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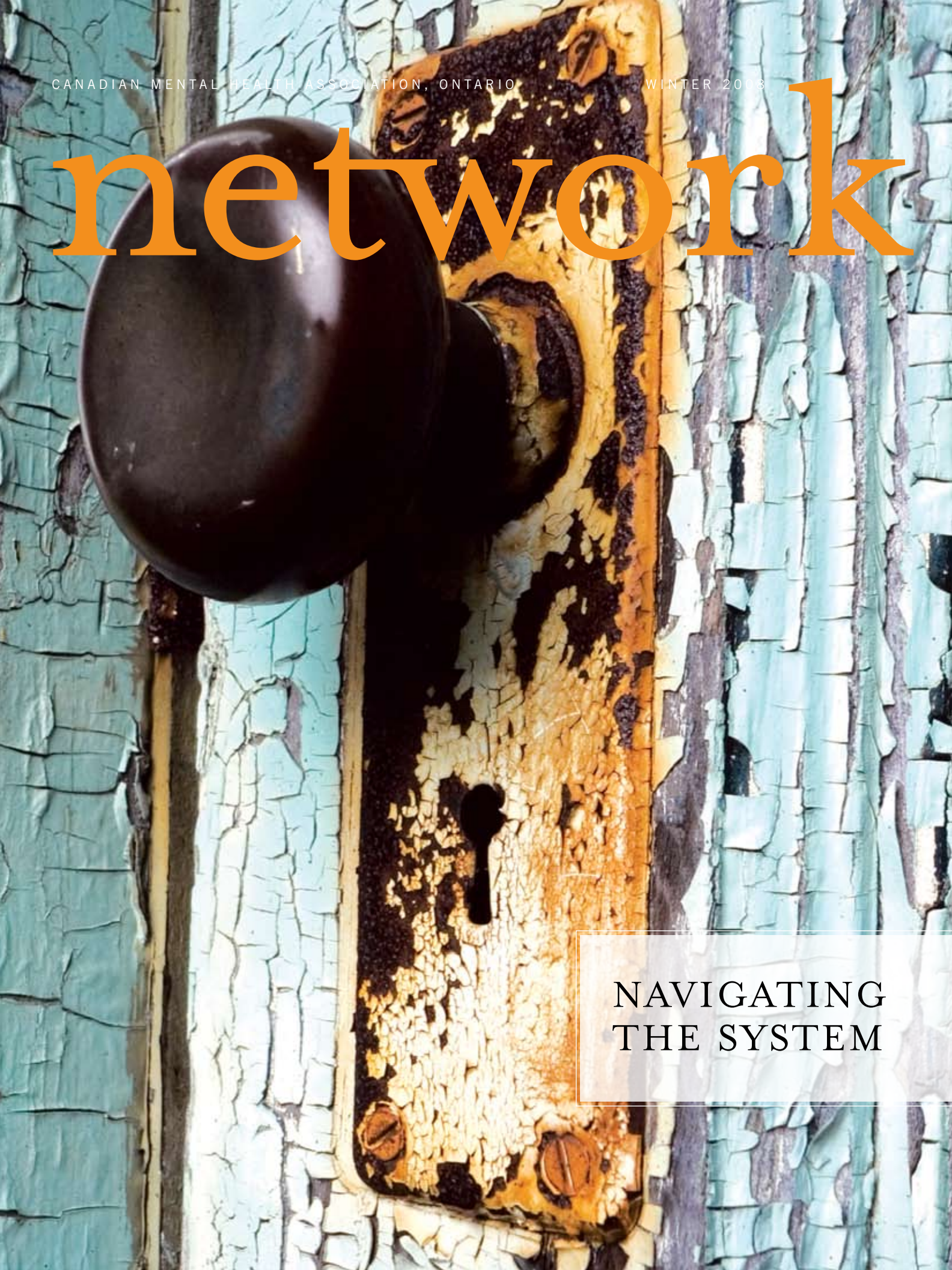

NAVIGATING THE SYSTEM

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Working on behalf of, and with our branches, CMHA Ontario promotes mental health and advances excellence in the delivery of mental health services through knowledge transfer, policy development, advocacy and the inclusion of consumers and family members in decision-making.

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Monika Szopinska, *Welcome* (photograph).
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Finding Our Way in a Complex World

Lorne Zon

In the not so distant past, getting directions was a relatively straightforward process. Look on a map, stop at the corner gas station or ask someone on the street for directions. In most cases, it worked and you found your way to your destination.

Today, information abounds but access is somewhat more complex. We have GPS systems, Internet sites that provide maps and directions, or, of course, the old-fashioned way. We, however, sometimes forget that these many options still leave little opportunity for some. GPS is expensive. The Internet needs computer access and knowledge of what to do. Asking for directions requires knowledge of the language spoken in the community.

Finding your way around the health system is far more complex, and although "tools" and "technologies" are becoming more common, simply finding your way remains a major deterrent to receiving the care and support you need. If you have a serious mental illness, live in poverty, and/or don't have a place to live so someone can contact you, finding your way is an extreme hardship. I do not mean to imply that the government, health professionals and service providers don't want to help. Often they face the same problems of not knowing what's available in the community, or how to find it and get access.

For those trying to access the wide range of supports that might be needed to help along the road of recovery, directions are not enough. Continuing the getting around analogy, going from point A to point B requires many things: roads, a mode of transportation, bridges and so on. For consumers of mental health services, knowing where to look for care is an important start, but waiting lists, costs, language barriers and many other factors can make the journey a dead end.

In this issue of *Network*, we examine some innovative and important approaches to helping consumers, families and professionals gain better access to what is needed in a timely and effective manner. A particularly interesting development, explored here by Pam Lahey, is the emerging partnership between primary care providers and community mental health providers. Primary care has often been referred to as the gatekeeper to the health system. However, many family physicians would readily admit their lack of knowledge of housing, income supports, case management, etc. The coming together of these two groups can vastly improve access for those using this particular route.

Also in this issue of *Network*, we examine some quite different approaches to improving access and navigating the system. Elizabeth Lines looks at the role of mental health case managers and peer support workers as "system navigators." These are individuals whose job is to help people find their way through the maze and access what they need. Scott Mitchell offers a profile of ConnexOntario, the provincial information and referral organization that helps people find the most appropriate mental health, addiction and problem gambling services in their communities. Nicole Zahradnik writes about a new, multilingual guide to the mental health system for newcomers.

Navigation of people is one element of an accessible and appropriate service response. Moving the right information that supports care is also receiving considerable attention. Scott Mitchell reports on the current state of an e-health project that's helping Ontario healthcare providers share information and improve continuity of care. Donna Hardaker writes about a collaborative project in Champlain East, where several hospitals and community mental health and addiction service providers have come together to improve navigation and access to resources for clients with concurrent disorders and other complex needs. Finally, Michelle Gold takes a closer look at the concept of continuity of care and how we measure system integration.

I hope you find our directions helpful.

Lorne Zon is chief executive officer of the Canadian Mental Health Association, Ontario.

Opening Doors to Better Care

By Pam Lahey

YOUR ODDS OF RECEIVING appropriate mental health services in a timely fashion improve dramatically when you walk into a "collaborative care" environment. Community Health Centres (CHCs) and the newer Family Health Teams (FHTs) are two approaches to health care delivery that enable you to have your needs met by the right professional at the right time. Integrated and multidisciplinary teams of health professionals are a hallmark of CHCs and FHTs, and they are improving the quality of health care provision in Ontario. Partnerships between community mental health agencies and CHCs/FHTs are expanding that model even further to provide collaborative care for people with mental illnesses.

Community Health Centres and Family Health Teams operate within a multidisciplinary model, which simply means that a team of professionals with a diverse range of skills share responsibility for providing services at one point of entry into the health-care system. CHCs and FHTs are two elements of a provincial strategy to increase access to primary health care. There are, however, some differences between the two. Family Health Teams are designed to give doctors support from other professionals in providing primary health care to the general population. CHCs, by comparison, are intended to serve high-risk communities and populations who may experience barriers to health care. They are non-profit organizations with a focus on health promotion, and

for this reason they generally offer a wider range of services and more direct access to community supports.

People with mental illnesses are among the target population for CHCs. They often have to cope not only with the mental health disability itself, but with the added burden of other chronic health conditions. Inaccessible and inadequate health-related services, coupled with stigma and discrimination, only serve to heighten that disadvantage. CHCs are meant to lower the barriers to care. Still, it is not a given that you can access appropriate mental health care at any CHC or FHT. But this situation is changing, thanks to a growing number of partnerships with community mental health agencies.

Many local branches of the Canadian Mental Health Association, for example, have developed formal agreements with primary care providers in their community to supply information and referral, mental health assessment, counselling, case management and other services. These partnerships with CMHA have strengthened the multidisciplinary care model of CHCs and FHTs by adding an essential health service to the mix.

One example is the partnership between CMHA Elgin Branch and the West Elgin Community Health Centre. By working together, both organizations have been able to increase the range and availability of mental health services for residents of western Elgin. Heather DeBruyn, executive director (ED) of CMHA Elgin Branch, and Cate Melito, executive director of the West Elgin CHC, believe the strength of the collaborative care approach lies in its ability to help individuals access a number of services that are sometimes difficult to get, including mental health care.

The CMHA Elgin head office is located in St. Thomas, but the branch also has several satellite offices co-located with partners around the county. One of those partners is the West Elgin CHC in West Lorne, 45 minutes west of St. Thomas. Three CMHA staff members work on-site at the CHC with residents of West Elgin who need intensive case management, a service for persons with serious mental health issues.

"Having our staff down at the CHC as part of their Integrated Mental Health Team," explains DeBruyn, "is about getting the most appropriate support for the individual at the right time. That happens best if they are co-located. For a marginalized population, having the full team in one place really does help get them access to a number of services that are sometimes difficult to get — a dietitian or a chiropodist, for example, as well as a family practitioner. And it's all together, so if transportation is an issue, you are just going to one location."

"I think people really appreciate getting their care close to home," observes Melito. "It enables them to stay in a smaller community, which is important because they've always lived here or because they have family that lives here."

Even though the various mental health workers report to their individual agencies, working together in one location "creates a team opportunity," says Melito. "I think there are real benefits to the collaborative care approach. There is a continuum of mental health services offered by a team that has common goals and a common philosophy. We work in partnership with CMHA using common policies and protocols that govern how this multidisciplinary team works together. Another advantage is that the team of physicians and nurse practitioners here at the centre are supported in taking on patients with complex health issues. The collaborative care approach benefits both teams."

Eric Sutton, ED of the Barrie Family Health Team, echoes this belief in the value of collaboration. The team's partnership with the CMHA Barrie-Simcoe Branch, Sutton observes, "has increased our capacity to meet people's needs. Before, physicians would struggle along doing their own counselling, thinking, 'There are no other resources. I better do this.' Now they have a resource to refer to."

CMHA Barrie-Simcoe Branch has a written agreement with the Family

PHOTO BY SUSAN KING

"For a marginalized population, a collaborative care approach really does help get them access to a number of services that are sometimes difficult to get — a dietitian or a chiropodist, for example, as well as a family practitioner. And it's all together, so if transportation is an issue, you are just going to one location."

Heather DeBruyn,
CMHA Elgin Branch

CMHA ELGIN STAFF, MEMBERS OF THE INTEGRATED MENTAL HEALTH TEAM AT THE WEST ELGIN COMMUNITY HEALTH CENTRE (LEFT TO RIGHT): CASE STROMENBERG, MELANIE KENNEDY, DIANA HANDSAEME AND KATHY GEE.

Health Team to provide all their mental health and addiction services. CMHA also acts as a gateway to other community resources. The strength of this partnership lies in CMHA's ability to navigate the system on behalf of physicians and their clients. CMHA executive director Nancy Roxborough explains: "The doctors simply do not have the community awareness of all those resources in town. So that is one way we can help them. [Patients] may not need the actual service from us, but then we can refer them on to other, more appropriate services."

The doctors are grateful for the support CMHA Barrie-Simcoe offers. "Demand is huge and the team is relatively small," says Sutton. The number of primary care patients is higher than in other parts of the province — in June 2007, the Barrie FHT had 1,738 patients per physician, while the provincial average was 1,208 — and referrals for mental health services grow on a daily basis. To facilitate the referral process, CMHA Barrie-Simcoe designed a one-page referral form, "a ticky box" for the physicians to fill out and fax to the CMHA office, where a team of nine mental health workers is located. This method works best, Roxborough explains, because "doctors are not going to fill out pages and pages of information, we try to make it as simple as possible."

While these collaborative approaches translate into quicker and better quality health care for individuals experiencing mental health issues, the partnership models and modes of referral differ across the province.

CMHA Elgin case managers, for example, are an integral part of a larger mental health team located on-site at the West Elgin CHC. The three CMHA staff members work alongside a psychiatrist, a psychiatric nurse from Regional Mental Health Care, St. Thomas, as well as a psychologist and several social workers employed by the West Elgin CHC who address the mental health needs of children, youth and seniors. The team works as a whole to conduct intakes for mental health services for the moderately and severely mentally ill of all ages, and the collaboration is successful because they operate within a common philosophical framework. The multidisciplinary approach of West Elgin CHC ensures that mental health and primary care services are not just linked but entwined. This full integration translates into a seamless referral process, enhancing patient care.

"If you come into the Community Health Centre and say, 'I am feeling so depressed that I have to see someone,' you probably are not at all concerned with a discussion about whether you should see Regional Mental Health Care or CMHA. You want to see someone who is able to address your depression. It is a very invisible process," confirms Cate Melito, ED of West Elgin CHC. The referral process in the CHC appears seamless to the patient, since all members of the team are located under one roof. If you express a need for counselling, the receptionist will collect basic information from you and the form simply gets walked over to the mental health team. The team reviews it to determine the level of mental health care needed and then hands the referral to the appropriate team member for follow-through.

In eastern Ontario, CMHA Ottawa Branch offers mental health case management services through two of the six CHCs in Ottawa. One of these partnerships is with Pinecrest-Queensway Health and Community Services, located in a densely populated multicultural community in the city's west end. Wanda MacDonald, ED of Pinecrest-Queensway, explains that the partnership with CMHA was formed because "the [CHC's] multicultural clients were not accessing intensive case management

PHOTO BY JOHN TAMBLYN

services the way one would have expected, given the numbers." Immigrants make up a little over 22 percent of the total population of Ottawa. In 2006, according to the most recent census, 3.2 percent of newcomers to Canada settled in Ottawa, putting it among the top ten destinations.

While the central referral system for mental health services is housed at the CMHA office in downtown Ottawa, two CMHA staff members work on the counselling team at the Pinecrest-Queensway site. The intensive case management services provided through Pinecrest-Queensway are available to any resident of Ottawa, regardless of where they live or if they are a client of the CHC.

Marnie Smith is director of operations for direct and specialized services at CMHA Ottawa. From her perspective, the great advantage of their partnership with Pinecrest-Queensway is the reciprocal relationship, which "has opened up a more direct connection to primary health care" for CMHA's mental health clients. MacDonald agrees: "One of the challenges for clients with severe mental health issues is accessing primary care, and [the partnership] helps create linkages for clients who may not have primary care providers."

Through an equivalent partnership with the Somerset West Community Health Centre, CMHA Ottawa provides case management for Cambodian, Vietnamese and Chinese clients. CMHA also has purchase-of-service agreements with the Sandy Hill Community Health Centre and the Centretown Community Health Centre, where it works in partnership with the CHCs to co-facilitate concurrent disorder treatment groups. Both of these CHCs have regional addiction programs, so the partnerships create a link between the addiction services sector and community mental health.

Nancy Roxborough at CMHA Barrie-Simcoe believes her partnership with the local FHT also opens up more options for patient care: "Bringing allied health care professionals [like CMHA] into the practice will free up time and help to increase their capacity. Quality of care is getting better." The physicians, who identified mental health issues as the number one priority in the formation of a partnership, are pleased to have the support of CMHA. With a referral from the Family Health Team, clients can get access to the services provided by CMHA's multidisciplinary team of social workers, registered nurses and a consulting psychiatrist.

The benefit of this partnership, explains Roxborough, is that individuals can see the most appropriate health care provider as quickly as possible. The new referral option also means doctors do not have to divert their focus from patient care to figure out where and how the various community resources work. "[Doctors] don't have time to wind their way through how you get somebody connected, because it is complex," says Roxborough. Maintaining a feedback loop with CMHA allows the primary care physicians to get just as much information about their patients as they need, Sutton adds, without feeling overwhelmed: "They get progress notes after each session [with a CMHA team member]. They really feel that they are kept up to date with what is happening with their patients. They hadn't felt they were getting enough feedback when they made referrals to the mental health system previously."

System navigation is about more than getting the patient from A to B, Roxborough contends. It is also about the referring agency helping the primary provider ease the client into care. "I think some of the navigation means not handing somebody over," Roxborough explains. "It's about working with another organization so they don't have to hold the whole ball of wax themselves." So, for example, if a client needs the additional resources that an addiction agency can provide, CMHA Barrie-Simcoe will refer the patient and stay connected until that agency has a program space available and can start providing service, ensuring continuity of care. "We will be there as partners to support them in whatever way we can while they are doing the work they need to do. And then at some point, the client would be handed over," explains Roxborough.

The majority of FHT referrals to CMHA Barrie-Simcoe are on behalf of people who have moderate mental health issues. Serving people with moderate mental health issues is a gap, Sutton says, that has been filled as a result of the partnership. Before the FHT came into existence in December 2006, there was "such emphasis in the mental health system on serving people with serious mental illness that there wasn't a resource there for people with significant but not major mental illness to get seen." Roxborough confirms that most of the 40-plus referrals per week they receive from the FHT are for people with a moderate mental illness who need short-term support. "You know the stat that says three-quarters of the people with mental illness don't reach out for help? This is the group we are reaching, so it is very rewarding." Who are those people? According to Roxborough, they are average people dealing with situational issues that have become overwhelming, like family breakups, teenage angst, and

"One of the challenges for clients with severe mental health issues is accessing primary care, and [our partnership with CMHA Ottawa] helps create linkages for clients who may not have primary care providers."

Wanda MacDonald,
Pinecrest-Queensway
Community Health Centre

"There are real benefits to the collaborative care approach. There is a continuum of mental health services offered by a team that has common goals and a common philosophy."

Cate Melito,
West Elgin Community Health Centre

death. But their lives, Roxborough explains, "have layers and layers of complexity. Some of the stories are so incredible that it makes Dr. Phil look like simple work."

The CMHA/FHT partnership is beneficial to patients. It means quicker access to mental health services and appropriate referrals to an agency that understands the client's mental health needs and will advocate on their behalf. Roxborough insists that CMHA is in the best position to offer that support. "Now [individuals] are being cared for by a mental health professional who knows the system and how to navigate that system and will fight for the services our clients need. We have been successful in doing that. Family physicians are unable to do that. They don't have the knowledge or the time."

Knowledge transfer is a behind-the-scenes activity that helps to enhance system navigation, and it is an activity that is deeply valued in these partnerships. The Pinecrest-Queensway /CMHA Ottawa partnership has, MacDonald believes, allowed CMHA to build on and make use of the cultural competencies that Pinecrest-Queensway has in order to enrich the intensive case management programs for clients coming from other cultures. According to Sutton, enabling an interdisciplinary team of professionals to share their expertise, as they do in Barrie, is how the collaborative care model was intended to work: "That way, you get physicians building up their knowledge and capacity." Sutton also suggests that knowledge exchange could be taken one step further by implementing case consultations.

Access to resources is broader than primary care when you are a client of a CHC or an FHT. The CHC acts as a gateway to a wide range of health and health-related supports. The underlying philosophy of Community Health Centres is that primary care should address a range of health determinants, including the social supports necessary to have a decent quality of life. Melito explains how this holistic view of care benefits the clients of the West Elgin CHC: "Someone who has a serious mental health issue may also have young children and want to participate in parent-and-tot programming." Or the CHC, Melito continues, may have a senior client who needs Meals on Wheels or needs help finding affordable housing. (The West Elgin CHC offers a supportive housing program for seniors.) Melito knows that offering a range of services locally under one roof and ensuring that clients are linked to the right service at the right time translates into fewer hospitalizations for people with serious mental illness and gives them the ability to maintain themselves in their own community.

Clients appreciate the holistic approach to health care because it allows them to access other supports in their community. Nadia (not her real name) is grateful for the practical assistance that the CHC staff was able to offer her: "I cry a lot, I am very sick, they help me a lot. They help me find a house. They help me with transportation. They are very helpful people. They call me every time to ask me how I am doing. They bring me a taxi to bring me there. They pay for it. They provide interpreter service. They help me find ESL classes."

A member of the Barrie Family Health Team shares a similar story about a client's experience: "My client was upset, talking about self-harm. I immediately thought of [CMHA], and another staff member made calls on my client's behalf. My client's housing situation was dismal but he left with practical information about a rooming house with a large room that might assist him to re-establish himself."

Melito believes that a focus on getting services to the clients, instead of the other way around, "confirms to the residents of western Elgin that they are important, that they have a right to these services, and that these services are flexible and willing to come to them. It feels more community based." A collaborative care model is about ensuring that people get the right service, by the right provider at the right place and time. Some Community Health Centres and Family Health Teams, by partnering with community mental health agencies like CMHA, are answering that need.

Pam Lahey is a community mental health analyst at CMHA Ontario.

PHOTO BY JOHN TAMBLYN

Imagine arriving to a new country. You have been separated from family and friends and you cannot speak the language. You learn that your new homeland does not value your skills and education, and as a result you are now unemployed. Not surprisingly, feelings of loneliness, isolation, sadness and confusion soon begin to overwhelm you.

Navigating *for* Newcomers

By Nicole Zahradnik

Physically you feel terrible. Emotionally, psychologically and spiritually you feel unwell. You seek assistance from your settlement agency, but when you do, you find yourself at a loss for words when trying to describe your symptoms and emotional distress. Feelings of frustration, confusion and isolation overwhelm you once again.

Sadly, this is the experience of many new immigrants when trying to navigate Ontario's mental health system. "Many settlement agencies are mandated to assist with settlement issues, but are unable to provide or link up with mental health services due to lack of funding and limited resources," explains Deqa Farah, an immigrant herself and a health promoter at Community Resource Connections of Toronto (CRCT). "When individuals are able to see a medical practitioner," she adds, "language is often a barrier. Terms for certain symptoms or diagnoses of mental illness often do not exist in other languages or cultures."

Farah, a young Somali woman who immigrated to Canada when she was 17, became interested in working with immigrants and refugees while she was

"We noticed a really strong need for culturally appropriate mental health information in different languages, especially for those communities that were dealing with war trauma and its aftermath." *Navigating Mental Health Services in Toronto* is "intended to demystify the system for newcomers."

Deqa Farah,
Community Resource
Connections of Toronto

in school and active in her community. In 2001, she was hired by CRCT as a community mental health consultant with a special focus on the Somali community. Shortly afterwards, she expanded her role to work with all newcomers who were facing additional barriers because of stigma, language, culture and war trauma. As a result, she learned very quickly about the shortage of culturally appropriate mental health resources for new immigrants.

And so, *Navigating Mental Health Services in Toronto: A Guide for Newcomer Communities* was born. Published by CRCT in May 2007, the 90-page handbook provides mental health information for consumers, their families, and service providers in six different languages: English, Tamil, Somali, Dari, Pashto and Urdu. "It is a tool to navigate the system, including rights, housing, the roles of therapists, entry points, etc. It's intended to demystify the system for newcomers," says Farah, who served as project coordinator.

The guide provides more than just a list of mental health services in Toronto. It gives an overview of everything a newcomer might need to know when experiencing a mental health problem. It talks about stress, the different types of mental illness and their treatments, an individual's rights, the criminal justice system, how to help someone with a mental illness, as well as how to find help in various languages. It answers such questions as, Will mental illness affect my application for citizenship? Where can I get help with daily living? and How can I stay healthy? Most importantly, it is written in plain language, which makes it not only easy to read, but also easier to translate. And although many of the mental health services listed in the book are specific to Toronto, most of the information is relevant for any region across Ontario.

"Our guide was very well received by the newcomer communities, consumers, family members and service providers themselves," notes Farah. "Many were delighted to receive this vital information. In addition, the guide is helpful for settlement agencies and other ethnocultural organizations that are not funded to provide mental health services and do not have the skills or training, but who may provide social services to consumers and their families. Many welcomed a guide explaining the mental health system in plain language."

"This navigation tool is also useful for immigrant professionals who worked in the field of mental illness in their countries," observes Aqeel Saeid, a settlement, domestic violence and problem gambling counsellor for the Arab Community Centre of Toronto. "It is useful for them to know about the providers of mental health services and to update their information in regards to terminology used in the field."

Research indicates that immigrants and refugees in Canada experience far more stress than first-generation Canadians. Stresses associated with immigration and resettlement may put immigrants and refugees at increased risk for developing mental health problems. Some of the stresses involved in resettlement may include an inability to speak one of the official languages, prejudice and discrimination from the host society, low socioeconomic status, and isolation from one's cultural background. In addition, some newcomers may have experienced extreme events, such as natural disasters, accidents, war or torture, before arriving in their adopted country.

Canada accepts roughly 225,000 new immigrants a year, 20,000 of whom are refugees. Immigrants constitute approximately 20 percent of the Canadian population, and almost half live in Ontario, making up more than a quarter of the province's population. Research by Statistics Canada shows that immigrants tend to have a lower rate of self-reported mental disorders than the native-born Canadian population, with the exception of post-traumatic stress disorder (PTSD). Among those immigrants and refugees who experienced torture, war and persecution in their home countries, the incidence of PTSD is high. Responding effectively to the needs and expectations of Ontario's increasingly diverse population poses a challenge for the province's health care system, and especially its mental health care system.

An individual's cultural background influences their perceptions of mental health and mental illness. It has been well documented that many mental disorders have similar symptoms across cultures, but the way in which people communicate their symptoms varies across cultural groups. Some people are more likely to present emotional problems as physical problems. Their level of comfort when communicating also differs. Some may feel comfortable disclosing all of their symptoms to a health professional, whereas others may prefer to divulge only a little. Similarly, some individuals only want to discuss their symptoms with a spiritual leader, who may know the person quite well and already have established a level of trust and comfort.

Culture determines whether and when people seek help, what types of

NAVIGATING MENTAL HEALTH SERVICES IN TORONTO IS AVAILABLE IN SIX LANGUAGES: ENGLISH, TAMIL, PASHTO, DARI, SOMALI AND URDU

help they seek and the level of stigma they attach to mental illness. Evidence shows that ethnic minorities experience stigma around mental illness more harshly than majority groups. Due to family-shared shame, as well as cultural perceptions of mental illness and its causes, many members of minority groups delay treatment. Others may experience barriers when seeking treatment because of discrimination and/or mistrust of the health system and its service providers.

Seeking help early and getting the proper treatment are important as they result in better outcomes. The longer a person delays treatment, the more likely their symptoms will worsen. Research shows that delaying treatment often leads to an increased resistance to getting help, worsening of symptoms, longer hospital stays, and a longer time to recover. *Navigating Mental Health Services in Toronto* is meant to help people identify a mental health problem early on and seek treatment as soon as possible.

As a community mental health organization, CRCT strives to support and enable adults with serious mental illness to live with dignity and fulfillment in the community. It focuses in particular on individuals and communities facing additional barriers, such as the homeless, those in conflict with the law, or other obstacles such as language, race, culture, ethnicity, immigration status and sexual/gender orientation.

CRCT offers a range of programs, from outreach to assessment to linking and advocacy. Many of the programs are able to provide language- and culture-specific services to the Tamil and Somali speaking communities, among other groups. The Community Support Service, for example, provided outreach and assessment to 358 individuals in one year, 70 percent or whom identified their culture as other than Canadian, while 60 percent identified themselves as persons of colour.

CRCT also partners with other ethno-specific organizations to meet the needs of their target population, but the demand for mental health services in newcomer communities at large far outstrips the supply. "Over the past few years," observes Farah, "CRCT has seen a significant increase in requests for mental health information in different languages from service providers, consumers and their families." In 1999, CRCT partnered with three other organizations to provide information and training on mental health issues to the Somali community. "It was a huge success," recalls Farah, "but as the project continued we noticed a real shortage of mental health resource information for other refugee and newcomer communities such as the Dari, Pashto, Urdu, Arabic and Tamil."

Farah responded by surveying 55 Toronto agencies that provide services for immigrants and refugees to learn more about the mental health service needs of their clients. At the same time, she consulted with partner agencies, who suggested that there was a glaring need for mental health information for the Tamil, Somali, and Afghan (Dari and Pashto) speaking communities.

"What we noticed the most was a really strong need for culturally appropriate mental health information in different languages, especially for those communities that were dealing with war trauma and its aftermath. This really motivated us to make *Navigating Mental Health Services in Toronto: A Guide for Newcomer Communities* become a reality."

In total, the project took approximately two years from inception. The project team began by reviewing all the mental health literature for newcomers and developing an inventory. Next, they carried out focus groups and community consultations.

"We really wanted to know what each community's needs were, what cultural perspectives and competencies with respect to mental health information needed to be addressed, and what strategies would ensure that this information would be accessible to the communities," says Farah.

Early on in the process, Farah learned that many of the newcomers relied on informal networks, since there was little mental health information available to them. "Many individuals depend on their local mosque, family and friends, religious school and community for information. Informal networks play a large role in these communities. But that's not all," she adds. "We learned that many individuals from our chosen

Research indicates that immigrants and refugees in Canada experience far more stress than first-generation Canadians. Stresses associated with immigration and resettlement may put immigrants and refugees at increased risk for developing mental health problems.

newcomer communities are illiterate, especially senior women from the Tamil, Somali and Afghan communities. This presents one more barrier, and therefore, in the future we hope to provide the guidebook in audio format."

They hired a writer during the first year to develop a draft of the guide based on the information gathered and feedback from the focus groups and community consultations. "We also asked a psychiatrist to make sure everything was clinically valid," adds Farah.

Throughout year two of the project, the cultural appropriateness of the translated information booklet was tested among the newcomer communities, consumers, and family members. In total, 60 community members and 35 service providers attended two consultations to ensure that all the information was culturally appropriate and not lost in translation. Five thousand copies were printed in each language (Tamil, Somali, Dari, Pashto, Urdu and English).

"I never considered the amount of revisions and drafts that would be needed," comments Farah. "In our initial few drafts, there was too much jargon and not enough plain language. This delayed many things in regards to meeting our initial timelines, but the Trillium Foundation was always open to re-negotiating. Throughout this process I learned humility."

Each community hosted its own event to publicize the project and disseminate the guide among its members. In the Somali community, Midaynta Community Services helped organize a launch in the west end of Toronto and the Somaliland Women's Organization helped with a launch in the east end. Thorncliffe Neighbourhood Office assisted with the launch in the Urdu-speaking community, and Sabawoon Afghan Family Education helped in the Afghan community. The Tamil community launch, organized by Vasantham, a Tamil Seniors Wellness Centre, was the most successful, with 200 participants attending. CRCT also organized an event to create broader awareness of the guide among service providers, with a particular focus on settlement agencies across Toronto.

The entire process was overseen by an advisory panel made up of individuals from each newcomer community, consumers, family members, service providers and mental health providers, including Across Boundaries, CMHA Toronto Branch and Afghan Women's Organization. The panel helped with reviewing the guidebook for clarity and cultural appropriateness, final translation, and strategies to effectively disseminate the information within the communities.

"After the initial launch, however, we did receive many calls from service providers inquiring as to why their organization was not listed," says Farah, "but the guidebook was not meant to be an inventory. I think of these comments as compliments and not criticisms. Obviously, many service providers considered our guidebook to be a valuable resource and were hoping to be included."

Future projects depend on the availability of funding, but CRCT hopes to have the guidebook translated into Arabic, Farsi, simplified Chinese, French and other languages. "Many individuals from other newcomer communities were disappointed that the guidebook was not translated into their language," says Farah. "Unfortunately, we are dealing with an unmet need with very limited resources."

Until there are more mental health agencies serving newcomer communities, the demand for services will continue to grow. In the meantime, a very useful guide exists to help new immigrants identify their mental health symptoms early on and get treatment.

The guide also serves as a tool to "build bridges and break down walls," observes Dr. Khalid Sohail, a psychiatrist at the Creative Psychotherapy Clinic in Whitby, Ontario. "It will help to educate immigrants about Canadian culture and mental health workers about other cultures. Such education will break down walls of prejudice and ignorance and build bridges of caring and compassion. It will help in increasing social consciousness so that we can all work together to create a humanistic society where people and families with emotional problems and mental illnesses are treated with respect."

For more information about CRCT or to download a PDF version of *Navigating Mental Health Services in Toronto: A Guide for Newcomer Communities*, visit www.crct.org.

Nicole Zahradnik is a community mental health analyst with CMHA Ontario.

fast FACTS

20

Percentage of immigrants in Canada's population (Source: Statistics Canada, 2006)

69

Percentage of Canadian population growth accounted for by immigration, which has now outpaced the natural birth rate (Source: Statistics Canada, 2006)

9.3

Percentage of new immigrants to Canada in 2006 who spoke neither French nor English (Source: Statistics Canada)

140+

Number of languages spoken in Canada (Source: Statistics Canada, 2006)

1 IN 50

Number of Canadians who require an interpreter for health care (Source: Health Canada)

By Scott Mitchell

WHO ya gonna call

Wouldn't it be nice if there was a single phone number to call, any time of the day or night, where you could talk to someone who understood the mental health system, who would listen to your needs and then tell you exactly who to contact for help? In Ontario, that number is 1.866.531.2600.

Mental Health Service Information Ontario (MHSIO) has been answering the call — 24 hours a day, seven days a week, 365 days a year — since December 2005.

While the service is relatively new, the organization behind MHSIO brings more than 15 years of experience to the job. Now known as ConnexOntario, they've been running the Drug and Alcohol Registry of Treatment (DART), a similar service for the addictions sector, since 1991. The Ontario Problem Gambling Helpline (OPGH) was added in the fall of 1997. All three services are funded by the Ministry of Health and Long-Term Care and governed by a community-based board of directors. The call centre itself is located in downtown London, Ontario.

Finding answers is hard enough when you have a physical health complaint, but the system can seem like an impenetrable maze when you or someone you care for has a mental illness. Community mental health providers in Ontario, including the Canadian Mental Health Association, have long advocated for a centralized registry of services. When the government gave the go-ahead a few years ago, the process of creating the new service began with a province-wide roadshow to get input from the field.

"The feedback was very positive, from providers as well as service users," according to Barry Fellinger, manager of information and referral services at MHSIO. "There was definitely a need for a one-stop shop for information and referral, to help people navigate the mental health system and to help

BRAD DAVEY, EXECUTIVE DIRECTOR, CONNEXONTARIO

professionals understand the services that were available in their communities that they might not be aware of."

The MHSIO database now lists more than 2,600 programs offered by upwards of 300 organizations across the province. The telephone service is free, confidential and anonymous. Web users can also access program descriptions and contact information at www.mhsio.on.ca. The online directory is searchable by location, program name, service type, and/or population group. Whether you live in Toronto or Timmins, whether you need case management, court support, housing or employment counselling, you can search the MHSIO website (or call the toll-free number) to find the nearest available provider of mental health services. Google maps are embedded in the directory, providing an instant visual aid and offering directions from wherever you are to the provider's front door.

Telephone inquiries to MHSIO are answered around the clock by a rotating crew of six full-time staff and a handful of relief workers. Staff members bring to their role a wealth of background experience. All have worked with people with serious mental health issues, whether it's in vocational programs, dual diagnosis, homelessness, the justice system, or some other aspect. All full-time staff are also certified as Information and Referral Specialists (CIRS) through the Alliance of Information and Referral Systems (AIRS).

Aside from their previous mental health experience, explains Fellinger, "We try to choose people who can think beyond just the local area, because we do serve the province. It's a vast mental health system out there, and programs and organizations are different across Ontario. They also need excellent listening skills, to be empathetic on the phone, with an ability to really hear what the caller is saying."

Often people are looking for help but they don't know exactly what kind of service they need. Caller education becomes a necessary component of the conversation.

"If it's somebody's first contact with the mental health system, they may not be familiar with terms like case management, ACT teams, or supportive housing," says Fellinger. "They may say, 'My family member really needs somebody who will just come and visit them a few times a week and make sure they're doing okay, because they're living in their own apartment and they have this mental health issue.' So we would probably start thinking about case management, but the person may not know to call it that."

"Sometimes we get calls about medication issues and we might refer them to the pharmacy line at the Centre for Addiction and Mental Health. Often people want to know more about a specific illness, such as schizophrenia. While we may give them some general information, typically that's not our major role, so we would refer them to an organization like the Schizophrenia Society of Ontario. We're a system navigator in the sense of helping people find their way through what can be a confusing system, as well as educating them about the system itself."

Understanding someone's needs and conveying information when the caller doesn't speak English is yet another challenge. While some staff are bilingual and can provide service in French, MHSIO is also equipped to handle calls in 170 different languages through translators provided via Language Line Services.

"One of the difficulties when you're talking to someone with a different language background is getting them to understand that you're going to put them on hold and to be patient while you connect to the service," observes Ron, one of MHSIO's I&R specialists. "Sometimes it takes a couple of minutes to track down a suitable interpreter and set up the three-way call, but once they understand, people are very appreciative of the fact that we have those services."

"Our experience to date with the

PHOTOS BY SUSAN KING

Language Line is that they're really exemplary," adds Fellinger. "They've been wonderful in helping to facilitate the calls. They're very specific. Even around certain languages, they'll ask, 'Are you looking for this version or that version? Is it this country? Is it Vietnamese? Is it Haitian?' It might be the same language but a different dialect. On the mental health side, we've used everything from Portuguese to Tamil to German to Mandarin."

While each of the three information services — MHSIO, DART and OPGH — has its own telephone number, mental health and gambling and addiction issues inevitably overlap. Concurrent disorders are common. Studies have shown that between 40 and 60 percent of people who have mental health problems will also have a substance use problem. These percentages are similar for people who seek help for their substance use.

"It's not unusual, especially if it's a family member calling on behalf of someone they're concerned about," observes Fellinger. "They know there's a mental health issue, but as our staff take them through the conversation, the person might say, 'Well, yes, there's an addiction problem, too.' Our system allows us to do a specialized search for concurrent disorder programs across the province. If MHSIO staff think the DART staff might have more information to share or more support to give the caller, they might finish the mental health portion of the conversation and then simply say, 'Let me transfer you over to someone with specific expertise in addictions."

Many of the staff at ConnexOntario are also cross-trained to work in both the DART and MHSIO databases, as well as OPGH. This strategy allows more flexibility to handle call volumes and ensure that, on busy days, a caller will get a live answer.

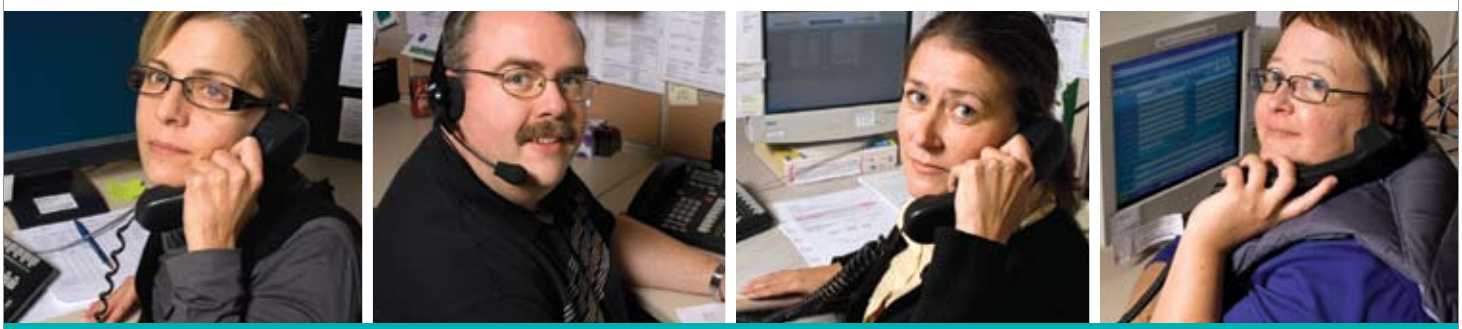
"If our lines are occupied," explains Fellinger, "then the caller may end up getting a voicemail intercept, asking them to either wait in the queue until an agent is free or leave a message and we'll get back to them. But now, with cross-trained staff, if no line is free on the MHSIO side, the phone system will flip over to the DART side and they're able to handle the call. I don't think it's any secret that a number of individuals have concurrent disorders, so I think our cross-training approach speaks to the integration of services in providing information to support the caller around both the addiction and the mental health issue."

Mental health services listed in the MHSIO database are restricted to those funded by the Ministry of Health and Long-Term Care. If a caller needs a broader range of community supports, then it often falls to a local mental health agency to make those connections. Information and referral, therefore, becomes a necessary function at the local level. It is often embedded in the case manager's job description, but some community mental health agencies have chosen to develop dedicated resource centres with trained I&R staff.

While MHSIO provides a strong, centralized service, it also relies on the network of I&R specialists in other organizations throughout the province. "I think it's really important," says Fellinger, "because they can provide a local flavour. While we're providing information on a provincial basis, based on what the organizations have given us, we're doing it because someone's called the provincial number. We may provide a contact for one of the CMHA programs in Peel, for example, where the local branch has a strong I&R function. But the person obviously didn't know to call that number first. We're able to provide it for them and redirect the call. Locally they may be aware of some adjunct services that aren't necessarily mental health related, so they're able to give the person that local flavour of information. But we're able to at least point them in the right direction."

Knowing who to call for help when you don't know the mental health system has always been a challenge, not only for consumers and family members, but also for other health care professionals and public service providers. Police services in Ontario are a case in point.

Executive Director Brad Davey recalls his own personal experience prior to joining ConnexOntario. "I began my working life at a large regional psychiatric hospital. We were located just off the 401 corridor, and the police were constantly bringing us folks who had been dropped off at the local service centre because truck drivers like to have people in the cab to keep them awake, or at least they used to. The challenge the police faced, and particularly the OPP, was they picked someone up who might not have any ID and they'd claim they were from Brockville, but clearly there was some sort of disorder going on. The person would say, 'Yes, I have a worker named Bob.' As



TELEPHONE INQUIRIES TO MHSIO ARE ANSWERED AROUND THE CLOCK BY A ROTATING CREW OF SIX FULL-TIME STAFF AND A HANDFUL OF RELIEF WORKERS.

"We're a system navigator in the sense of helping people find their way through what can be a confusing system, as well as educating them about the system itself."

Barry Fellinger, Mental Health Service Information Ontario

a young fledgling in the mental health business, I was low man on the totem pole and I spent hours making phone calls, trying to find organizations and trying to connect people back to whoever they were receiving service from."

Since launching in 2005, MHSIO has made a point of reaching out to police, among other professionals, who regularly come into contact with people with mental health issues. One initiative has been the wide distribution of wallet-sized plastic cards, in both English and French, featuring all three ConnexOntario help lines.

"It just seemed we could provide a very good resource to the cops, and there's certainly been a huge amount of interest," says Davey. "We've distributed over 80,000 of our little *aide-memoire* cards to police services and victim services across the province."

Among other initiatives, Davey is particularly enthusiastic about the recent development of an "eServices dashboard" that allows mental health providers to manage their own listings in the MHSIO database and get a behind-the-scenes look at referral data for their agency. "People can very easily, with a few keystrokes, go online and update any information or personnel that have changed. That gets sent to us automatically and we vet it and update the database."

ConnexOntario has always had the capacity to provide data reports to the Ministry of Health and Long-Term Care, showing referral patterns and identifying categories of need expressed by callers. But system planners at all levels, including Local Health Integration Networks (LHINs), are excited by the prospect of a hands-on tool that will allow them to dig into the database themselves, at least at an aggregate level.

"Another strength is the availability tracking we do," Davey adds. "We've done it for years for the residential addiction treatment sector. We've now got it built on the mental health side. We haven't rolled it out yet, but a lot of organizations that have been embracing eServices are already giving us their availability data for short-term crisis support beds. We will be talking with the LHINs about it, and we certainly have a number of partner agencies who are very enthusiastic about getting on board."

The justice system in Ontario is one community in need of good information, and MHSIO has the capacity to provide access to it.

"We tend to look at the provincial picture, and justice is a provincial system, so it's logical that we provide the whole system with good support," Davey continues. "If a forensic bed or forensic assessment is needed, the judge in Toronto doesn't care if the bed's in Whitby or in St. Thomas or wherever. He just wants that assessment done. I see our direction in the future as doing more and more things with sectors that have a provincial focus."

While professional callers — police, physicians, pharmacists, social workers, EAP providers and others — have always been among the target audience for MHSIO, more than 50 percent of calls continue to come from individuals seeking help for themselves. Another 30 percent are from family members. While some callers are in distress — about 3 percent are crisis calls, including people feeling suicidal — many are simply looking for a phone number.

"The calls vary and you never know where the next one's coming from," says Ron. "We do get the odd crisis call, but I tend to get a lot of parents calling for children's mental health issues. I try to get them connected with different services, even though we mainly have adult mental health programs in our database. Some people are so grateful for finding them a number that they spend several minutes just thanking you."

"Just being able to reassure them, to listen to them for a couple of minutes, they're so appreciative. It's really rewarding working here. The thing I often hear is, 'I've been looking in the phone book all day trying to find programs and I can't find anything.' And that tells me a lot right there."

For more information, visit www.mhsio.on.ca. The toll-free number for MHSIO is 1.866.531.2600.

Scott Mitchell is director of knowledge transfer at CMHA Ontario.

PHOTO BY SUSAN KING

System Navigators

PEER SUPPORT WORKERS:
Learning from Experience

IT'S HARD TO IMAGINE A BETTER PERSON to help you navigate a complex system than someone who's done it before. The peer support worker has become one of the most valuable navigators within the mental health system, and Peggy Guiler-Delahunt has learned this through personal experience. Currently with the Mental Health Rights Coalition of Hamilton, she was a peer support worker for 10 years at the Haldimand Norfolk Resource Centre and trained peer specialists for the centre. Both organizations are consumer/survivor initiatives (CSI), concerned primarily with meeting the needs of local consumers and providing peer support.

"Yes, that's what we do," explains Guiler-Delahunt. "We help consumers find mental health services as well as other services. Maybe somebody needs to know how to get to the food bank, or they're too embarrassed to go on their own, so we go with them."

The idea of connecting consumers to all the services they need in the community is not new. A 2002 study led by University of Western Ontario researcher Cheryl Forchuk was a breakthrough in this area. It tested an alternative approach to supporting people with chronic mental illness as they made the transition from hospital to the community. The transitional discharge model has been developing for almost a decade. In it, CSIs team up with hospitals in order to reintegrate people into the community upon discharge by helping them better navigate the system. Although different people may need different levels of assistance, peer support remains an ongoing element in order to ensure a flexible, responsive system that works for the consumer. With this kind of support, peers, like family, are the system of continuity.

This element is especially important, stresses Guiler-Delahunt, "because those of us who've been there and had mental illnesses, a lot of us have had hospital experiences and know what it's like to come out. We recognize people's needs and can sometimes encourage them better than the professionals can. A peer support worker may not have any big letters next to their name, but it's still somebody who understands, who cares, and somebody who wants to make sure that you're getting the help that you need."

"So this is what the many consumer/survivor initiatives have done," continues Guiler-Delahunt. "We work with the consumer right from the hospital stage, bringing them out into the community and hooking them up with all kinds of services. We can also just be a friendly face in a world turned upside down."

The peer support model also includes the training of consumers who may eventually become peer support workers themselves. In fact, the Ministry of Health and Long-Term Care now includes "peer specialists" on Assertive Community Treatment (ACT) teams, usually people trained through a CSI. As an added benefit, the training often provides consumers with other marketable skills, such as first aid, CPR and crisis intervention.

"I think it's very important to have that continuum of care for people who come out of hospital," says Guiler-Delahunt. "I think we also have to realize and accept that professionals do not have to deliver all of the services and that's where the peer support people come in. In the medical model, the basic premise is that only medical professionals can help somebody. That is not true. It's the whole community that helps people recover."

For more information about the Mental Health Rights Coalition of Hamilton, see www.mentalhealthrights.ca.

Elizabeth Lines and Jennifer Walker

CASE Managers

By Elizabeth Lines

Breaking Down Barriers to Care

"Getting through the system can be a struggle for anyone, but particularly for someone under the influence of a substance or experiencing symptoms that impair their ability to think clearly and navigate situations for themselves. It's crucial to have access to people who are well versed in what the community resources are, where they are, and how to get them."

So says Martha Connoy, director of community mental health programs at Mission Services of London and co-chair of the Addictions and Mental Health Case Management Committee of the Ontario Federation of Community Mental Health and Addiction Programs. "In the context of our agency, where we have outreach and shelter workers filling the role of case managers for the seriously mentally ill homeless, navigating the system is exactly what we do. Our staff are the resources who know the who, what, where, when, why, how and how long of it all."

"The issues are definitely complex," confirms Joanne Mullins, a community support worker and resource centre coordinator with Mission Services. "For someone who has a mental illness and may also be concurrently disordered with a substance abuse issue, who is living in poverty, who's likely suffered abuse in their life, who has had a dysfunctional family and so on — there are just so many factors that intensify the problems they have."

Susan Meikle, executive director of North Toronto Support Services and long involved in the development of training materials for mental health case managers, fully agrees that system navigation is central to case management. "There are so many case management positions that take on a variety of tasks. But one thing I think we can all agree on is that case management in mental health was created because it's so difficult for mental health consumers to find their way through the system."

"I think that adult mental health is quite different from other sectors in that the system navigator is also the service provider in many cases," Meikle continues. "What we learned in the 60s through deinstitutionalization was that you can't just give a mental health client who's been hospitalized for weeks or months a phone number and say, 'Here's your case manager. Give them a call and they'll tell you where to go.' That's a sure recipe for people just disappearing. And that's what happened for years until we finally woke up and realized we need somebody who's going to take the initiative, who's going to connect with the individual, who's going to walk with them through the process. So it's very hard to take the system navigation piece out of the direct service piece in adult mental health, and that's why the case management approach has been so successful — because it combines them. You can't work with our clients by sitting behind a desk. And the more special the population, the greater the need for system navigation."

Judith Peak functions as a case manager in the addictions and mental health field. Working in the Champlain District (Ottawa area), Peak is an addiction assessment case manager. Like Mullins and others, as a case manager who faces sometimes reluctant and often disenfranchised clients, Peak's services often begin as an invitation to participate in the system.

"Since my focus is on assessment, I tend to support clients in entering and going through the system. For example, I might find treatment placements for clients and then advocate for community support services afterwards." Peak helps meet a broad spectrum of needs for clients who are coping with addictions in the community. "It's a very client-driven process, but it depends on the situation. For example, people in the shelter system are difficult to keep track of, but they are encouraged to contact me."

Being a case manager and playing the role of system navigator are virtually one and the same for Peak. "Anything I do, including advocacy, is really intended to help people move through the system in the most therapeutic manner for them. The assessment is supposed to help direct the level of care that is needed and is geared toward residential placement. But sometimes I get a client who's not appropriate for a residential placement, so we will sit down and talk about the resources they need: Do they need medical services? Psychiatric services? Housing? And so on. I will serve as a kind of resource centre for a client, even if they're not going ahead with treatment

CASE MANAGER JOANNE MULLINS (LEFT) RECEIVES HER AWARD OF EXCELLENCE FOR OUTSTANDING CASE MANAGEMENT SUPPORT IN ADDICTIONS AND MENTAL HEALTH FROM MARK LAROUCHE AND DAVID KELLY OF THE ONTARIO FEDERATION OF COMMUNITY MENTAL HEALTH AND ADDICTION PROGRAMS

CASE MANAGER JUDITH PEAK (RIGHT) CELEBRATES HER AWARD OF EXCELLENCE FOR OUTSTANDING CASE MANAGEMENT SUPPORT IN ADDICTIONS AND MENTAL HEALTH, WITH SERENITY HOUSE EXECUTIVE DIRECTOR MONIQUE BRISSON, WHO NOMINATED JUDITH FOR THE AWARD

in a residential program. I start with the client's needs and try to ensure services that can help them to stay safe."

Connoy observes that our systems seem to be set up for people who already know what they need and what door to knock on. But not everybody knows what door to knock on, or how many doors you have to go through and tell your story before you get the service that you need, when and where you need it.

The routes to and through the addictions treatment system are perhaps the least known. "A lot of people are coming to the table with absolutely no idea of how to proceed," laments Peak. "And unfortunately, most of these people are in crisis, which is problematic because people in crisis are often not appropriate for residential services. So we try to steer them to services like withdrawal management. But we have a sad lack of stabilization services in the system, especially for women. And there are times, when someone's in real crisis, that we send them to emergency. I must say that overall I think the addiction community as a whole has been very proactive and empathetic to people who have absolutely no idea of where to go next."

"Certainly given the challenges faced by our clientele, we don't want to frustrate them any more than they already are," says Connoy. "Their lives are already fairly chaotic. So we need to be able to link them to an appropriate referral within a reasonable length of time without setting them up for failure."

But, almost by definition, systems are not easy. According to Peak, part of the problem is that the public, oftentimes along with professionals, do not know where to start. "My point is that, whether in doctors' offices or community centres, there just isn't enough information around about the system and how to access it appropriately. And I have clients who call me up to say that their doctor doesn't know what to do, or they're actually receiving misinformation. Yet, family doctors are often the first contact, so clearly they need more information. Otherwise, it's too confusing and frustrating for everybody in the end."

Jim Henderson, a community outreach worker with Streetscape, a branch of Mission Services, describes the work this way: "Our job is to provide outreach, advocacy, referral and engage in case management with people who are homeless or are at risk of becoming homeless and especially those with mental health and/or addiction problems." When it comes to addressing the needs of our most marginalized citizens, Henderson notes that as helpful as agencies try to be, there really isn't a true understanding of what these people are going through — neither of their potential nor their limitations.

More education for frontline staff would be welcome, according to Mullins. Otherwise, the agencies that are there to provide service become barriers themselves.

Among the barriers are assumptions built into the system's basic operating rules that can end up as hurdles for those who live outside of the mainstream. Sometimes, they're seemingly little things. For example, Henderson notes that "things that

> "One thing I think we can all agree on is that case management in mental health was created because it's so difficult for mental health consumers to find their way through the system."
>
> Susan Meikle,
> North Toronto Support Services

may seem simple to us, like keeping appointments, can be challenging when you're on the street or in a shelter but have no clock. In fact, you may not know what day it is."

And then there's the assumption of literacy. "For instance," explains Mullins, "a client may need to apply for social assistance. But many of our clients are illiterate, or have very little education. So if a government agency says, 'Take these forms and fill them out,' many times these instructions won't be carried through, and it could be due to a combination of literacy limitations and an untreated mental disorder. Even having to look at forms with so many words on them can create great anxiety. I have clients who don't open their mail if it has a government insignia on it. They bring it to me because they're so anxiety-ridden about it. People definitely need support in this area."

"Giving clients a choice is very important," continues Mullins. "I find in many programs, whether it be through the courts or the hospitals or elsewhere, clients are told that they have to participate in certain things. Or they are made to do something that is not always within their realm and they may become anxious, etc. However, what we find here is, if given the chance to make the choice themselves, clients know their needs and limits and can make good choices. Many of our clients are not joiners, so they're not going to be comfortable entering a classroom or group situation, for example. They need more support in dealing with those issues before a group setting will be possible."

> "Anything I do, including advocacy, is really intended to help people move through the system in the most therapeutic manner for them…" Judith Peak, case manager

"Our clientele tend to get very frustrated very easily," says Henderson. "Sometimes you hear the attitude in the public that these people want to be the way they are, but I disagree. There are just too many barriers for them to get through and they've given up. Sometimes they're astounded that we would help them because their opinion of themselves is so low."

"We do whatever it takes to get them off the street and whatever it takes to keep them off the street," he adds, "including setting up appointments for them, going to appointments with them, making phone calls for them — breaking down the barriers that they can't get through on their own. So, if they can't get by the front line of Ontario Works, we'll do that for them. If they can't get a lawyer, we'll find them a lawyer. If they don't qualify for legal aid, we'll go after legal aid for them. We do a lot of advocacy for them, a lot of knocking on doors."

Mission Services also works to avoid creating unnecessary barriers to service in its own practices. "All we ask is, 'By what name can we call you and how did you hear about us?' That's our intake," explains Connoy. "So there's not a barrier there. And that's one of the things we've tried to do across all of our programs — to be as barrier-free as we can be. We have very few rules. People may come here under the influence and many agencies don't do well with people arriving not sober. But we don't base access on how much you've had to drink but whether you can be socially acceptable. And if you can be, then you're welcome to be here. Of course, we don't allow any imbibing on the premises. But we're trying to build relationships, rather than give people reasons not to like us. And we're quite successful at it."

Similarly, client needs do not always comfortably conform to the system's rules and regulations, but Mission Services has developed practices that are in the best interests of the client. "I have some clients that may remain on my case load — on and off — for five years," says Mullins. "Because of government stipulations, we can only keep a person on the books for three months without seeing them. But if somebody comes back, I just reregister them. Our clients do not feel they are just case numbers."

Effective case management in the context of a special population with complex needs is first and foremost a human enterprise. In his work on the street, explains Henderson, "we will meet with people and just ask, 'What can we do for you today?' That's where we start. Like today, I was coming back from court with a lady and she said, 'I think there are a lot of other problems you can help me with,' and I said, 'I think you're right.' I knew right then she trusted me. And that's crucial. So many have been so beaten down and have heard 'no' so many times that trust is the big issue. Once you've established trust you can almost see the change, even though the problems haven't gone away. But they're willing to let you help them."

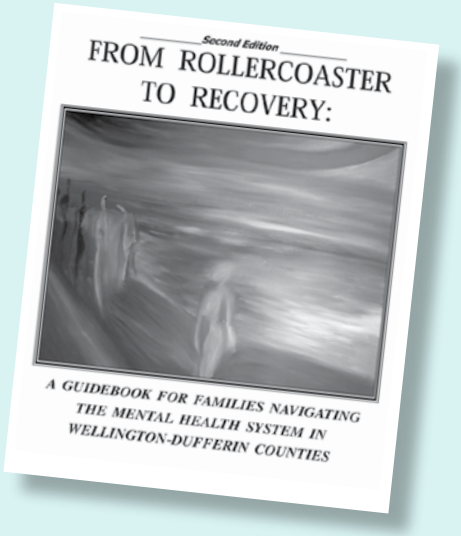
Mullins adds, "It can be very scary for our clients to make these changes in their lives, and they can feel like a puppet on a string out there where everyone else is playing with the strings. They can feel very out of control. So they need to be empowered and feel that they have a hand in making decisions about themselves and learn, too, to live with the consequences of their decisions."

"We open doors for people who can't open them themselves. That's basically what we do," says Henderson. "And once we've walked them through the door and done what we can to help them, the next time we go through that door, maybe we don't need to be in front but just be beside them. And then down the road, we'll be in the background. And eventually, they'll walk through that door and call us at the office and say, 'I did this all by myself.'"

Elizabeth Lines is a researcher/writer in the areas of health and social issues.

FAMILY MEMBERS:

Riding the Rollercoaster



FAMILIES ARE THE SINGLE LARGEST group of caregivers for people with mental illness. In many ways, they act as informal case managers — encouraging and supporting treatment, finding housing, arranging for income assistance, and helping with system navigation. They often provide crisis intervention and advocate on behalf of their ill relative. Not surprisingly, family support can play an important role in recovery.

Yet the stress of caring and advocating for their loved one is often overwhelming, as families are left to find their way by chance through a complex and under-resourced mental health system. Family self-help groups, where they exist, can be enormously supportive. They provide a caring atmosphere where families can share coping strategies, exchange information and find emotional support. Who better to show you the ropes than someone who's been there and has experienced the emotional ups and downs?

A few years ago, family members in the area around Guelph, Ontario, decided to put their hard-earned knowledge down on paper so others could benefit. In 2005, the Family Mental Health Network published the first edition of *From Rollercoaster to Recovery: A Guidebook for Families Navigating the Mental Health System in Wellington-Dufferin Counties*. This collaboratively created self-help guide offered advice on coping with a crisis, understanding mental illnesses, medication, legal issues, housing, employment, education, and approaches to recovery. The practical tips were accompanied by contact information for local hospitals, help lines and community mental health resources.

The first printing of 500 copies sold out in six weeks. It wasn't just family members buying the book — service providers were also eager to get their hands on such a useful resource. So the group printed a few thousand more. In April 2007, with the support of donors and a grant from the Guelph chapter of the Schizophrenia Society of Ontario, they produced a second edition. New chapters were added on such topics as dual diagnosis and concurrent disorders, cultural issues, seniors, and caring for the caregiver. An editor was hired and the content was vetted by professionals in the community.

Now the Family Mental Health Network wants to share the fruits of their labour with other communities in Ontario. In March 2008, they're launching a brand new website (www.mentalhealthfamilyguide.ca) to promote the guidebook. Visitors will be able to purchase the print edition online or pay to download an electronic version. They can also buy rights to reproduce the core contents of the guidebook, adding their own resources and localized contact information. A legal agreement has been developed to allow other communities to adapt the material to their local needs.

Rob Davis, chief of the Guelph Police Service, calls the guidebook "a genuine life-saver." The police have used it for officer training and provided copies to families in need. It is being used in hospital emergency departments and community agencies throughout the two counties.

Beyond the practical advice, the authors have also included brief quotations from family members, sprinkled throughout as "hopeful stories for people in the thick of it." According to teacher-librarian Val Morse, a member of the family network and chair of the project steering committee, *From Rollercoaster to Recovery* was truly a group effort. "Hundreds of participants gave input," she explains, "people who have been through the system and want to make the way easier for others." *Scott Mitchell*

We Are Family

"Family" describes people with a strong and emotional, psychological and/or economic commitment to one another — regardless of the nature of their relationship. "Family" can include those connected by biology, adoption, marriage or friendship. Ultimately, it is the person seeking services (whether it be a family member or a consumer) who defines his or her own "family."

Source: Family Mental Health Alliance et al., Caring Together: Families as Partners in the Mental Health and Addiction System *(2006), available at www.ontario.cmha.ca/family.*

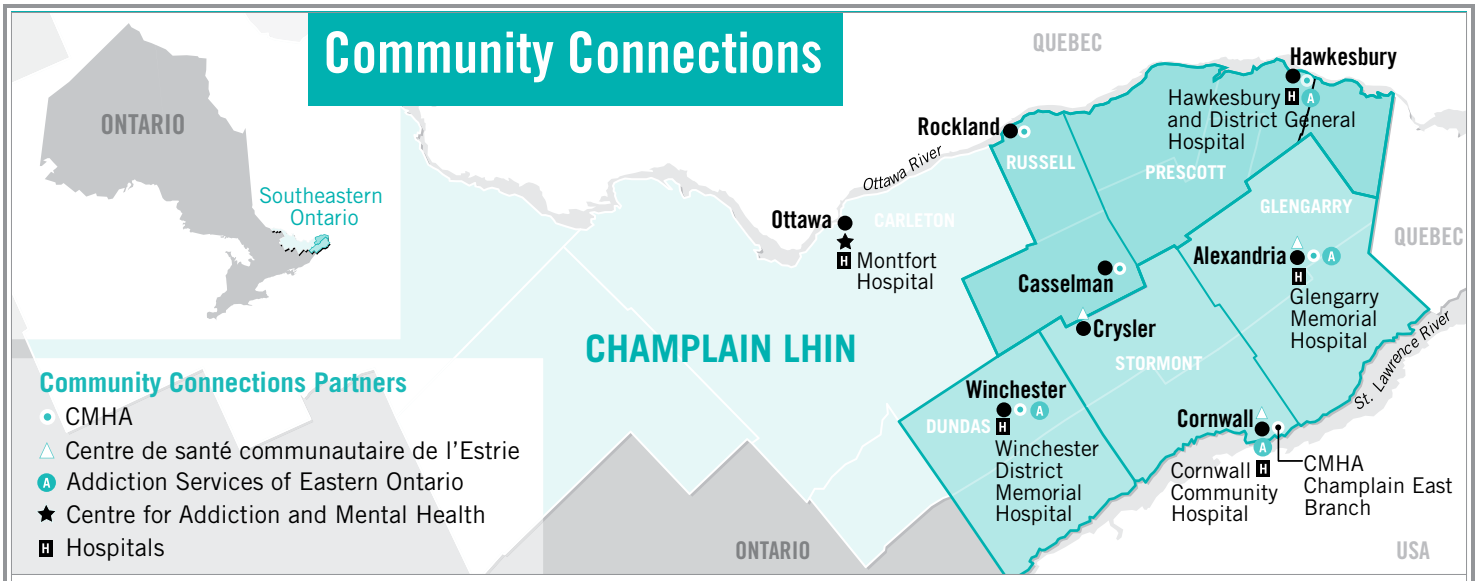
Connecting Communities in Champlain East

BY *Donna Hardaker*

"Although we are English and French, hospitals and community agencies, we all care about one thing: the client — and how to provide better service."

Sylvie Lemaire, program director at the Canadian Mental Health Association, Champlain East Branch, is describing the shared motivation behind a successful partnership that has transformed access to addiction and mental health services in the five eastern Ontario counties of Stormont, Dundas and Glengarry (S.D.G.) and Prescott-Russell (P.R.).

For three years, a group of passionate, caring and tenacious service providers from hospitals and community mental health and addiction agencies worked together in a focused effort to remove barriers and streamline access to services. The outcome: Community Connections, an information and referral service that includes a central access phone line and a one-time screening process for callers, who are then referred to an appropriate service provider for assessment. (See www.mycommunityconnection.ca.)



MAP BY ROSE ZGODZINSKI

For CMHA and its partners in Champlain East, the process of working together to improve access illuminated the many barriers to treatment: the tangle of wrong doors, waiting lists, multiple assessments, disjointed services and confusing criteria for access to programs. While other regions in Ontario experience many of the same service delivery problems, Champlain East is significantly disadvantaged by higher than average rates of unemployment, mental illness, addiction and concurrent disorders.

The area known as Champlain East occupies the easternmost tip of the province, a knuckle of land with towns and farms running along the St. Lawrence River and gently nudging the underside of Quebec. Almost 70 percent of the population of P.R. is francophone, while S.D.G. is 70 percent anglophone. Language and cultural barriers combine with the rural nature of the area to exacerbate problems with service delivery for people with mental illness and addictions.

Simply getting a referral to the right service provider was a long-standing challenge. Trudy Reid, CEO of Winchester District Memorial Hospital, was hearing from her physicians and nurses in family practice and in the emergency room about the difficulty they had in making appropriate referrals to community services for mental health and addictions. She sought out community partners to delve into the issue. "Mental health and addictions is not part of the mandate for this hospital, so we see ourselves as collaborators," says Reid. "Our staff were spending a lot of time on the phone trying to find out where to refer patients, so we needed to establish a more seamless system, to make this easy for providers and the public to get to the right resource at the right time."

During initial meetings with local providers to review community services, Reid, from her perspective as an outsider, observed a fragmented system of "smaller organizations with small budgets trying to do a job that is insurmountable. I asked myself, 'Why are there so many silos and service providers? Why is the language and information so organization-specific? Why do roles overlap so much?'"

At about the same time, a few other groups in the region began identifying ways to improve access to services. They saw an opportunity to work together. Five hospitals — Cornwall Community, Winchester District Memorial, Glengarry Memorial, Hawkesbury and District General, and Montfort — joined forces with several community agencies, including CMHA Champlain East, Centre de santé communautaire de l'Estrie, Addiction Services of Eastern Ontario (ASEO), and the provincial services of the Centre for Addiction and Mental Health (CAMH). Together they identified four common goals: create a seamless client system, avoid unwarranted waiting list duplication, prevent multiple screening processes, and apply evidence-based best practice approaches.

The collaboration eventually took the form of one steering committee for the five counties and two inter-agency review committees, one each for the geographic regions of S.D.G. and P.R. The ongoing purpose of the review committees is to evaluate all referrals and to discuss cases in a continuing effort to close gaps in service. A longer-term evaluation and analysis of the program is being conducted by a PhD student.

During the many inter-agency meetings, the partners learned about each other's strengths and weaknesses, resources and needs, philosophies and approaches. "What may have been seen as conflict at the beginning, changed into opportunities," says Johanne Renaud, team supervisor for CMHA Champlain East. Renaud sits on the review committee for P.R. and supervises the staff who answer the Community Connections line for P.R. The CMHA team supervisor for S.D.G., Kim Height, sits on the review committee for S.D.G.

One clear outcome of the Community Connections project has been easier access for people with concurrent disorders, who need to get treatment for both their addiction and their mental illness. In the past, mental health service providers and addiction service providers have often worked at cross purposes, each insisting that the person must deal with their other problem first. Before getting access to mental health services, for example, people were expected to get treatment for their addictions, and

vice versa. Best practices for treating concurrent disorders, however, suggest that both the addiction and the mental illness should be treated at the same time, in a coordinated way.

Now, when someone calls the Community Connections line or contacts one of the partner organizations, a common screening form is used to gather information about all their needs, including both mental health and addiction issues. Best practices from both sectors were taken into account when developing the form. Sharing the same form across multiple service providers makes the referral process much simpler and helps provide a more complete picture of the person's needs. To honour the diversity of the two areas within Champlain East — S.D.G., which has larger urban centres and is primarily English speaking, and P.R., which is mostly rural and predominantly French-speaking — the partners created two slightly different versions of the screening tool, each one adapted to the area's needs and available services. It was also decided that there would be two Community Connection phone lines, one for S.D.G. and one for P.R.

To benefit their clients with concurrent disorders, mental health workers at CMHA became certified as addiction counsellors and the CAMH anti-stigma training program Beyond the Label was delivered to CMHA staff. "This holistic approach gives continuity of care and we get to know our clients in different domains," says Renaud. "They trust us and already have a relationship that's built when we help them with ODSP, housing, or legal problems." She goes on to describe the benefits for staff who report that "when they deal with clients with concurrent disorders, they are more open and more welcoming now. In the past they felt overwhelmed, but now they feel confident and have expressed how their values have changed. We don't have to send clients [with addictions] elsewhere."

The executive director of CMHA Champlain East is Michael Lloyd. He recently announced that the branch has adjusted its primary service focus from mental illness alone to concurrent disorders, in order to fill this gap in community programming. "We even have our own training package for concurrent disorders that has been certified," says Lloyd. With strong community programming, as well as education and support groups for people with concurrent disorders offered at the branch, the goal is to reduce hospital visits and help people stay in the community.

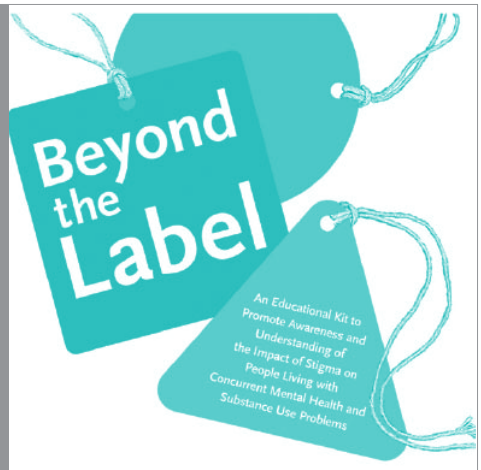
As a consultant to the process of developing Community Connections, Monique Bouvier of CAMH says that two levels of involvement were essential: the executive directors or CEOs at the steering committee level, and the clinical staff at the review committee level. The project required no extra funding. "This is a very exciting time, and it's doable without merging organizations," says Bouvier, who chairs the review committee for P.R. "All partners contributed. It took resources and time, and people took up the challenge and went with it."

Planning for this initiative began long before the Champlain Local Health Integration Network (LHIN) was in place, but it fits well within the LHIN environment. Lloyd says that the message he would give to other regions trying to improve service for mental health, addictions and concurrent disorders is to "work with community partners because the LHINs don't have new money. They can only shuffle the deck. You can come up with collaborative initiatives amongst your partners without the need for new money, and you can adjust your own services and start a new service without having to turn to the ministry for funding." Lloyd says that the review committees who examine each referral are reporting great success. "Our review committees are finding that referrals are all appropriate. That to me is a good thing."

David Henry, who manages the mental health crisis team at Cornwall Hospital and sits on the review committee for S.D.G., sees great potential for expanding the partnership to other service providers. "When we get more time under our belt," he says, "we can expand to include domestic violence and sexual abuse services, for example. When you develop anything that is somewhat new, there's always a need for a period of time to demonstrate that this way of doing things is an improvement."

Community Connections is a living demonstration of how organizations can work together to improve the system, by focusing on the needs of clients, overcoming historical differences and learning a collaborative approach to service delivery. "While respecting everybody's mandate," says Sylvie Lemaire, "we are all more client-centred now."

Donna Hardaker works at CMHA York Region Branch where she delivers the Mental Health Works program.



BEYOND THE LABEL

Beyond the Label is an educational kit and training package designed to raise awareness and understanding among service workers regarding the impact of stigma, prejudice and discrimination on people living with concurrent disorders or substance use problems. It allows service providers to ensure that their services are accessible and supportive, with concrete tools for reflection on unexamined prejudices or misconceptions.

For more information, or to download the kit, see www.camh.net.

Say Farewell *to the* Fax

By Scott Mitchell

Despite the rapid advance of Internet communication technologies, many health-care providers in Ontario still use the humble fax machine, and even hand-delivered paper forms, to make referrals for their clients. All that is about to change, thanks to the innovative, province-wide e-Referrals & Access Tracking system being developed by the Continuing Care e-Health (CCeH) office.

On January 21, 2008, a pilot project for the community mental health and addictions sector went live, when an electronic request for service was transmitted from The Scarborough Hospital's Short Term Case Management Team to the Canadian Mental Health Association, Toronto Branch.

"We look forward to being able to receive and respond to referrals more quickly," says Laura Monastero, manager of CMHA Toronto's Case Management and Intake Information and Referral Services. "A faster referral process means we can spend more time assisting people, providing information and guiding families through the mental health system."

Improving access to client care is the primary goal of the e-referrals project, but there are additional benefits. E-referrals are safer and more secure than faxes. And the quality of client information collected and shared among service providers will continue to improve. In the future, health information transmitted via e-referral will be imported directly into the organization's record-management system, rather than being re-keyed. This will speed up the processing time and reduce the risk of misinterpreting handwritten requests.

Health-care agencies using the e-referrals system will receive immediate notification of new referral requests, and both the sending and receiving organization will have the ability to follow the status of referrals. By tracking e-referral activity and gathering data on wait times and other events, the system will eventually allow organizations to monitor and improve their own referral processes, while system planners can watch for bottlenecks and better understand overall patterns of movement as people receiving care are transferred from one agency to another, across all parts of the health care system.

CMHA TORONTO BRANCH STAFF CELEBRATE THE LAUNCH OF THE E-REFERRALS PILOT FOR MENTAL HEALTH AND ADDICTIONS (LEFT TO RIGHT): TARA MCKAY, TANYA GORDON, LAURA MONASTERO AND TED JUZKOW

By working together to understand their own and each other's referral processes, organizations can strengthen their relationship and make the system more effective. They can also be more accountable to the people who are trying to access their services.

"The Scarborough Hospital is proud to be part of taking a giant step forward in the evolution of health communication systems," comments Sara Kirkup, manager of Crisis Programs at TSH. "e-Referrals paves the way to future efficiencies in the delivery of mental health services."

For more information about e-Referrals & Access Tracking, see the Continuing Care e-Health pages at www.ehealthontario.ca.

Scott Mitchell is director of knowledge transfer at CMHA Ontario.

> "A faster referral process means we can spend more time assisting people, providing information and guiding families through the mental health system."
>
> Laura Monastero, CMHA Toronto Branch

PHOTO BY BRENDA FINLAYSON

THE GOLD STANDARD

By Michelle Gold

CONTINUITY OF CARE:

Start with the End in Mind

System navigation means that people are able to access the right services at the right time and in the right place. The *system* focus implies that services and supports are interactive and work together to achieve a common goal. *Navigation* suggests that this is somewhat of a journey, with people often requiring access to more than one type of service or support, either at the same time or in a specific order. In mental health, the concept of system navigation is associated with the need for continuity of care. We start with the premise that continuity of care depends upon a comprehensive *continuum* of services. Indeed, a framework for a broad system of mental health services and supports is provided in *Making It Happen*, Ontario's policy directions for persons with a mental illness.[1]

> Opportunities for achieving good outcomes will be thwarted in systems that lack capacity. Simply improving navigation through an insufficient mental health system is unlikely to achieve better outcomes.

The concept of continuity of care has much to offer any discussion about system navigation and is a timely issue, as Ontario's local health integration networks (LHINs) develop an effective and efficient integrated health system. Continuity of care has been a principle of service integration within the mental health sector since the 1960s.[2] With the onset of deinstitutionalization, continuity of care meant ensuring continuous services for psychiatric patients through stable provider-client relationships as they were discharged from hospitals into community care.

Over time, this approach was perceived as too narrow because it only focused on moving clients out of the acute (hospital) care system. By the late 1970s, continuity of care was associated with case management and how providers would assist clients to access the various services and supports they needed. By the 1990s, with health system restructuring taking place in many locations, continuity of care became a goal for system reform. Thus, the emphasis expanded from a focus on the individual provider helping the client navigate the system, to the *system itself* being planned and coordinated in order to support continuity of care.

Today, continuity of care for persons with a mental illness is understood to be a multi-dimensional concept, incorporating aspects of individualized accessible care, the client-provider relationship, as well as system integration. The Alberta Continuity of Services Scale for Mental Health (ACSS-MH) is a recent development.[3] The scale focuses on three dimensions: system integration, service responsiveness and clients' relationships with their health providers. It is particularly appealing because it includes the client's perspective. When measured through the ACSS-MH, continuity of care is associated with lower severity of symptoms, better self-reported quality of life, greater satisfaction with services, and improved functioning in the community.[4]

The ACSS-MH was used in a 2002 Alberta study which investigated the relationship between continuity of care and financial costs to the publicly funded health system.[5] A broad range of service use and associated costs were tracked. These included emergency room and physician visits, inpatient days, ambulatory care, home care, community mental health services, and medication. Four hundred and thirty-seven individuals were followed for 17 months. The total cost to the system used by this group was $10.5 million during the study period, which was equal to $7.4 million per year. The study found that better continuity of care was associated with lower hospital costs, although community costs were higher. However, there was no significant difference in total costs to the system. Conversely, poor continuity of care was associated

with lower community costs and higher hospital costs. This is not surprising as enhanced continuity of care supports better clinical outcomes. The study also found that individuals with higher functional ratings cost the health system less overall.

These findings highlight the fact that appropriate investment in community services and supports enhances continuity of care, with all its ensuing benefits. Thus, health systems that provide adequate funding for a comprehensive *basket of services* increase continuity of care. The findings also expose a basic truth and impel a cautionary note: opportunities for achieving good outcomes will be thwarted in systems that lack capacity. Simply improving navigation through an insufficient mental health system is unlikely to achieve better outcomes.

This logic was validated in a recent review that investigated why system integration itself was not associated with improved outcomes for persons with a mental illness.[6] The researchers found that system integration was linked to a mediating variable: continuity of care. This relationship was in turn dependent upon other system factors, including access to a full continuum of services and supports. The study found that centralized access and better case management services within the mental health sector were associated with better continuity of care and that continuity of care was greater in systems that had performance targets.

As the work of the LHINs proceeds, it will be important to consider whether system navigation is being defined as an activity or whether it is mistakenly pursued as an end result. And then we need to move the discussion to the real issue: Good outcomes for people in Ontario with a mental illness will be dependent upon investing in a comprehensive continuum of care that supports continuity of care. The last few years have seen a noticeable increase in funding for mental health reform, but funding remains uneven across the province. We need to ensure continued funding, as well as equitable access to a full spectrum of services and supports for people in Ontario with a mental illness. Let's make sure the dialogue stays focused on this key end result.

Michelle Gold is senior director of policy and programs at CMHA Ontario.

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CALENDAR

March 7, 2008
Sudbury Regional Mutual Aid/Self-Help Conference. Ontario Self-Help Network (OSHNET) and the Sudbury Social Planning Council. Howard Johnson Plaza Hotel, Sudbury, Ontario. 416-487-4355, 1-888-283-8806 (toll-free), shrc@selfhelp.on.ca, www.selfhelp.on.ca.

March 29, 2008
Supporting Mental Health: What Can Families Do? 5th Annual Conference of the Family Initiatives Project. Holiday Inn, Cambridge, Ontario. 519-766-4450 ext. 240, benderl@cmhagrb.on.ca.

April 22, 2008
Celebrating Innovations in Health Care Expo 2008. Ministry of Health and Long-Term Care and Local Health Integration Networks. Metro Toronto Convention Centre, Toronto, Ontario. www.health.gov.on.ca.

April 28-29, 2008
Risk and Recovery Conference. St. Joseph's Healthcare Hamilton Centre for Mental Health and Addictions Forensic Program. Sheraton Hotel, Hamilton, Ontario. 905-522-1155 ext. 36493, ckelley@st.josham.on.ca.

May 5-11, 2008
Mental Health: Make It Your Business. Mental Health Week 2008. Canadian Mental Health Association. 416-484-7750, info@cmha.ca, www.cmha.ca.

May 21, 2008
Improving the Prevention of Eating-Related Disorders: Collaborative Research, Advocacy, and Policy Change. Hospital for Sick Children Symposium. Toronto Board of Trade, Toronto, Ontario. sarah.bovaird@sickkids.ca, www.sickkids.ca/communityhealth.

May 29-30, 2008
The Power of Positive Aging. 27th Annual Ontario Gerontology Association Conference. Crowne Plaza Hotel, Toronto, Ontario. 416-535-6034, info@gerontario.org, www.ontgerontology.on.ca.

June 15-17, 2008
The Full Meal Deal: Education, Incentives, Implementation, Evaluation. 9th National Conference on Collaborative Mental Health Care. Victoria, BC. CollabMHCConf@viha.ca, www.shared-care.ca.

August 22-23, 2008
Canadian Mental Health Association National Conference. Presented in association with CMHA Nova Scotia Division. 1-877-466-6606, tootonc@eastlink.ca, www.cmha.ca.

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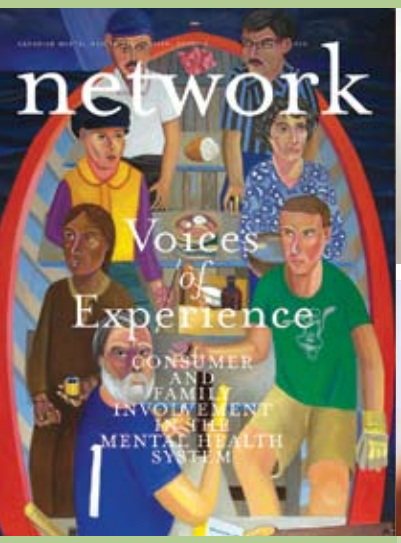

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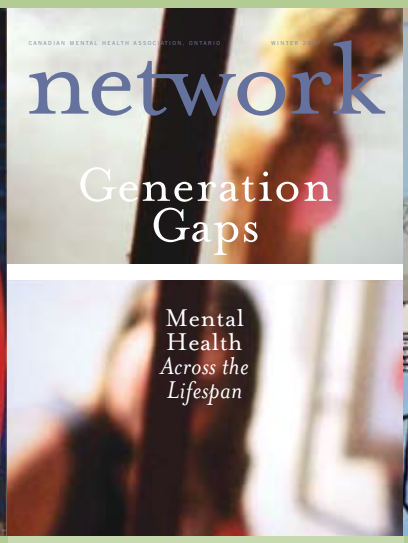

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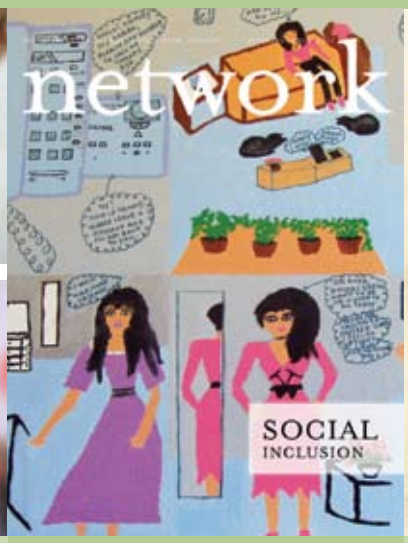

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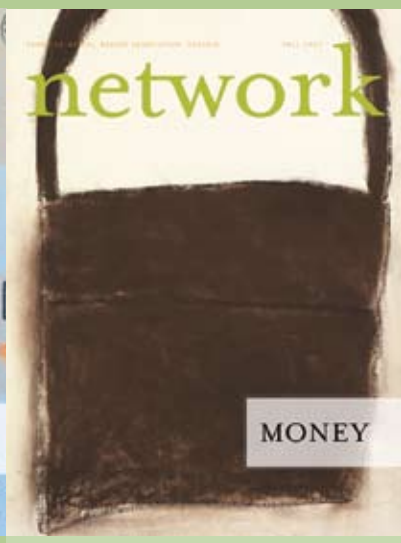

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