

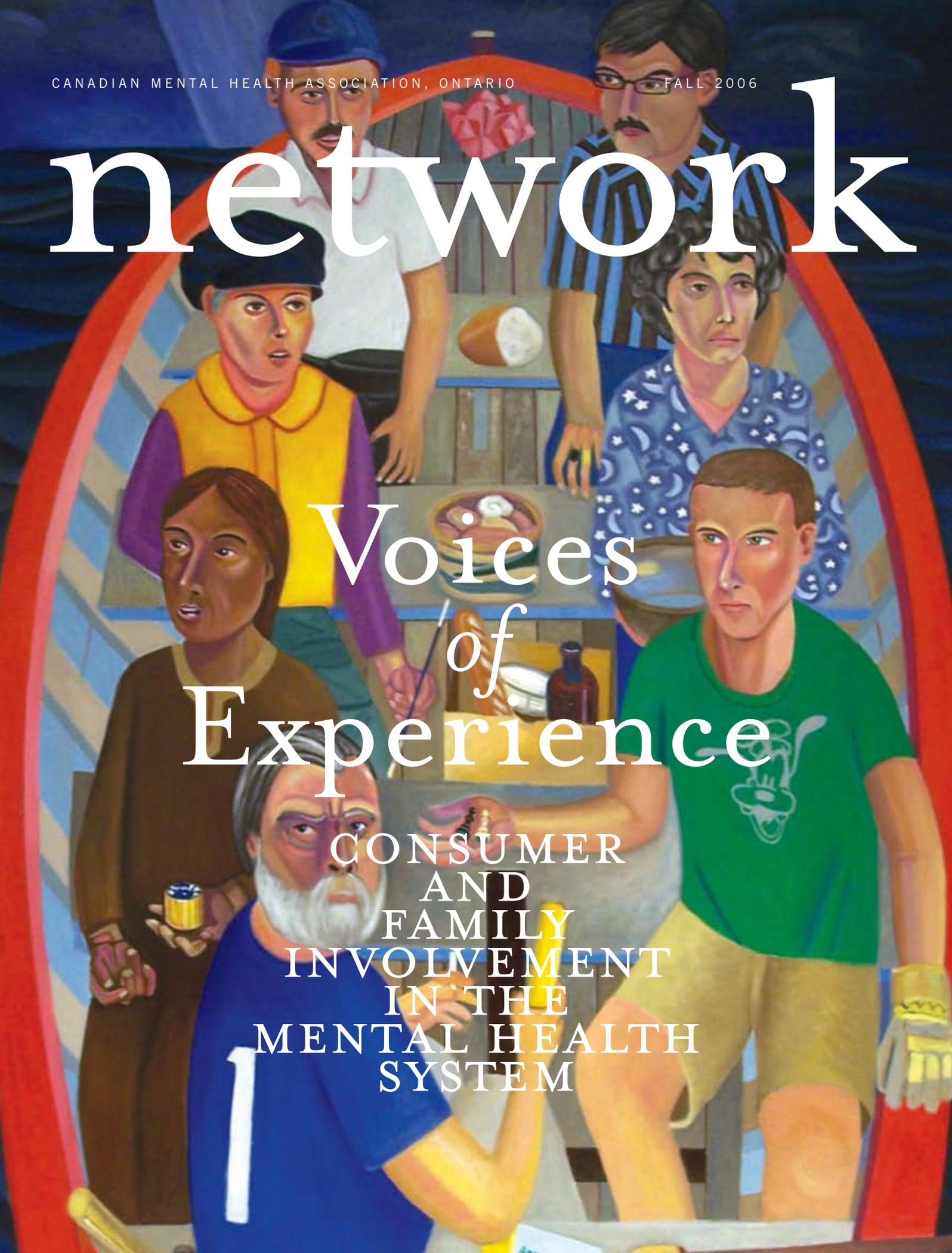
CANADIAN MENTAL HEALTH ASSOCIATION, ONTARIO

FALL 2006

network

Voices of Experience

CONSUMER
AND
FAMILY
INVOLVEMENT
IN THE
MENTAL HEALTH
SYSTEM





CANADIAN MENTAL
HEALTH ASSOCIATION, ONTARIO
ASSOCIATION CANADIENNE
POUR LA SANTÉ MENTALE, ONTARIO

EDITORIAL COMMITTEE

Scott Mitchell, Editor
Judith Coulman
Michelle Gold
Joan Jones
Gilles Myner

CHIEF EXECUTIVE OFFICER

Karen McGrath, BSW, MBA

CONTRIBUTORS

Michelle Gold, Donna Hardaker,
Elizabeth Lines, Heather McKee,
Sandy Naiman, Leith Peterson,
Judy Watson, Nicole Zahradnik

DESIGN

Soapbox Design Communications Inc.

ADMINISTRATIVE ASSISTANT

Susan Macartney

OUR MISSION

To promote the mental health of all individuals and communities in Ontario by providing leadership through knowledge enhancement, policy development, advocacy, and the advancement of best practices in service delivery.

Network magazine is published 3 times each year. © 2006 by the Canadian Mental Health Association, Ontario. All rights reserved. Reproduction in whole or in part without written permission from the publisher is prohibited. Statements, opinions and viewpoints made or expressed by the writers do not necessarily represent the opinions of the Canadian Mental Health Association, Ontario or the branch offices. Readers' views are welcomed and may be published in *Network*. Comments and views should be forwarded to *Network* at the following address:

Network, c/o
Canadian Mental Health Association, Ontario
180 Dundas Street West, Suite 2301
Toronto, Ontario M5G 1Z8

TELEPHONE 416-977-5580
FAX 416-977-2264
E-MAIL network@ontario.cmha.ca
WEBSITE www.ontario.cmha.ca

Printed in Canada ISSN 1181-7976



The financial support of the Ontario Ministry of Health and Long-Term Care is gratefully acknowledged.

3

Editorial

Bringing Our Voices to the Table

4

All Aboard

CMHA branches help mental health consumers and family members make the transition to a leadership role

8

Catching Up with Reality

Families are often the main caregivers for people with mental illness, but they have yet to receive the recognition and support they deserve

12

Education Is the Key

Since the early 1950s, CMHA London-Middlesex Branch has made great strides in helping families to overcome the stigma of mental illness through education

14

Hearing Is Believing

Toronto Sun reporter Sandy Naiman talks about stigma and the parallels between hearing loss and mental illness

17

Information of Concern

Personal health information is being collected in police databases across the province, but there are no consistent policies to guide police decisions about releasing information to potential employers or volunteer organizations

22

Making the Great Stride Outward

Through volunteering, people who have a mental illness can develop their skills, connect with their community, and overcome isolation and hopelessness

26

The Gold Standard

Local Health Integration Networks must develop policies for meaningful family, as well as consumer, involvement in planning and monitoring the mental health system

27

Calendar



Re: Cover

Alan Parker, *Life Boat* (oil on canvas, 40" x 70.75").

Reproduced by permission. This work appears in the Being Scene 2006 art exhibit at the Centre for Addiction and Mental Health in Toronto.

Bringing Our Voices to the Table



Judy Watson, BScN, MSA

IT IS INDEED A PLEASURE TO BE ABLE TO CONTRIBUTE TO THIS EXCITING ISSUE OF NETWORK, IN WHICH WE RECOGNIZE THE CONTRIBUTION OF VOLUNTEER CONSUMERS AND FAMILY MEMBERS WITHIN THE CANADIAN MENTAL HEALTH ASSOCIATION AND ACROSS THE MENTAL HEALTH SYSTEM IN ONTARIO.

I have been fortunate to serve as a volunteer board member with CMHA for about 11 years, initially at the local level, and now at the provincial and national levels. During this time, there has been an enormous change. Mental health is finally “on the agenda.” It is being seen as an integral component of health for all Canadians, rather than being viewed as a separate issue for only the one in five directly affected by a mental illness.

In my life role as a family member and my CMHA role as a board member, I have had many opportunities to help get our message out, whether speaking from a personal perspective or meeting with funders and political leaders on behalf of CMHA. I feel that both roles have provided me with a chance to give back to my community, to learn, to form new friendships, and to become more appreciative of my fellow citizens.

People in Ontario and across Canada are speaking out about their personal experiences and helping communities and politicians understand the “good, the bad and the ugly” of dealing with mental health challenges. The lobbying, education and programming done by CMHA has improved these experiences and increased public understanding.

I have noticed the great commitment of CMHA board members and staff during my association with CMHA, across all three levels of our organization. Board members are appreciated and often serve to help bring forth the consumer, family and citizen voice as we lobby to create a world where everyone’s mental health matters and all are treated with respect.

One of the key elements of pride for all of us “CMHA-ers” is the value that we place on the inclusion of the consumer and family voice within our organization. Many other health

care organizations aim for this, but have yet to incorporate this philosophy into their core values. We are known and recognized for our inclusive approach, and we must work to continue and even enhance this voice.

Consumers (who are not current clients) and family members are active on voluntary boards and branch advisory committees. CMHA Ontario has always had consumer and family membership on its board. Many, however, may decide not to disclose this personal information while at the board table.

CMHA Ontario is currently exploring means to enrich consumer and family input and to ensure that it is always provided at the highest level of board decision-making. One way could be through the formation of an advisory council, with a member of the council having representation at the board table. This is the model in place at our national CMHA level. The mechanics of how we will meet this CMHA Ontario objective will be defined within the upcoming year for consideration at next year’s June annual general meeting.

CMHA continues to lead the way in mental health, through its wealth of volunteers and staff, its education and services, and its commitment to having a strong consumer and family voice within the organization. All of us associated with CMHA can be proud of our people and of our accomplishments, as we work towards our willed future and vision: “A society which values human dignity and enhances mental and emotional well-being for all.”

Judy Watson is president of the CMHA Ontario board of directors and a member of the CMHA National board.

all aboard

*Promoting Leadership
Among Consumers
and Families*

A ccording

to Julie Flatt, a consumer of mental health services and senior manager of consumer initiatives with the Canadian Mental Health Association, National Office, the time has come for CMHA to step back and remind itself of the importance of consumer participation and leadership within the organization.

“In the early 90s, consumer participation was right at the top of the agenda,” recalls Julie. “Organizations like CMHA felt the need to have consumer participation, and they got it.” In fact, in the 1980s, CMHA National struck a consumer task group that was charged with the mandate of creating a national consumer network (presently known as the National Network for Mental Health). “But,” Julie explains, “over the years that impetus faded somewhat, often in the face of growing administrative pressures.”

With this in mind, CMHA National recently completed a project called “Back to Basics: Enhancing Our Capacity to Promote Consumer Participation and Inclusion.” Julie describes it as “a refresher on consumer involvement and participation within our association. Its main purpose was to help CMHA branches, regions, divisions and national get back to the very basics of how to involve consumers and ensure their meaningful participation.” The project wrapped up in March and created resources that are now available on CMHA’s intranet.

The impetus to promote greater consumer participation is not unique to CMHA. The Ontario Ministry of Health and Long-Term Care states that “clients and family members can and should play an active role in their own care and treatment” (*Operating Manual for Mental Health Services and Addiction Treatment Services*, 2003). In addition, the ministry specifically mandates the participation of former clients and family members on the boards of all government-funded mental health agencies in the province.

Nevertheless, “the challenges remain the same as they’ve been for the past 15 or 16 years,” says Julie. “They’re things like people feeling comfortable enough to join a board or a committee — having that confidence. Also, if they haven’t had the experience before, it can be quite daunting to get on one. And once you’re on, it can be overwhelming. That’s when a lot of people will drop out. So I think a major challenge

is the confidence to get involved.”

The issue of confidence is no small matter. A person’s sense of confidence is often seriously shaken by the experience of mental illness. Not only can the illness itself undermine a person’s sense of identity and purpose, but the onset of illness can interrupt the course of knowledge and skill development. Mental health consumers may also face discriminatory attitudes and practices that work against them. Reclaiming a sense of confidence is a very important aspect of recovery.

In part, participating in branch programs can help consumers to establish a foundation of skills and with it, the confidence that can later encourage their pursuit of leadership opportunities.

“At CMHA Peel Branch, we have a program called Speaking Out, which is an eight-week program that runs on an as-needed basis for consumers who want to develop their presentation and speaking skills,” explains Executive Director Sandy Milakovic. “We also have a Helping Hands workshop that helps people develop their facilitation skills. And we have opportunities within our clubhouse for consumers to sit on committees like our personnel committee and take part in interviewing staff and in staff performance appraisals. So all of these things at a program level help to build leadership potential.”

Similarly, Alternatives, the social recreation program at CMHA Brant County Branch, provides some leadership training. “The focus is not directed specifically towards participating on our board but to leadership roles in general,” notes Executive Director Peg Purvis. “However, in terms of consumers who’ve been on our board, I think most have been through this program.”

This was certainly Wayne’s experience. Now a consumer member on Brant’s board, Wayne explains that “Alternatives is for consumers and consumer-run. They take day trips, do crafts — basically anything that consumers want. They have their own executive dealing with the day-to-day

operations, and my experience on their executive helped me to feel I could contribute to the board.”

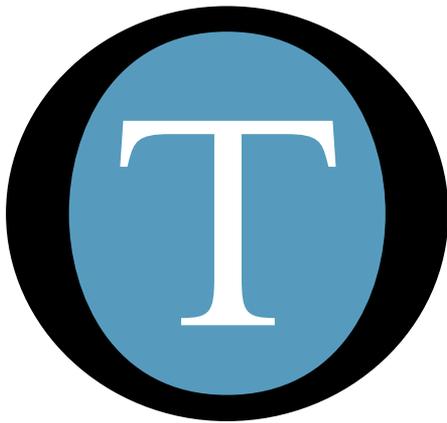
Still, Sandy from Peel Branch notes that the route from program experience to board member cannot be assumed. “We need to find ways to help individuals who’ve pursued leadership opportunities through our programs to make the transition to board involvement once they are no longer receiving services. But one issue there too is that, once they are no longer receiving services, they want to get on with their lives and may not want that type of involvement.”

Like consumers, family members too may lack the confidence to join a governing board. Maryanne is a family member who’s now been on the CMHA Peel Branch board for a year. However, she came to it with some previous professional experience and notes that “family members who’ve never been on a board would likely need more education and encouragement so that they won’t feel intimidated to apply. The board may need to reach out more, rather than vice versa.”

The issue of confidence is no small matter. Not only can mental illness undermine a person’s sense of identity and purpose, but the onset of illness can interrupt the course of knowledge and skill development. Reclaiming a sense of confidence is a very important aspect of recovery.



EXECUTIVE DIRECTOR SANDY MILAKOVIC (LEFT), PRESIDENT KAREN MURPHY, AND MEMBERS OF THE CMHA PEEL BRANCH BOARD OF DIRECTORS HOLD A BRIEF BOARD MEETING AT THE CONCLUSION OF THE ANNUAL GENERAL MEETING.



The Ministry of Health and Long-Term Care recommends that mental health agencies take deliberate steps to ensure that clients and families are active participants. Agencies are encouraged to develop policies and procedures that promote consumer and family involvement. They should consult with clients and family members to identify ways to help them participate more fully. And they should establish formal and informal links with local networks or groups of individuals who can represent consumer and family interests.

According to Julie Flatt, “The first thing to do to attract consumers to

your board is offer them a true partnership. Make sure consumers know that they are full partners and equal as opposed to tokens. Tokenism is one of the major problems that we still see at times. The organization must believe in the importance of consumer participation and the value they bring to the organization. They add legitimacy to whatever the organization does, and we have to recognize their importance and the right they have to be part of the decision-making process.”

At an operational level, Julie notes that simple meeting logistics can make a difference, “like the time of the meetings or the length of the meetings — sometimes they’re very, very long and it’s difficult for some to concentrate that long. Also, make sure there’s more than one consumer on the board and see that consumers have buddies so that someone can fill in for them if they’re away.”

Sandy adds, “We need to pay more attention to the out-of-pocket expenses that board members can incur and ensure reimbursement so that lack of money is not a barrier to involvement.”

“We need to find ways to help individuals who’ve pursued leadership opportunities through our programs to make the transition to board involvement once they are no longer receiving services.”

Sandy Milakovic, Executive Director, CMHA Peel Branch

Once on a board, all new members receive orientation and introductory training on board functioning. “All of our board members have the opportunity to attend a one-day training workshop to learn the principles, policies and procedures for governance,” explains Karen Murphy, president of the Peel Branch. “In addition, we have an evening where we have the new board members come and review the policies and procedures and go through a mock board meeting to see how a board works.”

Mentoring is another approach to helping new members make the transition to a governance position. While Peel Branch has initiated a mentoring process to help new members through their first year on the board, Sandy adds, “We need to strengthen our mentoring and buddy system. It can be very helpful.”

“Also, at the start of each board meeting, we have a ‘check in,’” says Karen. “We go around the table and ask people to tell us how they’re doing either that week, or that particular day, and we can all be supportive for the person if they’re having particular challenges.”

“For consumers, I think being on the board puts them on the road to moving forward,” continues Karen. “And on a board like ours, they know they’re safe. They know they can share with us the problems or the challenges they may be having on any particular day and know that the board has the compassion, the insight and a lot of the expertise to help them if they are having trouble.”

The Back to Basics project offers CMHA branches and divisions a refresher on the very basics of how to involve consumers and ensure their meaningful participation.

“There are always accommodations,” adds Sandy, “but these are individual and are offered to all as needed. We use a document produced by the United Way called ‘Consumers on Board’ and we’ve found that very helpful as a resource.”

Still, the transition to becoming a board member may well require some specific skill building. Leadership development programs can help new members to bridge the gaps in their knowledge and experience. One example is the Consumer Empowerment and Leadership Training (CELT) program developed by the Mental Health Association of Virginia. CELT Leadership Academy is a four-day group training session designed to give mental health consumers important tools for successful leadership and the skills to make their voices heard. Similar programs have been operating in the U.S. for a number of years now, and studies indicate that they work. Not only can they help consumers to learn necessary skill sets for advocacy and leadership, but they can also promote an improved sense of self-esteem and confidence.

The value of consumer participation to the board and consumer alike cannot be underestimated. In terms of system impact, Peg Purvis notes that “consumers’ perspectives on service issues are particularly unique and assist in informing board decisions that are grounded in real experience. And consumers will sometimes question directions taken, not only by the organization, but maybe too by the ministry, and so really help direct us in our advocacy efforts around mental health reform.”

Family members too offer unique contributions to the organization and its advocacy efforts. “When we met with our local MPPs,” explains George, a family board member with CMHA Windsor-Essex County Branch, “I think the value of my presence was to tell the story of my son and illustrate the importance of having the right services in place, and that’s the kind of thing CMHA can do. Being a board member

and a family member allows me to bring a special perspective to issues like these, and I think it’s appreciated.”

Consumer and family participation also allow for unique spinoff effects in the community. For example, George continues, “Being a family member on the board allows me to connect with the rest of the community in an important way. It allows me to tell my story and it creates a dialogue. When I’m chatting with people, they ask what I’m up to and I tell them I’m on the CMHA board. When they ask ‘why,’ I’m able to tell my story. And then, so many people have their own story to tell. It opens up the door. I find so many people with friends and relatives with mental health issues. Talking about being on the board is the catalyst to opening up discussion with others in the community.”

For the consumer, “I think being on the board can help consumers with their self-esteem, it helps them to do other things in the community,” comments Karen Murphy. “It shows them that even though there are challenges there is hope and they can move forward and they can even help others in this situation.”

Julie knows this only too well. She puts it this way: “Recovery is very important. And it’s very important as part of our recovery to be part of the decision-making process.” The Back to Basics project serves as an important reminder of this basic fact.

Wayne, now entering his fifth year

of service as a consumer member of the CMHA Brant board, agrees that participating is empowering. “I wanted to try to make a difference in my life and pass on what I’ve learned to others,” he says. “Also, it’s a learning experience for me. I’d never been on a board. I really truly enjoy it. I’ll be going into year five in September. I’ve met a lot of nice people. They’re from all different parts of the community, representing a range of professions and interests. I also sit on the personnel committee, which is very rewarding. It gives you an idea of the day-to-day operations and challenges of the branch. I strongly encourage consumers to get involved.”

For a list of leadership development resources, visit www.ontario.cmha.ca/network.

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



MEMBERS OF THE CMHA PEEL BRANCH BOARD OF DIRECTORS AT WORK IN THE BOARDROOM.

Catching

Up

with

Reality

Recognizing and Valuing the Family's Role in Recovery

O

ver 600 million dollars are spent every year in Ontario by the provincial government on community mental health services alone. Hundreds of millions more are dedicated to hospital-based psychiatric services. Despite this investment, access to a full continuum of care for every individual with serious mental illness is lacking in every community in Ontario.

When people in crisis can't access services, when they are turned away at emergency rooms or told that a waiting list is closed, where do they turn? In many cases, to the people they can always rely on, any time of night or day — their family.

"When you're talking about community support, like supportive housing, and you're dealing with a system where there's not enough of it, far too often community support means relying on family support," says Emily Collette, a community outreach worker from FAME, the Family Association for Mental Health Everywhere.

FAME is a community mental health agency that is organized for and by families to support them in their role as caregivers. Three of the four community outreach workers at FAME discussed the issues facing family involvement in the mental health system with *Network* magazine. Mary Jursinic says that she and the other workers support families "in their roles providing emotional, practical and financial support" to the family member with a mental illness. FAME's services include providing professionally facilitated peer support groups, one-to-one support, and educational events. They also run psychoeducational groups for young children with a family member with a severe mental illness and youth support groups.

Despite the reality that families provide support, and for many people are the main caregivers, families as a group have little formal role in the mental health system and receive almost no government funding. The Canadian Mental Health Association's position paper *A Framework for Support* states that "Families are the single largest group of caregivers, often providing financial, emotional and social support, although their role generally goes unrecognized.... It is ironic that professional service providers... receive almost 100 percent of the mental health dollars, while families, who also provide care and support, receive virtually no financial resources."

Families want that to change. They say that the time is right during the current transformation of the health care system in Ontario to "make the case" for recognizing the role that families play.

"Our concern is that families are a critical part of the mental health and addiction systems but are often not included, either in the planning of the system itself, having services dedicated to families or sufficient financial support for family self-help," says Ursula Lipski, director of policy and research at the Schizophrenia Society of Ontario. The Schizophrenia Society provides support and education to improve the quality of life of families affected by schizophrenia. Through the provincial office and their network of chapters across Ontario, they promote community awareness and seek to empower families.

One of the first steps toward formally involving families is to recognize the degree to which family caregiving is essential to our health care system.

Families struggle to fill the considerable gaps that exist in the system, starting with the period when a person first becomes ill but isn't yet connected with mental health services. Marta Campos of FAME says, "We support families even when there is no formal diagnosis, when someone doesn't want to see a doctor but the family doesn't want to 'form' them [fill out a form under the Ontario *Mental Health Act* which allows the police to take a person to a hospital for psychiatric assessment]. We take the time to meet with these families where, even though there is no diagnosis, there may be involvement with the police or Children's Aid services, or the person may have an addiction or be homeless."

The family's role in the system may involve connecting the ill person with both acute-care hospital services and with the needed community supports afterwards. "A lot of people don't go into the system willingly," observes Jursinic, "so when you see that some-

one is unwell, it's the family member who has to get the Form 2 [which must be signed by a justice of the peace], who has to call the police, and go to the hospital, and help get them admitted."

After a stay in the hospital, there is still work to be done. "A lot of people when they're discharged from hospital don't want to talk about housing or ODSP [government income support]," says Jursinic. Family members will often step in to assist in filling out the forms, and get people on the waiting lists, so that when their loved one is ready, the services will be in place for them.

A key piece of the work of family organizations like FAME is educating families about the array of mental health services and supports that are available. "Navigating the system," says Campos, "is like starting at 'square one'" for family members who have never been exposed to it before.

But even when people are connected to services, families are still involved. "I

An underfunded mental health system relies on families to make up the gap between the needs and the available resources. "If you're on ODSP, even if you're in supportive housing, unexpected costs come up. How can you afford a phone? Clothes? It's families who 'chip in.'"

Mary Jursinic
Family Association for
Mental Health Everywhere



“Families are a critical part of the mental health and addiction systems but are often not included, either in the planning of the system itself, having services dedicated to families or sufficient financial support for family self-help.”

Ursula Lipski, Schizophrenia Society of Ontario

think it's important to note,” Jursinic reminds us, “that although the government is putting more money into the mental health system, such as investments in case management and assertive community treatment teams, the family still plays a big part. Whether it's taking their loved one to the psychiatrist, reminding them about appointments or helping with groceries,” families are there.

Beyond the practical and emotional support, there is also the reality of families financially supporting their loved

ones. “If you're on ODSP, even if you're in supportive housing, unexpected costs come up. How can you afford a phone? Clothes?” Jursinic asks. “It's families who ‘chip in,’” Jursinic answers, underscoring the fact that an underfunded mental health system is relying on families to make up the gap between the needs and the available resources.

The Schizophrenia Society and FAME are members of the Family Mental Health Alliance. Together with other family groups and individual family members, the Alliance “raises the profile of families, to get more services for families, and to get greater acknowledgment for the work that families do,” explains Lipski.

The Alliance and other groups are collaborating on an advocacy paper that will be launched in the fall of 2006. “Families: Partners in the Mental Health and Addiction System” describes the impact mental illness and addictions have on families, outlines their role and contribution — to both the recovery of their loved ones and also the formal health care system — and explains what families need. CMHA Ontario, the Ontario Federation of Community Mental Health and Addiction Programs and the Centre for Addiction and Mental Health are also partners in the project.

“It's a tool, an advocacy document to really make the case for families,” Lipski of the Schizophrenia Society says. “It's an opportunity to stake our ground in this shifting landscape in health care right now.”

What are families asking for? Lipski identifies four broad areas that are described in detail in the advocacy paper. Families need services dedicated to families. They need peer support, the opportunity for families to learn from each other. They need health care providers to recognize families as partners in their loved one's care, rehabilitation and recovery. And finally, they need recognition by government and health-care planners of their role as partners in system planning and decision-making.

“It sounds very basic,” says Lipski, but when the Alliance tried to find out exactly how much funding the Ontario government was investing in family services, no one could provide an exact dollar figure, as it's such a small sector. As Collette says about FAME, “an organization like ours, which focuses exclusively on family support, is really unique.” The Alliance says that more of these unique organizations are needed, and that funding from the government is required.

Funding would allow family organizations to provide increased opportunities for professional one-to-one support, peer support and family-to-family educational programs. These investments are needed, Lipski says, “because if you don't look after families, they can go through crisis themselves, with their own health compromised. When they're not well, they can't be effective caregivers for their loved ones.”

Families are available 24 hours a day, 7 days a week, putting great stress on them. Jursinic says that family respite services are desperately needed to help families safely take a break without worrying about their family member. Collette says flexibility would be essential for these services. “I've heard families say they want a 24-hour telephone support line that's specifically for them.”

Recognition for their role in their loved one's care, treatment and recovery is also one of the needs identified by the Family Mental Health Alliance. “We have to start with the very basics and open the lines of communication,” Collette says. Privacy concerns are one of these basics. “I can't believe how many family members are still being told that they aren't even allowed to speak with the doctor,” Collette says.

While family organizations are actively educating both families and professionals about the reality of privacy legislation and its impact upon them, this isn't something that can simply be mandated, Lipski says. “We need an attitude change, a mind shift with some professionals, so that they can spend even ten minutes with a family. They

don't have to break confidentiality. There's a lot that professionals can do to educate the family without going into the specifics of a situation."

Finally, families need to be involved at a systems level, to be able to participate in the transformation of the health care system. "Family members have a 'front-row view' of the system, how it works and how it doesn't," Jursinic says, which makes it essential that their perspective is recognized. Involvement, however, has to take into account the reality of families' lives. As Lipski says, family members are often working and providing care to their ill relative. "Then to expect them to be involved, whether it's at planning tables, sitting on committees or running peer support or psychoeducational groups — there's only so much that individuals can do."

"If we want families to be meaningfully involved," Lipski continues, the system has to accommodate them. That can mean holding consultations after work or on weekends, providing honorariums for attendance and pay-

ing for transportation costs.

Family advocates say that change is happening, but that the pace is slow and uneven. "There's beginning to be recognition that we do have something to contribute," Lipski says. They're planning to use the advocacy paper to continue to push for increased recognition.

Recent consultations organized by Ontario's Local Health Integration Networks (LHINs) have demonstrated some of the successes and ongoing challenges family advocates face. LHINs are the new organizations created by the provincial government to transform the health care system. "There have been opportunities and openness with some of them," notes Lipski. The Family Mental Health Alliance successfully advocated for the Toronto Central LHIN to specifically include families in community consultation events. "If we didn't have the family organizations, we wouldn't necessarily be on the radar," says Jursinic. "We put families on the radar so that our issues get to people."

Family advocates are cautiously opti-

mistic. Commenting on the Toronto Central LHIN consultation process, Lipski observes, "It was quite a success to go from them not even knowing that we are a stakeholder to being seen as a fairly major stakeholder." As a result of this activism, the LHIN "allocated 20 per cent of the spaces at a mental health and addictions planning day to families."

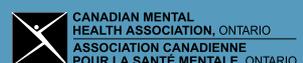
Despite these successes, observes Collette, "we're just at the initial phase of acknowledging that families are very often the main caregivers, and the system needs to catch up with that reality." Catching up to the reality is important not only for family members, and not only for the professionals who provide formal treatment and support, but most especially for the person with a mental health or addiction problem. "Family members play a key role in a person's recovery process," Campos reminds us, "because your family are the people you can always count on."

Heather McKee is a community mental health analyst with CMHA Ontario.



CHANGE THE WAY YOU THINK ABOUT MENTAL HEALTH. READ NETWORK ONLINE.

WWW.ONTARIO.CMHA.CA/NETWORK



Education *is the key*

On April 8, 1952, the London Mental Health Association got an earful from the superintendent of the local psychiatric hospital, Dr. George H. Stevenson. According to a *London Free Press* article that appeared the following day, Stevenson asserted that many mental diseases are not inherited, but caused by parental “infection” in early life. The mother infects the child with mental illness, said Stevenson, just as the tubercular mother does.

“No wonder families felt challenged to declare ‘My child has a mental illness’ if the superintendent of the psychiatric hospital is saying, ‘Well, that’s because you’re a mentally defective parent,’” responds Mike Petrenko, executive director of the Canadian Mental Health Association (CMHA), London-Middlesex Branch. During his 22 years with the organization, Petrenko has studied the history extensively. Since the 1950s, he observes, CMHA has made great strides in helping families to deal with the stigma attached to mental illness.

Overcoming stigma begins with education. From the beginning, the London Mental Health Association (which later became CMHA London-Middlesex Branch) has devoted both staff and volunteer resources to public education activities. From 1951 to 1954, public education focused on the mental health of children. In 1953, according to minutes of the executive, this expanded to include “the aged, relatives of people with mental illness, and the rehabilitation of patients.”

Many of the founding members were professionals who worked with consumers in the hospitals, along with family members who contributed their time as volunteers. There was very little consumer involvement in the beginning, except for “the silent consumer who didn’t want to identify himself, because he didn’t want to be labelled,” says Petrenko. Even for family members who participated, their involvement was very much behind the scenes. As a result, rather than education or support directed at other fam-

ily members, CMHA London-Middlesex concentrated on programs for the entire community, using such methods as radio broadcasts and panel discussions.

Miss Edith McDowell, dean of the University of Western Ontario’s School of Nursing, was a board member in the early years. She complained at the May 16, 1951, executive meeting that the education series presented in the winter of 1950/1951 was “depressing, in that every program left the listener in doubt as to whether help [could be] obtained in a tragic situation.” Arguing for “a more positive approach,” McDowell got a motion passed that future programs should be built around “how members of a happy family conduct their interpersonal relationships.”

McDowell’s motion was acted upon. Mrs. Jay Peterson, a London artist, produced two posters for the local CMHA Mental Health Week, May 4-10, 1952. One poster presented a dysfunctional family situation and the other a functional one. In the edgy dysfunctional montage, Peterson included many terms that still ring true today, such as “escape,” “fearfulness” and “keeping up with the ... ‘Jones’.” On the functional poster, she cited balanced mental and physical activities, “proper food, adequate sleep,” and the “ability to communicate ideas to others.”

The Public Utilities Commission displayed this artwork in a large window during Mental Health Week. The posters were also put on view at the May 26, 1952, executive meet-

ing so members could see their effectiveness. In addition, photographs of the artwork were sent to the “Toronto head office” of CMHA.

Over the next several decades, economic pressures on the health care system and the advent of modern psychopharmacology led to more and more consumers being let out of psychiatric hospitals. The drugs controlled or suppressed symptoms, but while psychiatric hospitals emptied, beds in outpatient facilities filled with consumers who could not find adequate community support or treatment.

Many consumers had trouble finding, and affording, a place to live. As the process of deinstitutionalization accelerated from the 1960s to the 1980s, many consumers sought out family members for support. While many relatives were unprepared to meet the responsibility, others faced the issue straight on.

One of the family members who confronted the crisis was Carolyn Dykeman. A retired doctor’s assistant who has a number of bipolar relatives, Dykeman recalls that she “hit every brick wall possible” trying to get help for them. In the late 1980s and early 1990s, she attended a few meetings of the local CMHA mood disorders group, and she came to the conclusion that family members with mentally ill relatives should have their own support group. So, in June 1990 she formed Families and Caregivers Together (FACT), an independent self-help group that operated out of the CMHA local branch until 2005. The group provided a very important outlet for family members or friends of the mentally ill. These people often felt angry and overwhelmed. FACT gave them an opportunity to let off steam and talk with people who understood what they were going through.

In the fall of 2004, Dykeman developed the Family Psychoeducational Group (FPG) course, along with Patricia (Trix) Van Egmond. Van Egmond is the public education and information and referral team leader for the local branch. Dykeman cofacilitates FPG with Marnie Wedlake, the branch research/information coordinator and mental health public educator. Targeting the same clientele as the FACT group, FPG teaches them about specific mental illnesses, offers anger and stress management techniques, and provides information about local resources. Participants in

“It is *very* important that families and consumers work together for the best of all involved. Mental illness needs team players. The days of hiding your head in the sand are thankfully long over for most people.”

Carolyn Dykeman, CMHA London-Middlesex Branch

the course get a binder of reading material they can take home with them to share with the ill family member. After the course, participants who have attended at least seven of the eight sessions are eligible for free counselling for six weeks from the London Interfaith Counselling Centre.

People who have taken the course often cannot say enough about how much it has helped them. “Education is key in coping with mental illness in a family,” commented the mother of an adult son with bipolar disorder. “It is a daily struggle, and the information given and personal knowledge of the facilitators is invaluable.” Another participant added, “For the first time in 20 years, I can finally sleep through the night. I now know that it’s *not* my fault.”

Supported and educated family members can make a critical contribution to their relative’s recovery, and CMHA London-Middlesex has come a long way since the 1950s in recognizing the challenges that family members face. The Family Psycho-Educational Group is a “much needed, long overdue program that gives families some tools to help them when mental illness strikes,” says Dykeman. “There is no life manual for it, so some sense has to be made about it. It is *very* important that families and consumers work together for the best of all involved. Mental illness needs team players. The days of hiding your head in the sand are thankfully long over for most people.”

Petrenko adds: “Families and friends of people with mental illness have always had the ‘burden’ or ‘joy’ of supporting their loved ones. This role is much more difficult when the formal mental health system has significant weaknesses. I would observe that when large numbers of consumers lived in psychiatric hospitals, the support role for families was significantly different than today, in that food, clothing, shelter, daily activities, etc. were looked after by others. The struggle today for appropriate housing and supports for independent living preoccupy many families. Through family education and support, CMHA can best help families to be heard. In Ontario, we need to support this voice in each and every Local Health Integration Network, where the significant decisions will be made to improve the lives of consumers and their loved ones.”

Leith Peterson is a freelance writer living in London, Ontario.



MIKE PETRENKO, EXECUTIVE DIRECTOR OF THE CANADIAN MENTAL HEALTH ASSOCIATION, LONDON-MIDDLESEX BRANCH, OBSERVES THAT SINCE THE 1950S, CMHA HAS MADE GREAT STRIDES IN HELPING FAMILIES TO DEAL WITH THE STIGMA ATTACHED TO MENTAL ILLNESS.



HEARING IS BELIEVING

In December 2005, I had to be fitted with hearing aids — not the nifty little ones that fit invisibly inside your ears, but two big, behind-the-ear hearing aids — that's how serious my hearing loss was.

PHOTO BY SUSAN KING

I decided that if I had to wear hearing aids, I'd wear mine as fashion accessories, like eyeglasses, with pride. A local artist designs hearing aid covers. Bananas, her best sellers, appealed to me, and I bought a pair as soon as I ordered my hearing aids in two different colours — red for the right ear and blue for the left. Like hot and cold water taps. Part of the reason was purely practical. They'd be easier to tell apart.

There was, however, another reason, and it had nothing to do with my ears, but more to do with what's between them.

For one thing, with the bananas on my hearing aids, I could wear both my invisible disabilities at the same time.

For years, as my hearing was failing, unbeknownst to me, I was receding into a world of social isolation, unable to participate in dinner party conversations. During the last year or two, I couldn't watch television without constantly disturbing my husband with requests to repeat phrases that I couldn't discern. Hearing loss affects all members of one's social circle — family, friends and co-workers.

In 1999, I was banished from the *Toronto Sun* newsroom because I was considered to be disruptive. I have a loud voice and it carries. My mental illness was thought to be the culprit.

It is well known at the *Sun*, and everywhere else — I have never made it a secret — that I have lived with a mental illness for many years. I'm out. When I was hired there in 1977, the powers-that-be knew I had bipolar disorder (manic-depression back then). I am a vibrant and engaging interviewer — a hypomanic personality — and my office antics were increasingly disturbing and distracting my colleagues.

It was made abundantly clear to me that working at home was the solution. It was the best accommodation for me and my mental illness — which seemed to define me. It was how I perceived myself and how others perceived me. I had no reason to think otherwise.

For a while, the arrangement worked quite well, but gradually, I began to feel

increasingly isolated working at home. While this arrangement seemed like an enlightened solution, at the same time, I also felt that my mental illness had taken me away from a place I'd always considered my second home and away from the people I considered my second family. Technology kept me connected but it cannot replace a sense of belonging.

I always put a positive spin on it to myself and to others. I rationalized: "Aren't I lucky not to have to commute to work, fight traffic, deal with office gossip." But as much as I joked about being "banished from the newsroom for being disruptive," deep down it hurt. I felt, in a way, that I had been disinherited.

On those odd occasions when I did "visit" the newsroom, my colleagues, surprised to see me, assumed I was a part-timer or freelance. But mostly they forgot about me.

Out of sight, out of mind.

Yet I was quite sane. Mentally healthy. There was a strange disconnect between how I was doing and how I was perceived to be doing. While I was working with my editors — usually the only people with whom I spoke in person on the phone — as far as the full-time staff was concerned, I was simply a disembodied byline in the paper. Invisible. And over the years, as people came and went, the reason for my "not" being in the newsroom was forgotten.

I was just not there. Though, curiously, from a mental health perspective, I was perfectly sane — "all there."

Working at home, where my time was flexible, I was able to fit in more of my mental health advocacy, public speaking all over Canada and in the U.S.

And all the while, I was losing my hearing. When you live alone, you have no way of knowing it. People always assumed that when I raised my voice in excitement, the excitement was the mania that had hospitalized me 20 times since I was misdiagnosed as having schizophrenia in the early 1960s. (My diagnosis was changed five times.)

I am a histrionic personality and

always have been. I'm passionate. That's who I am. For more than 21 years, I had worked quite successfully in close proximity to my colleagues in the *Toronto Sun* newsroom. No one, to my knowledge, ever complained about my exuberance, my vibrancy, or my loud speaking voice. But back then, my hearing was fine.

I now realize the root of the disruption I was causing more than five years ago was my hearing loss, not my mood disorder that has always been well controlled with medication and therapy. I have been in therapy for 46 years and with my current psychiatrist for more than 15 years.

I had an enormous advantage entering the world of hearing loss, which, I discovered, is also deeply stigmatized and linked inextricably to an image best summed up in the insensitive, erroneous and archaic phrase "deaf and dumb."

As I was losing my hearing, I was inadvertently pumping up the volume of my speech. That's what happens. You cannot hear others or yourself.

One well-meaning colleague once suggested I take one of my "pills" when I got excited about something and raised my voice. She assumed my excitement was hypomania, when in fact it was just exuberance. Sometimes it's hard to tell the difference.

People always seemed to tell me to "calm down." That's because my mental illness is so much a part of who I am and how I am perceived. But what they were really saying was, turn down the volume.



In 1999, I was banished from the *Toronto Sun* newsroom because I was considered to be disruptive. I have a loud voice and it carries. My mental illness was thought to be the culprit. It is well known at the *Sun*, and everywhere else – I have never made it a secret – that I have lived with a mental illness for many years. I'm out.

PHOTO BY SUSAN KING

I knew the difference.

One night, years ago, I stayed in the newsroom all night writing. Flying high as kite. When I'm manic, I never think anything is wrong with my mind, but rather, that everyone else is crazy. I'm delusional.

I was convinced I was the publisher of the *Sun*, so I was putting all my notes about reorganizing the editorial department into my computer. You know. Firings, hirings, promotions.

I was playing the keyboard of my computer like a piano. When my editor came into the newsroom the next morning and found me there, she called my psychiatrist and a cab. We went downstairs to the lobby in the elevator. But I wouldn't let anyone into that elevator because "it was my elevator. I was the publisher."

While I was waiting for a cab, a young man walked into the building. I started talking to him. He was applying for a job.

I told him *I'd* hire him as my assistant, on the spot. Because I was the publisher, after all. I noticed he had no front teeth. For some reason, I had \$200 cash in my pocket. I handed him the money and said, "Look, before you start working for me, you've got to get your teeth fixed." As I was getting into the cab, I remember yelling at him, "Get your teeth fixed."

Needless to say, I never saw him, his teeth or that \$200 again.

My last manic episode was in 1988, when my medication was changed and

in addition to Lithium, I started taking an anticonvulsant called Carbamazepine often used in the treatment of epilepsy. Since then, I have never had another major manic episode.

My hearing loss was having a profound effect on my mental health advocacy, through which I first began sensing that I was losing my hearing.

I found that I could easily address an audience and be heard without a microphone if one was not available. The inevitable "question and answer" period, however, the section of my presentations I have always most enjoyed, became increasingly problematic because I couldn't hear the questions. As my hearing loss increased, I insisted microphones be set up in the auditoria so questions were amplified, but this presented a problem.

Many people who wish to ask questions are uncomfortable walking up to a microphone and becoming more visible to an audience of strangers.

Stigma is so entrenched that even an empathetic group of people either directly or indirectly affected by mental illnesses may feel threatening to someone with a question about "their" mental illness. Even if a microphone was passed to them, they wouldn't stand up because they didn't want the spotlight shone on them. I was unconsciously depending on lip reading in order to converse, but I couldn't lip read if all I heard was a voice from the crowd and I couldn't see a face. I was learning through my hearing loss how deep and affecting the stigma of

mental illnesses is.

On the other hand, I had an enormous advantage entering the world of hearing loss, which, I discovered, is also deeply stigmatized and linked inextricably to an image best summed up in the insensitive, erroneous and archaic phrase "deaf and dumb."

Compared to the long, rich, sad and storied history of stigma and mental illnesses, however, having a hearing loss presented almost no problem to me. I have always felt quite comfortable having a mental illness. I considered it like any other illness because of the enlightened attitude of my family and principally my mother who always instilled in me a sense of the "normalcy" of having a mental illness. She always said it was just like any other chronic illness.

I never felt ashamed because she was never ashamed, and most of all, she always believed in me, even when the psychiatrists, early on, told her there was no hope for me.

In April 2006, I was asked to return to the newsroom. Since then, a number of different editors have told me "how happy they are to have me back," and how I "brighten up the newsroom."

I'm still the same person. Exuberant. Passionate. I still take my medication for my mental illness. I still see my psychiatrist on a regular basis. But with my hearing aids, I can once again work at my home away from home.

Sandy Naiman is a reporter with the *Toronto Sun* and a stigma-buster.

INFOR- MATION OF CONCERN

THERESA CLAXTON HAD NO EXPERIENCE WITH POLICE RECORD CHECKS UNTIL SHE APPLIED FOR ONE OF HER FIRST VOLUNTEER POSITIONS. AT THE TIME, HER ONLY KNOWLEDGE OF POLICE RECORD CHECKS CAME FROM THE EXPERIENCE OF FRIENDS AND ACQUAINTANCES. SHE ASSUMED THAT THE CHALLENGES THEY FACED WHEN TRYING TO SECURE EMPLOYMENT, VOLUNTEER POSITIONS, OR SCHOOL PLACEMENTS WERE THE RESULT OF A CRIMINAL RECORD. WHAT THERESA DISCOVERED ABOUT POLICE RECORD CHECKS IS SOMETHING THAT AFFECTS THE LIVES OF HUNDREDS OF PEOPLE WITH MENTAL ILLNESS EVERY YEAR.



Theresa served on the board of directors at a sistering organization that helps children and youth with disabilities. As chair of the agency, it came to her attention that the organization was hiring volunteers to work with a vulnerable population without having them complete a police record check. The board decided to initiate the process, and Theresa asked all staff members and volunteers to comply.



fter being on the board for a number of years, Theresa decided to volunteer as a sister. Under the policy she had implemented, she was now required to undergo another police record check. She consented, and to her surprise a few weeks later, she was called into her executive direc-

tor's office. Theresa had no idea what the meeting was about, because she knew she did not have a criminal record. Her boss explained that the form had been returned to the agency with a note saying that the police had "information of concern" about Theresa. "It was quite embarrassing," Theresa recalls. "I never disclosed anything and did not take the volunteer opportunity. I made up some sort of excuse as to why I could not volunteer. It was quite devastating."

Theresa did not understand why she had a police record, but the thought of it made her apprehensive. "I started to become fearful and a little paranoid. Every time I heard a siren, I thought the police were coming to get me. I had a police record and it meant that the police were looking for me — it created this thinking and logic."

Eventually, Theresa found out that she had an opportunity to get a copy of her police record. Of course, there was a charge for the service. It was 50 dollars, and at the time she was living on a limited income and had to ask her parents to loan her the money. This resulted in numerous questions from her parents, provoking even more anxiety.

Once Theresa received a copy of the police record check, there were more questions that needed to be answered. The report, recalls Theresa, stated that there was "police contact due to a mental health crisis, something about a suicide attempt, and something about a caution." Why were the police keeping personal health information in their database, she wondered? Why was she not made aware earlier that she had a police record? And why was the information being released to a third party? If someone had diabetes or suffered a heart attack, would the police flag that as "information of concern" for potential employers? Consumer groups, health care providers, and mental health advocates across the province are asking the same question: Why is mental illness being treated as a criminal offence?

Consumer groups, health care providers, and mental health advocates across the province are asking the same question: Why is mental illness being treated as a criminal offence?

To begin, criminal record checks and police record checks are not the same thing. Criminal record checks show information only about convictions a person has received. Information is obtained from the Canadian Police Information Centre (CPIC), which is operated by the Royal Canadian Mounted Police. CPIC's automated criminal convictions records retrieval system, set up in 1972, is accessible to all law enforcement agencies across Canada. Over 60,000 police officers have access to the same information on individuals who have a criminal record for any criminal code or other federal statute offence. Included are criminal records of persons who have been judged not criminally responsible for an offence because of a mental disorder, as well as individuals pending criminal charges or those on probation. Criminal record checks are often requested by banks, retailers and other employers who have financial security concerns. Employers can only obtain criminal record information if the individual gives permission. No one (except law enforcement agencies) can access another person's criminal record without consent of the person to whom the record relates.

Police record checks are much broader than criminal record checks. A police record check includes a criminal record check, plus a search of the local database maintained by the police agency where the individual resides. Information stored in a local database will relate to any involvement with the police, such as convictions, charges, or information about an individual as a complainant, victim, suspect, or witness to an occurrence, including allegations of offences where charges were not laid. Any contact with the police, in fact, will result in the police recording information relevant to the incident — reporting lost identification, for example, would result in a police report coded as a lost property occurrence. Similarly, incidents relating to the Ontario *Mental Health Act* are also stored, including voluntary and involuntary transfers to medical facilities.

Police record checks are intended for individuals seeking employment or volunteer positions where they will be responsible for the well-being of one or more children or vulnerable persons. The *Criminal Records Act* defines children as "persons who are less than 18 years of age." It defines vulnerable persons as "persons who, because of their age, a disability or other circumstances, whether temporary or permanent, (a) are in a position of dependence on others; or (b) are otherwise at greater risk than the general population of being harmed by persons in a position of authority or trust relative to them." As mental illness is considered a disability, persons with a mental illness are included in the definition of vulnerable. The Act further states that when an individual applies for employment with an employer responsible for vulnerable persons, the employer may request that the police query the pardoned sex offender registry. However, there is no mention in the legislation of a check for incidents linked to the *Mental Health Act*.

Police record checks are used widely by many volunteer agencies and employers who are guided by a duty of care for

their clients. The numbers vary depending upon the size of the city or region and how many agencies are requesting vulnerable sector searches. The London Police Service, for example, completed 16,263 checks in 2005, while the Toronto Police Service completed close to 32,000 in the same year.

Persons with mental illness may come into contact with the police for a variety of reasons, many of which are not criminal in nature. When a loved one is in crisis, a family's first reaction is to call for help, and often they end up calling the police. But what family members do not realize is that their call for help often results in a police record.

"I have been formed," says Theresa, referring to the *Mental Health Act* form that family members can use, with authorization by a justice of the peace, to compel police to put someone in custody and take them to a doctor for examination. "They have come to my house looking for me and escorted me to the hospital, but it never came to my attention or my family's attention that I would have a police record. At no point did anyone tell me a police record was being generated."

When families do find out that their loved ones have police records, they may be outraged and confused. But this is not the only challenge family members and consumers must face.

Retention of records varies among police agencies, ranging anywhere from two years to 35 years, or even longer, depending on the type of incident and the local policy. Criminal convictions, regardless of the seriousness of the offence, are permanently recorded, unless the applicant has been granted a pardon. Similarly, a murder investigation, even without a conviction, will continue to show up on a records check and vulnerable position screening. Records of police investigations of less serious incidents may be kept on file for shorter periods of time. Apprehensions under the *Mental Health Act*, for example, may be stored for five years before the record expires and the incident is deleted. As each police occurrence report reaches its expiry date, it is automatically purged from the system.

Mental illness, however, is often cyclic in nature, and this poses a challenge. Many consumers will experience episodes of illness followed by periods of recovery. As frontline responders when someone is in crisis, the police have become de facto mental health workers. But repeated contact with the police will result in a continuing police record, as new incident reports replace the earlier ones.

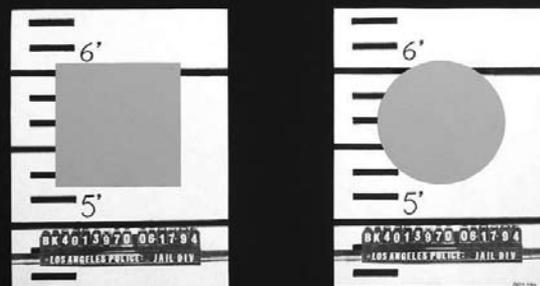
"If a police record is kept for five years plus the current year," observes Theresa, "then in my case and in the experience of my peers, there is the possibility that we will continue to have police records for a long time, as long as society relies on the police to escort individuals while in a mental health crisis."

With so many local police forces across Ontario, there is no standardization among agencies concerning the coding, retention and release of information. Each Ontario Provincial Police detachment, federal detachment and municipal force has different standards and processes for conducting police

There are no universal police policies in place to guide police agencies around issues of disclosure of personal health information, which means that information is released based on the personal discretion of a commanding officer or records management personnel.

record checks. Information requested on the application forms may vary. Some forces will ask an applicant to list complete addresses for the past three years, while others will request information on the last five or ten years. In addition, there are no universal police policies in place to guide police agencies around issues of disclosure of personal health information, which means that information is released based on the personal discretion of a commanding officer or records management personnel. Some police agencies will release all information that is found in the record, regardless of the type of position the person is applying for. Other agencies will treat each case individually and make a decision based on the position itself. Furthermore, information may be released to the individual, to the agency, or both, as each police force has different rules and procedures.

Regardless of the inconsistencies and lack of standardization among Ontario police forces, releasing information obtained under the *Mental Health Act* is stigmatizing and reinforces the assumed link between mental illness and criminality. It equates incidents where an individual may have behaved in a "disorderly" manner — which the courts have interpreted to mean behaviour that is to some extent irrational, although not necessarily unruly — with criminal



JASON HALL, SQUARE CIRCLE (MIXED MEDIA, 28" X 22").



“An applicant may have a history of depression where they have felt like hurting themselves and went voluntarily to the hospital escorted by the police. Their behaviour indicated harm to oneself and not to anyone else. We do not want to penalize those who were seeking help. In this instance, there is no information of concern.”

Sherry Joyes, Supervisor of the Central Records and Freedom of Information Unit,
London Police Service

convictions, sexual offences, and violence. The fact is that research indicates people with a mental illness who do not have a substance abuse problem are no more likely to be violent than the general population.

Including information about police encounters lowers the burden of proof from “beyond a reasonable doubt,” in the case of a criminal conviction, to “reasonable and probable grounds,” which is all that is necessary for an apprehension by police under the *Mental Health Act*. An officer can bring someone to a hospital for an examination as long as the person “apparently” has a mental disorder and has threatened or attempted to harm themselves, has behaved violently or caused someone to fear bodily harm, or has shown a lack of competence to care for themselves. Police must stay with the person until the facility decides whether to admit them. Frequently after evaluation, the individual is simply released and returns to the community.

When someone with a history of mental illness who has had contact with the police is required to complete a record check, they may be forced into an uncomfortable position — having to disclose their illness in order to explain why the police have “information of concern,” or to withdraw their application. This situation may contravene the *Ontario Human Rights Code*, which protects the individual against discrimination based on employment-related medical information. The Code requires that, if a potential employee’s disability affects his or her ability to perform the essential duties of a job, this assessment can only take place after a conditional offer of employment is made. Not surprisingly, the process of police record checks may act as a disincentive for people with mental illness to attempt to enter or return to the workforce. While the choice to participate in a police record check is called “voluntary,” the likely consequence of refusing to participate is to be excluded from consideration for the position.

However, there are progressive police agencies within Ontario who are working with various stakeholder groups and developing new systems that are fair and sensitive to the issues around disclosure, especially those that are of a personal or medical concern. The London Police Service, for example, has been working on ways to improve their system since formalizing the process in 2000. One of the

many contributing factors that led to the new system and its development was a London Police Service study indicating that police contact with people with serious mental illness had doubled from 5,000 to 10,000 during 1998-2001.

The London Police Service’s mandate for record checks is to protect children and the vulnerable sector while at the same time providing a fair and non-discriminatory process for the applicants, as many agencies rely heavily on volunteers.

The London Police Service began screening in 1988 for volunteer agencies and completed approximately 700 checks per year during that time. “The process of police record checks has come a long way,” says Sherry Joyes, supervisor of the Central Records and Freedom of Information Unit at the London Police Service. “The initial process when applying to work with the vulnerable sector involved a police records check whereby the agency provided their own information form,” says Sherry. “It was a blanket approach. The records screening operator would look at the information available and indicate on the form whether or not we had information of concern. Negative behaviour or interactions with the police were deciding factors in this determination,” states Sherry. This was the old way of doing things, and the London Police Service has made huge advances since the blanket approach.

The new system is based on a risk assessment. This involves the records screening operator reading the entire occurrence and seeing who was involved, analyzing the behaviour, the person’s actions, focusing on who was affected and then, depending on the type of position the applicant is applying for, making a decision based on whether there is concern that the person would harm someone else. For example, says Sherry, “an applicant may have a history of depression where they have felt like hurting themselves and went voluntarily to the hospital escorted by the police. Their behaviour indicated harm to oneself and not to anyone else. We do not want to penalize those who were seeking help. In this instance, there is no information of concern.”

Results of a police check from the London Police Service never reveal the nature of the incident, only whether the applicant does or does not have a local London criminal record,

a record in the national repository, or has information of concern. If there is information of concern, then an applicant may schedule a meeting to discuss what the concern is about. If the applicant chooses, they may also have someone from the agency be present to hear and discuss what the London Police Service's concerns are. Sherry stresses that "it is important for people to understand that the details of a police records check and vulnerable position screening are never released to an agency unless the applicant consents. If an actual copy is required, the applicant must make an application pursuant to the *Municipal Freedom of Information and Protection of Privacy Act* for a copy of the report so they themselves may share the information with the agency."

Before implementing their process, the London Police Service conducted information sessions with volunteer agencies and invited feedback from other stakeholders. In October 2006, they will be conducting an evaluation of their new system and look forward to receiving feedback from both agencies and applicants involved.

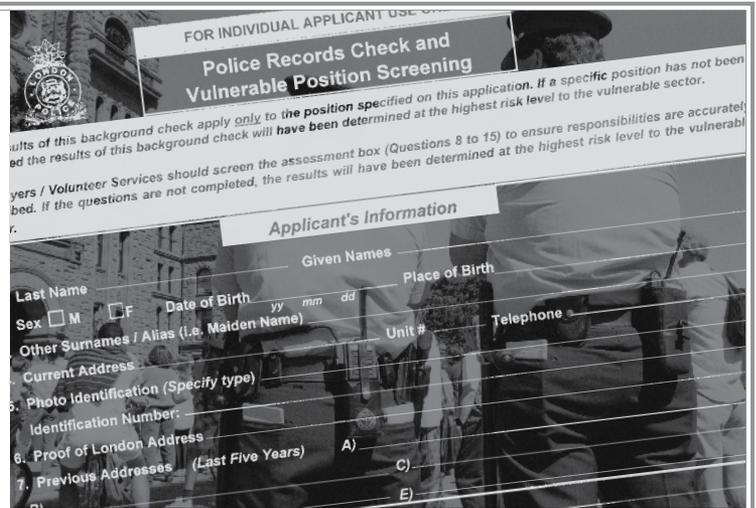
Although the London Police Service has adopted a new system which is fair and non-discriminatory for both applicants and agencies, this new system is only applicable in the London region. A consistent, province-wide solution is required.

David Simpson, acting director of the Psychiatric Patient Advocate Office, says that "since 2002 the PPAO has been receiving complaints from clients across the province about the devastating impact of the release of information regarding non-criminal contact with the police for mental health reasons as part of the police reference check process. Many police departments believe that they have a responsibility to protect the public interest and maintain public safety, but the police do not seem to be concerned about the harmful consequences of doing so. For some clients, it has resulted in them having to abandon opportunities that would have allowed them to participate fully in their communities as responsible citizens."

The PPAO believes that this practice discriminates against persons with mental illness. It brought this concern to the attention of the Ontario Human Rights Commission and is working with a group of agencies and consumer-survivor organizations to effect systemic change for the benefit of all individuals with mental illness.

"Where do you start?" asks Theresa, who now serves as chair of the Ontario Association of Patient Councils. The council is an advocacy organization that works to improve the quality of care for mental health consumers, both in hospital and in the community. "Who do you address it with? Each city has its own by-laws, making it very difficult. We at the Ontario Association of Patient Councils are working with others to address this issue. We've written letters to individual police departments, MPPs, and the premier, but so far no one has stepped forward to be a champion of the issue."

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



Police Record Checks

Forms to request a police record check are available from the local police service. Individual applicants must submit the form in person at their local police station to have the police record check completed. If the application is submitted by the potential employer on behalf of the applicant, the person may not need to visit the station, depending on the police agreement with the employer.

Fees for the screening process vary among police departments, but range approximately from 15 to 60 dollars. Fees are payable at the time of submitting the application. Some volunteer agencies have service agreements with their local police agency which cover the cost. Photo identification is also required and must provide proof of residency.

Processing time varies, but on average it takes seven business days. Results from the check may be returned to the applicant or to the agency, depending upon the police agency's regulations and signed authorization from the applicant. Read the section on "consent to disclosure of personal information" to verify where the results will be sent.

How do I view and correct information in my police record?

The formal procedure involves making an application under the *Municipal Freedom of Information and Protection of Privacy Act* to view your police records. If you feel that the information is inaccurate, then you may make another application requesting to correct the information.

Can the response "does have information of concern" be altered?

In London, you may write a letter to the London Police Service to appeal the information with supporting documentation, such as reference letters. The London Police Service will then review the initial records and may interview the investigating officer. Based on the information available, they will either overturn the original decision or support it. The process for other police departments may differ.

Making the
Great Stride
Out

Volunteering
& Recovery

"I DIDN'T KNOW I HAD ANYTHING TO GIVE UNTIL I STARTED VOLUNTEERING," SAYS LINDA STEWARDSON. "I TELL YOU, THAT EXPERIENCE CHANGED MY LIFE. IT GAVE ME MY LIFE. I WOULDN'T BE WHERE I AM NOW IF I HADN'T STARTED VOLUNTEERING." WHERE SHE IS NOW: A HAPPY, HEALTHY WIFE AND MOTHER WHO FILLS HER DAYS WITH VOLUNTEER ACTIVITIES, RAISING HER ACTIVE 16-MONTH-OLD ADOPTED SON AND DOING MOTIVATIONAL SPEAKING ABOUT HER EXPERIENCE WITH MENTAL ILLNESS AND ADDICTION.

As Linda attests, people with mental health issues can benefit tremendously from volunteering. For some, the volunteer experience is a positive first step in finding or returning to paid employment. It provides a gradual introduction or reintroduction to the workplace environment. At the same time, volunteering offers its own benefits. The power relationship between recruiter and volunteer may be more balanced than that between employer and employee. There is likely to be a support network, often free of limitations imposed by the workplace social hierarchy. And volunteering, like employment, can bring a sense of belonging, purpose and self-development.

What barriers prevent people with mental illness from volunteering? Not lack of skill, professionalism, dedication or social skills — but more often lack of confidence that they have anything worthwhile to offer. And lack of the offer to volunteer. Which is puzzling, when volunteer coordinators in the nonprofit sector compete fiercely for a rapidly shrinking pool of volunteers.

ward

Four years ago, a staff member at the Canadian Mental Health Association (CMHA), Thunder Bay Branch approached Linda about volunteering after she had participated in one of their programs. Although Linda was clean and sober, she felt her life had no purpose. She describes herself as being in constant crisis, in and out of psychiatric hospitals with repeated suicide attempts. “The people at CMHA made me feel good, and they were sensitive towards me. My self-esteem was really low but when I started to do things that helped people, I felt good about myself. My life changed. No way I would be stable enough to have had a child — I was pretty messed up before I began volunteering, very depressed, and suicidal... and now I have so much happiness!”

Linda sees her volunteering as fundamental to her recovery from severe childhood abuse and debilitating depression. “The volunteering worked for me kind of like medication. It gave me so much purpose and hope and it kept my spirits up, so that I could work on my underlying issues in therapy,” she says. She feels that volunteering helped her move outside of her shell of illness and isolation, into a world of making a difference to other people individually and in large groups. She does television appearances, speaks in high schools, and received the Courage to Come Back Award from the Centre for Addiction and Mental Health in 2004.

Linda credits her volunteering with helping her continue to stay well. “After what I’ve been through, so many people look up to me now, and I’m a role model to them.” She has interacted with hundreds of people who have needed education, support and hope. This puts a kind of positive pressure on her to continue to stay well.

Shelley Nummikoski, a mental health worker with CMHA Thunder Bay, says she doesn’t supervise Linda or any of her volunteers who have a mental illness any differently from those who don’t. “We always come with sensitivity and support, no matter what difficulties the volunteer may be facing. Our volunteers

come from all walks of life with different issues and challenges.” She says that accommodating volunteers is part of the job, regardless of the reason for the accommodation. Sometimes volunteers need to take a break, because of a setback in their illness or other reasons unrelated to mental illness.

She says that volunteer managers who don’t have an understanding of mental illness may make fear-based decisions. “We really don’t focus on the diagnosis, but focus on the person, getting to know them as a human being for who they are, and not being so stuck on labels.”

Susan Roach agrees. She is the program manager at the Haldimand-Norfolk Resource Centre, where she works with eight staff members and manages 45 volunteers. Every staff member and volunteer at the centre has a mental illness, and all staff are former volunteers. She says that the illness is secondary to “who the person is.”

She chuckles when asked about challenges she faces in managing volunteers with mental illness. It’s not lack of skill, commitment, interest or reliability, but lack of self-confidence that she identifies as her biggest management challenge. “Helping the volunteers have

“Our volunteers exhibit a real sense of commitment, resulting in improved marketable skills and an increase in self-esteem and confidence. It truly is a pleasure to include volunteers on our team and see such wonderful results.”

Jean Montgomery, program coordinator,
CMHA Haldimand-Norfolk Branch



"VOLUNTEERING WORKED FOR ME KIND OF LIKE MEDICATION. IT GAVE ME SO MUCH PURPOSE AND HOPE AND IT KEPT MY SPIRITS UP, SO THAT I COULD WORK ON MY UNDERLYING ISSUES IN THERAPY."
LINDA STEWARDSON, CMHA VOLUNTEER

the same faith in themselves that I do, helping them overcome their fear and gain self-esteem — helping them make the great stride outward to try new things. I feel like a cheerleader, saying, "You can do it!"

When volunteers at the Haldimand-Norfolk Resource Centre grow in con-

fidence and start looking beyond what the resource centre can offer, Susan faces another challenge. Successful volunteers who have a tremendous amount of skill and dedication need to move out into the world — a world full of stigma and misunderstanding about mental illness, where they may face powerful external barriers to recruitment. "Fortunately, we have helped some of our volunteers go on to other organizations like hospitals and residences for seniors," Susan says proudly. "But," she continues, "sometimes the results of a police record check [which may flag apprehensions under the *Mental Health Act* or other illness-related contacts with the police] can make this needlessly difficult, and both the volunteer and the organization can lose out." [For more information about police record checks, see "Information of Concern" on page 17.]

What do volunteers with mental illness need? Nothing special, according to Vincent. He's 26 years old, has obsessive-compulsive disorder, and volunteers at his local CMHA in the public education program "Kids on the Block." Since joining the program

three years ago, he has been promoted to coordinator and handles scheduling, customer service, and volunteer management, as well as taking on other duties at the CMHA branch office. Among all the volunteers in his city, Vincent was awarded the Mayor's Award for Volunteerism in 2005 — not because he has a mental illness, but because he's a great volunteer.

What workplace accommodations does he need? "Well, I just take longer to do some things," Vincent explains. "I have some rituals. I check a lot. Anyone looking at me wouldn't know that I do this. I've never had to ask for more time, and it's never been a problem. I always get my tasks done."

In fact, Vincent thinks that having a mental illness has contributed to his volunteering success. "There are a lot of skills that you learn when you have a mental illness, and those skills can be put into your job and the way you work in an organization. For example, pacing yourself. When you have a mental illness, you learn how to pace yourself, like when you need to slow down." Volunteers who have self-awareness and can independently

The key is not focusing on the volunteer's illness, but rather "getting to know the person first, and everything else becomes secondary. If we get caught up in the illness, we often lose sight of the person."

Susan Roach,
Haldimand Norfolk
Resource Centre

Tips for Managing Volunteers

VOLUNTEER COORDINATORS AT NON-PROFIT ORGANIZATIONS WHO DON'T HAVE A BACKGROUND IN MENTAL HEALTH MAY FEEL ILL-EQUIPPED TO DEAL WITH VOLUNTEERS WHO DISPLAY SIGNS OF MENTAL HEALTH PROBLEMS. AS WITH ANY EMPLOYMENT SITUATION, IT IS THE MANAGER'S RESPONSIBILITY TO ADDRESS ISSUES PROMPTLY AND PROFESSIONALLY. BUT HOW?

CMHA's Mental Health Works program helps managers in the workplace to address employee mental health issues, and volunteer managers can use the same approach.

Mental Health Works strategy:

1. I notice...
2. I'm concerned...
3. Let's focus on solutions.

To overcome communication barriers: Use observational, neutral statements. Show that you care about your volunteer. Explain the problem and why it's an issue. Offer help and/or accommodation. Stay focused on solutions.

For more information about Mental Health Works, visit

www.mentalhealthworks.ca

pace themselves make the coordinator's job a whole lot easier — especially important when coordinators are often strapped for time and resources, doing a full-time job in part-time hours.

Susan Roach enjoys describing the success stories of the eight staff at the Haldimand-Norfolk Resource Centre who have moved from volunteering to paid employment. Volunteer coordinators without a background in mental health may expect people with mental illness to be unreliable. Susan disputes this perception. "Absenteeism among our staff is remarkably low. We've had maybe three missed shifts in a year and a half." Her volunteers, too, demonstrate remarkable commitment to their work. She says that the key is not focusing on the volunteer's illness, but rather "getting to know the person first, and everything else becomes secondary. If we get caught up in the illness, we often lose sight of the person."

Regarding behavioural issues, Susan responds to volunteers with mental illness "the same as I did when I worked outside the mental health environment. I hold people responsible for their behaviour, whether they have an illness

or not, and I would expect the same for me, even though I have an illness." Susan applies an approach similar to the Mental Health Works strategy (see "Tips for Managing Volunteers"). She adds, "We won't set someone up to fail, and we also won't let them off the hook. Most of the time through conversation we discover that the task was a bad match," a possible pitfall for any volunteer placement.

Jean Montgomery, program coordinator at CMHA Haldimand-Norfolk Branch, which shares space at the resource centre, sums up her branch's experience: "Our volunteers exhibit a real sense of commitment, resulting in improved marketable skills and an increase in self-esteem and confidence. It truly is a pleasure to include volunteers on our team and see such wonderful results."

Through volunteering, people who have a mental illness can make that great stride outward from isolation and hopelessness toward connection and accomplishment. By looking outward, and making the great stride toward people with mental health issues, volunteer recruiters can enhance their



"THERE ARE A LOT OF SKILLS THAT YOU LEARN WHEN YOU HAVE A MENTAL ILLNESS, AND THOSE SKILLS CAN BE PUT INTO YOUR JOB AND THE WAY YOU WORK IN AN ORGANIZATION."
VINCENT, CMHA VOLUNTEER AND WINNER OF THE MAYOR'S AWARD FOR VOLUNTEERISM

organization by increasing diversity, filling their volunteer positions, and, most of all, gaining highly dedicated and skilled volunteers.

Donna Hardaker is a community mental health analyst with CMHA Ontario.

Did You Know...?

UNDER THE ONTARIO HUMAN RIGHTS CODE, "EMPLOYMENT" REFERS TO FULL-TIME EMPLOYEES, TEMPORARY AND CASUAL STAFF, CONTRACT WORKERS, MEDICAL AND PERSONAL ATTENDANTS, AND VOLUNTEERS.

Volunteers have the same right to freedom from discrimination in the workplace as paid employees. Disability, including mental illness, is one of the prohibited grounds of discrimination. This means that throughout the recruitment, hiring, training and termination process, organizations must provide reasonable accommodation to volunteers with disabilities when required to help a volunteer do the job. Accommodations are "reasonable" so long as they don't impose "undue hardships" on the employer.

Most accommodations for people with mental illness are easy to implement, inexpensive, and demonstrate a commitment to a healthier, more equitable workplace. They usually involve flexibility with scheduling or adapting of tasks. For volunteers who have physical disabilities, the cost of special equipment or workplace assists may be difficult to fit in to the ever-tightening budgets of non-profit organizations. However, before an organization can claim undue hardship, it is expected to seek outside sources of funding.

"We always come with sensitivity and support, no matter what difficulties the volunteer may be facing. Our volunteers come from all walks of life with different issues and challenges."

Shelley Nummikoski,
CMHA Thunder Bay Branch

THE GOLD STANDARD

By Michelle Gold



Family P L A N N I N G

Families are often an essential support and system navigator for loved ones with a mental illness. The Canadian Mental Health Association's *A Framework for Support* recognizes families as one of the pillars of support for persons with a mental illness.¹ Similarly, the vision for *recovery* asserts that the formal service system does not hold the key to assuring consumers live a satisfying and hopeful life. Consumers do. Recovery can be facilitated through consumers' natural supports and this includes their families. There is currently a call to establish standards for a recovery-oriented mental health system and this includes having families involved in collaborating, planning and monitoring the formal service system.²

Given the important role of families, one might presuppose that Local Health Integration Networks (LHINs) would include these key stakeholders in planning for an integrated and effective mental health system. However, there is in fact wide variation in the practices of the 14 LHINs to specifically engage families.

Ontario is moving ahead with LHINs, a "made-in-Ontario" solution that devolves the planning, funding, and monitoring of health services to the regional level. While each LHIN is governed by a community board and managed by a small professional staff,

a key strategy for LHINs to achieve their objectives — to enhance system integration and promote efficiencies to sustain Ontario's publicly funded health system — is through community engagement. Delegating these activities to the local level is intended to enable those who live and work in a community, and who know it best, to be "engaged" in the process. Families are among those who need to be at the planning table in every LHIN.

The new *Local Health System Integration Act, 2006*, provides minimal direction as to the scope and methods of community engagement. Consequently, each of the 14 LHINs in Ontario has developed its own community engagement framework. Most of these frameworks broadly define the community as the public, users, health service providers, interest groups and funders. Who to engage, and how, will be determined by the needs of each LHIN in order to carry out its work. LHINs have recently completed their first round of "relationship building" with communities of interest and are now focused on completing their integrated health services plans (IHSPs). Mental health services should figure prominently in the IHSPs.

Australia is considered an early adopter in setting policy directions for consumer

and family involvement. In 1992, their national mental health strategy directed that national, provincial and local levels involve consumers and families in planning to promote an effective mental health system. A review of the implementation of this policy found that while there were increasing opportunities for consumer involvement, caregiver involvement has been less significant.³ As a result, Australia's new National Mental Health Plan 2003-2008 gives more specific direction to decision-makers in the health system for involving families in meaningful participation.⁴ These directions include defining the need for formal structures to support family participation, providing support and training to families to strengthen their capacity to participate, placing the onus on decision-makers to demonstrate that meaningful participation has occurred, and evidencing outcomes arising from enhanced participation.

The province of Manitoba has recently developed a "Family Member and Natural Support Participation in Mental Health Service Planning, Implementation and Evaluation" policy, which directs regional health authorities to create detailed plans on how they will engage families in planning and evaluating the mental health system.⁵ This is not about generic

community engagement. Specific directions include involving family members in creating the family participation policy itself, specifying the communication strategies that will be utilized to inform family members of participation opportunities, identifying resources to be provided to enable effective family participation, and creating and publicizing a formal complaints mechanism to deal with problems with the experience or opportunities for participation itself.

Ontario LHINs must develop policies for meaningful family, as well as consumer, involvement in planning and monitoring the mental health system. It appears the LHINs should be open to this discussion, as evaluation of their community engagement activities has been promised. The dialogue should be about moving the LHINs from principles of community engagement to standards for meaningful consumer and family involvement.

Family members need to take action. I encourage families to locate their LHIN, familiarize themselves with the role of

LHINs, and identify opportunities to influence the health system. Ask that the discussion move beyond utilizing generic public participation models to a recovery-oriented approach to mental health reform.

In a previous column, I wrote about key elements for meaningful engagement of mental health consumers and families by LHINs, and that article may offer useful approaches to bring to the table.⁶ There will soon be a new report on the role, needs and opportunities to involve families in the mental health and addic-

tion sector, which should provide useful information to bring to the discussion. CMHA Ontario is a partner in preparing this report and it will be available on our website.

To contact your LHIN, go to www.lhins.on.ca or call the Ministry of Health and Long-Term Care information line at 1-800-268-1154.

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

Endnotes

1. Trainor, J., Pomeroy, E., and Pape, B. (2004). A Framework for Support. Third Edition. Canadian Mental Health Association. http://www.cmha.ca/data/1/rec_docs/120_Framework3rdEd_Eng.pdf
2. Anthony, W.A. (2000). A Recovery-Oriented Service System: Setting Some System Level Standards. *Psychiatric Rehabilitation Journal*. 24(2): 159-168.
3. Lammers, J., and Happell, B. (2004). Mental Health Reforms and Their Impact on Consumer and Carer Participation: A Perspective from Victoria, Australia. *Issues in Mental Health Nursing*. 25(3): 261-276.
4. Australian Health Ministers. National Mental Health Plan 2003–2008. Canberra: Australian Government, 2003. [http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/mental-pubs/\\$FILE/nmhp0308.pdf](http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/mental-pubs/$FILE/nmhp0308.pdf)
5. Manitoba Health. (2005). Family Member and Natural Support Participation in Mental Health Service Planning, Implementation and Evaluation. Policy HCS-210.3. <http://www.gov.mb.ca/health/mh/familymember.pdf>
6. Canadian Mental Health Association. (2005). Rules of Engagement. *Network* 21(2): 20-22. http://www.ontario.cmha.ca/includes/collection/collection_page.asp?clD=6135

CALENDAR

October 1-7, 2006 Mental Illness Awareness Week. Coordinated by the Canadian Alliance on Mental Illness and Mental Health. www.miaaw.ca.

October 10, 2006 World Mental Health Day. Building Awareness — Reducing Risks: Suicide and Mental Illness. Organized by the World Federation for Mental Health. www.wfmh.org.

October 25-27, 2006 Complexity of Suicide: Prevention, Intervention and Aftermath. Canadian Association for Suicide Prevention annual conference. Toronto, Ontario. 416-978-2719, ce.med@utoronto.ca, www.suicideconference2006.ca.

October 27, 2006 Culture, Spirituality and Mental Health: Accessing, Diagnosing and Treating Mental Illness in a Multicultural Society. Organized by Healthcare Conferences Canada Inc. Toronto, Ontario. 416-444-8455, careconference@rogers.com, www.careconferences.com.

October 29-31, 2006 Psychiatrists in Blue: Emerging Partnerships. Fifth annual conference of the Canadian National Committee for Police/Mental Health Liaison. Ottawa, Ontario. 613-233-1106 www.pmh.ca.

November 5-8, 2006 Making Gains in Mental Health and Addictions. Fourth annual joint conference of Addictions Ontario, Canadian Mental Health Association, Ontario, Centre for Addiction and Mental Health, and Ontario Federation of Community Mental Health and Addiction Programs. Toronto, Ontario. 705-454-8107, rachelandassoc@xplornet.com, www.makinggains.ca.

November 6-8, 2006 Alzheimer Research and Innovation: Yesterday, Today, Tomorrow. Twenty-eighth national conference of the Alzheimer Society of Canada. Toronto, Ontario. 416-595-1414, conference2006@alzheimer.ca, www.alzheimer.ca.

November 9-12, 2006 Psychiatry in the Next Decade: Our Future and Legacy. Fifty-ninth annual conference of the Canadian Psychiatric Association. Toronto, Ontario. 613-234-2815, ext. 242, conference@cpa-apc.org, www.cpa-apc.org.

November 16-17, 2006 Unique Challenges, Creative Solutions: Human Resource Answers for a Diverse Workplace. Conference of the Canadian Association for Supported Employment. Toronto, Ontario. 403-283-0611, info@supportedemployment.ca, www.supportedemployment.ca.

November 16-17, 2006 International Recovery Perspectives: Implications, Innovations, Implementation. Conference organized by Community Resource Connections of Toronto, Alternatives and the Family Outreach and Response Program. Toronto, Ontario. 416-285-7996, ext. 227, bmckinnon@iprimus.ca, www.crct.org.

November 27-28, 2006 Policy, Partners and Practice: From Evidence to Action. Children's Mental Health Ontario conference. Toronto, Ontario. 905-335-7993, janice@mmsonline.ca, www.kidsmentalhealth.ca.

> FOR COMPLETE CALENDAR LISTINGS, VISIT WWW.ONTARIO.CMHA.CA/EVENTS

Gateway to West
George Scott
Acrylic and canvas

Creative Works Studio

2007 Calendar

"Works of Transcendence" is a high-quality, professionally designed calendar featuring artwork by members of the Creative Works Studio. Proceeds from the sale of calendars go directly back to the studio to support its vocational, skill development and artistic initiatives for people living with long-term mental health issues.

To order your own calendar for \$15, contact Creative Works Studio at 416-465-5711.

www.creativeworks-studio.ca

creative
works studio

Images from a Community Art and Development Program

ST. MICHAEL'S HOSPITAL INNER CITY HEALTH PROGRAM IN PARTNERSHIP WITH JVS TORONTO

WORKS OF
TRANSCENDENCE
2007 CALENDAR

All proceeds go directly back to the Creative Works Studio, a non-profit program.

WE HOPE YOU
HAVE ENJOYED
THIS ISSUE OF
NETWORK MAGAZINE.

YOU CAN SUPPORT THIS PUBLICATION AND OTHER PROGRAMS AT CMHA ONTARIO BY MAKING A CHARITABLE DONATION TODAY.

PLEASE CALL 1-800-875-6213 EXT. 4138
OR VISIT OUR WEBSITE AT
WWW.ONTARIO.CMHA.CA/DONATE

CANADA POST PUBLICATIONS MAIL AGREEMENT #40006769

network

Fall 2006 VOL. 22 NO. 2



CANADIAN MENTAL
HEALTH ASSOCIATION, ONTARIO
ASSOCIATION CANADIENNE
POUR LA SANTÉ MENTALE, ONTARIO

180 DUNDAS STREET WEST, SUITE 2301
TORONTO, ONTARIO M5G 1Z8

PHYSICIANS: PLEASE PLACE IN YOUR PATIENT WAITING ROOMS.