current research. Families are treated as collaborators in the treatment process. Each one is assigned a family worker who has special training in family work, and is solely dedicated to work with the family and integrate the family in the treatment plan. Individual family needs are assessed and interventions tailored (psychoeducation, communication and problem-solving training, and later on group work) to meet these needs. Family needs are re-assessed after six months, one year, two years, and at discharge (three years). These assessments will contribute to long-term analysis of the success of working with families from the time of onset of illness.
As yet, however, there is no cure for schizophrenia. Treatments to prevent the illness do not exist either. While research has successfully contributed to improving the quality of life for individuals with this disorder, and created much hope for their families, there is still much work to be done.

As long as there is research, there is hope for a cure. As long as there is hope for a cure, dollars for research will be needed. Help spread the hope, for it helps all of us!

THE CANADIAN BRAIN TISSUE BANK

As advances continue to be made in research laboratories throughout the world, more and more people are beginning to appreciate the enormous potential of post-mortem human brain tissue research. Although promising results are being reported and our understanding of severe neurologic and psychiatric disorders is improving, more significant progress is actually being delayed because of a scarcity of brain tissue donations.

The Canadian Brain Tissue Bank was established in 1981 in order to support medical research through the collection, storage, and distribution of brain tissue to interested scientific investigators. Such research is concerned with the causes, treatments and eventual cures for the many psychiatric and neurological disorders affecting so many people today. These include schizophrenia, Alzheimer’s disease, dystonia, epilepsy, and many others. Research over the past decade has shown that the study of human brain tissue is essential to increasing our understanding of how the nervous system functions, and consequently in preventing and alleviating these illnesses. Most recently, post-mortem human brain research played a significant role in the development of a genetic test for Huntington’s disease and a treatment for Parkinson’s disease. Human brain tissue is also necessary because several serious neurologic and psychiatric conditions affect only humans and, therefore, animal models are not relevant. For comparative purposes, brain tissue is needed from healthy individuals, as well as from those who died with a neurologic or psychiatric illness.
The other half is placed in a special solution called formalin for pathological studies and determination of the exact disease process. The Brain Bank should be contacted as soon as a potential donor dies. Delay could result in the loss of the donation.

How to Donate

Becoming a prospective tissue donor is easy. Call the Canadian Brain Tissue Bank in Toronto at 416-977-3398. If you prefer, you can obtain a copy of the pamphlet entitled A Gift of Hope—Canadian Brain Tissue Bank, and fill out the attached donor card. But first, do the most important thing of all: inform your family that you would like your brain donated to the Brain Bank after death; they will have to do it for you and they must understand why you wish to donate.
Parkinsonism

Another extrapyramidal side effect, Parkinsonism is divided into two categories: hypokinetic and hyperkinetic. Hypokinetic symptoms include decreased muscular movement, rigidity, awkward and stiff facial movements, and possibly depression and apathy. Hyperkinetic symptoms are agitation of lower extremities, agitation, tenseness, tremors, rapid rhythmic movements of the upper extremities. These symptoms commonly occur between a few days and a few weeks of treatment for an acute phase.

Psychiatrist

A physician that specializes in treating mental and emotional disorders.

Psychosis

Hallucinations, delusions, and loss of contact with reality.

Rehabilitation

Programs designed to help individuals return to normal functioning after a disabling disease, injury or addiction. They are designed to help people with mental illness live as independently as is possible.

Receptor

Special places on nerve cells that respond to specific chemical messages between cells.

Schizophrenia

Severe and often chronic brain disorder. Common symptoms—personality changes, withdrawal, severe thought and speech disturbances, hallucinations, delusions, and bizarre behaviour.